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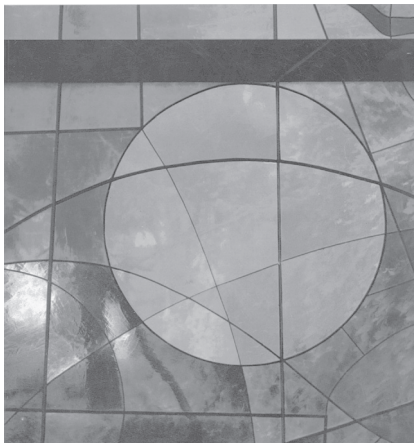
for Health Care Workers

The Hospital, Setting for Evangelisation: a Human and Spiritual Mission

15-16-17 November 2012

New Synod Hall
Vatican City



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15-16-17 November 2012

New Synod Hall
Vatican City

Meeting of Reflection and Prayer of Health-Care Workers with the Holy Father on the Occasion of the Year of Faith at the End of the XXVII International Conference

17 NOVEMBER 2012 • PAUL VI HALL

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Introduction

H.E. MSGR.
ZYGMUNT ZIMOWSKI
President of the
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Your Eminences, Your Most Reverend Excellencies, dear priests, men and women religious. I am very happy to greet the organisers of, and those taking part in, these two important events: the joint congress of Italian and European Catholic doctors on 'Bioethics and Christian Europe' (which is currently underway) and those taking part in the XXVII international conference, which had just ended, on the subject: 'Hospitals as Settings for Evangelisation: their Human and Spiritual Mission'.

I also greet most cordially the various organisations that dedicate themselves to the sick and the suffering, and in a special way the UNITALSI.

Dear sick people, thank you for your presence!

We now want to prepare ourselves spiritually for the meeting with the Holy Father on the occasion of the 'Year of Faith' in order to be true evangelisers, because of our baptism.

One of the most moving moments during the pilgrimage of the Holy Father the Blessed John Paul II in Poland in 1979 was when he knelt down in front of the baptismal font in the parish church of Wadowice.

At the beginning of his Petrine ministry, the Pope returned to the place where his personal journey of faith had begun. He returned to the moment when his parents took him to church so that through the door of Holy Baptism he would be introduced into the great communion of the children of God. The Pope returned to the sources. There is something extraordinary in that image of the Bishop of Rome kneeling in front of a simple, old, baptismal font.

During this Year of Faith it is suitable to reflect on the meaning of the sacrament of baptism and to bring to our minds the baptismal font of our parish churches where our journeys of faith began, our drawing near to the community of believers. At the same time I want to thank God for our parents and for the parish communities where our faith matured.

On Sunday 16 October 2011 the Holy Father Benedict XVI celebrated the Holy Mass for the New Evangelisation. During his homily he spoke the following important words: 'Precisely in order to give a fresh impetus to the mission of the whole Church to lead human beings out of the wilderness in which they often find themselves to the place of life, friendship with Christ that gives us life in fullness, I have decid-

ed to proclaim a "Year of Faith", which I shall have the opportunity to illustrate with a special Apostolic Letter'.

The apostolic letter *Porta Fidei* of Benedict XVI helps us to understand better the reasons for his Year of Faith. 'Only through believing…does faith grow and become stronger'[1] and thus faith must be explored and thought about anew. Today the task of the Church is the new evangelisation, which is possible only when, on the one hand, we are able to justify the credibility of what we believe in, and, on the other, we are credible witnesses though the example of the Christian life. The Pope emphasises the importance of the liturgy and the sacraments: 'Without the liturgy and the sacraments, the profession of faith would lack efficacy, because it would lack the grace which supports Christian witness. By the same criterion, the teaching of the *Catechism* on the moral life acquires its full meaning if placed in relationship with faith, liturgy and prayer'.[2]

Faith without charity does not bear fruit. Benedict XVI writes in this document: '"As you did it to one of the least of these my brethren, you did it to me" (*Mt* 25:40). These words are a warning that must not be forgotten and a perennial invitation to return the love by which he takes care of us. It is faith that enables us to recognize Christ and it is his love that impels us to assist him whenever he becomes our neighbour along the journey of life'.[3]

The meeting of Jesus with the Samaritan woman at Jacob's well is the beginning of a wish for faith: 'The people of today can still experience the need to go to the well, like the Samaritan woman, in order to hear Jesus, who invites us to believe in him and to draw upon the source of living water welling up within him (cf. *Jn* 4:14)', writes the Holy Father in his Motu Proprio *Porta Fidei*, 'We must rediscover a taste for feeding ourselves on the word of God, faithfully handed down by the Church, and on the bread of life, offered as sustenance for his disciples (cf. *Jn* 6:51)'.[4] Thanks to that meeting in the heart of that woman the seed began to sprout, the seed that grew and led the Samaritan woman to be a witness to faith: "Come and see the man who told me everything I have ever done, could he be the Messiah?"[5] How much the life of this woman changed after this conversion! We can meet Jesus Christ in prayer: 'The wonder of prayer is revealed beside the well where we come seeking water: there, Christ comes to meet every human being. It is he who first seeks us and asks us for a drink…Paradoxically our prayer of petition is a response to the plea of the living God: 'They have forsaken me, the fountain of living waters and hewn cisterns for themselves, broken cisterns that can hold no water!' (Jer 2:13). Prayer is the response of faith to the free promise of salvation and also a response of love to the thirst of the only Son of God'.[6]

The Year of Faith must also be used to return to the spring of living water, that is to say to baptismal water.

We could in the end ask ourselves: what is the purpose of prayer? The answer cannot be given in terms of human utility or efficacy but in terms of gratuitousness and of life, of gift and of service. Prayer is to *be more: to be new men*. In addition, prayer acts to *give more: to be the servants of life*. To be and to give: this is the yardstick of authentic prayer, measured by the person of Christ and the needs of friendship and total giving of life: 'For even the Son of Man did not come to be served; he came to serve'.[7] It is precisely in prayer that one learns to receive the gift of God so as to become, we as well, gift for others, to receive the transformation that enables us to love more and to serve better.

Let us remember the words spoken by the priest during our baptism: 'This is our faith. This is the faith of the Church. We are proud to profess it in Jesus Christ our Lord'!

Notes

[1] Benedict XVI, apostolic letter, *Motu Proprio 'Porta Fidei'*, 11 October 2011, n. 7.
[2] Benedict XVI, apostolic letter, *Motu Proprio 'Porta Fidei'*, 11 October 2011, n. 11.
[3] Benedict XVI, apostolic letter, *Motu Proprio 'Porta Fidei'*, 11 October 2011, n. 14.
[4] Benedict XVI, apostolic letter, *Motu Proprio 'Porta Fidei'*, 11 October 2011, n. 3.
[5] Cf. Jn. 4: 29.
[6] *Catechism of the Catholic Church*, 'Prayer in the Christian Faith', nn. 2560-2561.
[7] Cf. Mk 10:45.

Meditation

H. EM. CARDINAL ANGELO COMASTRI
Archpriest of the Papal Basilica of St. Peter in the Vatican, Vicar General of His Holiness for the State of the Vatican City

1. The Polish writer H. Sinkiewicz (1846-1916) bequeathed to us a moving historical novel entitled 'Quo Vadis?'. In this work, which is set at the time of the ferocious persecution carried out by Nero, the author imagines a conversation between a Roman officer, called Vinicius, and the Apostle Peter who has arrived in Rome from far away Galilee. The Roman officer only knows about Christianity through being with a young Christian woman called Lucia, with whom he is in love. But Vinicius is bemused by the novelty and the simplicity of the Christian message and asks the Apostle Peter for his help in understanding it.

"The Greeks", observes the Roman officer, "brought philosophy to the world and this is a merit that will remain for ever. The Romans brought to the world law and the organisation of the State: this is also an extraordinary fact, it is before everyone's eyes. But you Christians", he asks, "you Christians, what have you brought that is new to the world?"

Peter, according to the narrative of Sinkiewicz, listens carefully to the Roman officer and then without any hesitation answers him: "We Christians bring Love to the world! We bring the greatest and most revolutionary news, which is this: God is Love!"

Perhaps, today, we have somewhat lost awareness of how much this news is sensational and of the consequences that it has for our lives.

Blaise Pascal, that great and fervent Christian thinker, in one of his famous *pensées* writes: 'Many people find reason to curse the Christian religion because they are ill-informed about it. They imagine that it involves simply worship of a God who is seen as great, powerful and eternal; and this is precisely deism (the religion of philosophers) which is as distant from the Christian religion as atheism is, which is its complete opposite. The God of Christians is not a God who is simply the author of geometrical truths and the order of the elements…the God of Abraham, the God of Isaac, the God of Jacob; the God of Christians is a God of Love and of consolation, He is a God who fills the souls and the hearts of those whom He has taken possession of; He is a God who makes everyone feel, internally, their own misery and His infinite mercy'.

These are sacrosanct affirmations and ones that are evangelically true. Indeed, the news that God is Love, which is the 'Good News, that is to say the Gospel itself – this news upsets the ranking of values used amongst men and offers a key by which to read the events of human history in a completely new way.

The English journalist Malcolm Muggeridge, after going to the 'Home of the Immaculate Heart', and having met Mother Teresa of Calcutta amongst her poor people on a number of occasions, exclaimed: "the revolution of Christianity is here in its entirety: charity is worth more than all learning". This famous journalist of the BBC remembered Mother Teresa speaking the following words: "When we die, we will take with us just one suitcase: the suitcase of charity. Everything else will not go beyond even the threshold of the cemetery".

And Anthony Frederick Ozanum could rightly say: 'What we give is only truly ours: indeed what we give will remain ours for eternity, whereas everything else we rent for a very short period of time'.

For this reason the Apostle Paul, with full legitimacy, came to formulate certain assertions that are truly shaking. Well aware that revelation of the omnipotence of God as omnipotence of love imposes a total revision of the scale of values, he was to write: 'If I speak in human and angelic tongues, that is to say that I had all imaginable leaning, but do not have love, I am a resounding gong or a clashing cymbal that lasts for a few seconds and then falls into silence as though nothing had happened. And if I have the gift of prophecy and comprehend all mysteries, that is to say even if I had degrees from the most famous Church universities, but do not have love, I am nothing: an absolute zero'.

Why are these statements legitimate in Christian terms? Let us keep the question and slowly arrive at an answer.

2. During the month of September of the year 1896, exactly one year after her death which took place at the youthful age of twenty-four, Therese de Lisieux, by order of the Prioress of the Carmel, wrote the second 'little notebook' of the memoirs of her life.

She narrated that at a certain moment of her short existence she had experienced a terrible identity crisis. Strong opposing feelings boiled in her heat: she thought that to be a saint one had to tread all the pathways of heroism. She thus desired to be a Carmelite hidden from the eyes of the world but at the same time she wanted to be an apostle and missionary of the Gospel in all the corners of the earth. She wanted to be a priest and thought with how much love she would have welcomed Jesus in her hands and would have given him to souls. But at the same time she wished not to be a priest, following the example of St. Francis, who 'refused the sublime dignity of the priesthood'. The young Carmelite religious suffered and it seemed to her that the wind of desires for holiness had gone mad inside her soul. She

wrote: 'During prayer my wishes made me suffer a real martyrdom'. But specifically in prayer God offered light and peace to the heart of Therese. Indeed, when reading the Letters of St. Paul she came across chapter XII of the First Letter to the Corinthians. There the Apostle explains that the Church is the mystic body of Christ and that in this body there are many members and all of them are required for the life of that body. Therese wrote down in her diary: 'The answer was clear but it did not meet my wishes and it did not give me peace. Just as Mary Magdalene when bending over the empty tomb ended up by finding what she was looking for, so I myself, in lowering myself to the depths of my emptiness, rose so high that I was able to achieve my purpose'.

Indeed, when reading the Hymn to Charity of the Apostle Paul, Therese understood that charity is the indispensable point of departure and the ineluctable point of arrival of all vocations: and thus, in living charity, all vocations encounter each other.

With these splendid words Therese confided her wonderful discovery: 'Charity has given me the key to my vocation. I understood that if the Church has a body made up of different members then the most necessary organ, the noblest of all, is not absent from her; I understood that the Church has a heart and that this heat burns with love. I understood that only love makes the members of the Church act; that if love were to go out, the Apostles would no longer proclaim the Gospel; and martyrs would refuse to shed their blood. I understood that love includes all vocations. Then, in the excess of my delirious joy, I exclaimed: "Jesus, my love, I have finally found my vocation: my vocation is love! Yes, I have found my place in the Church and this place, my God, you gave me! In the heart of the Church, my Mother, I will be Love. Thus I will be everything! That is to say I will thus live all vocations, because the soul of all vocations is love".

It is incumbent upon me at this point to pose a question: why did Therese de Lisieux find peace in her discovery that love is the spring and the completion of all vocations in the Church? Is the heart of Christianity truly to be found here?

3. Let us go to the Gospel. The Evangelists, in agreement with each other, tell us that Jesus amazed his contemporaries with his goodness: a 360 degree goodness, which was limitless, disarming, gratuitous, ready to take the first step. At a certain point some people began to murmur. The Evangelist Luke tells us: 'The tax collectors and sinners were all drawing near [the verb in the imperfect indicates a habitual action] to listen to him, but the Pharisees and scribes began to complain, saying, "This man welcomes sinners and eats with them."' The Greek text translated literally reads: "This man leans towards the sinners and eats with them". And they were scandalised. 'So to them he addressed this parable. "What man among you having a hundred sheep and losing one of them would not leave the ninety-nine in the desert and go after the lost one until he finds it? And when he does find it, he sets it on his shoulders with great joy and, upon his arrival home, he calls together his friends and neighbours and says to them, 'Rejoice with me because I have found my lost sheep'"" (Lk 15:1-6).

It is evident that Jesus told this parable with the precise intention of correcting the idea of God that his listeners and denigrators had in their minds. Jesus first of all says: but you, when you lose a sheep, would you not leave the other ninety-nine in the sheepfold to look for the one that was lost?

This question surprises us somewhat. We would be at peace with the ninety-nine sheep in the sheepfold and send the lost sheep to the devil. But God's behaviour is different – divinely different!

And with refined delicacy, Jesus employs the radiant figure of the shepherd who, carrying the wounded and tired sheep on his shoulders, returns to the sheepfold after an unending say of searching. At this point he engages in a leap of thought which reveals his precise intentions. He says: "I tell you, in just the same way there will be more joy in heaven over one sinner [the Greek text lays emphasis on this particular point – over one sinner] who repents than over ninety-nine righteous people who have no need of repentance" (Lk 15:7).

Jesus, therefore, is speaking about heaven: but heaven is God! He, evidently enough, wants to correct those who are scandalised by the revelation of the unheard-of goodness of the Father that they perceive through the various actions of His person. And he wants to invite those who are scandalised to realise that God is totally different from how they imagined Him: God is infinitely *more good*!

And for this reason God would like to save everyone (not only ninety-nine sheep but all hundred of them), He would like to embrace everyone, grasp everyone to His heart in order to fill them with His joy. But man is free, man can reject, he can refuse Love and exclude himself from Love: but God remains tirelessly and faithfully Love.

The possibility of getting lost, therefore, lies in the mystery of human freedom and not in the limits of divine mercy. Let this be clear,

Let us follow Jesus again. At the Last Supper, with an unheard-of gesture, he further reveals the mystery hidden in the heart of God. He gets up from the table and sets himself to washing the feet of the Apostles. Note this: amongst the Apostles there was a traitor, there was the man who was going to deny him and the others were to flee during the hour of the Passion. Jesus had every right to say: "ungrateful worms, go away, go far away from me!"

Instead, he washes their feet so as to say unequivocally that God loves us not because we are good but because He is good: and His goodness is a challenge that provokes us and constantly knocks at our door. If we open our hearts, we are saved and God celebrates the return of one of His children.

And when the goodness of God finds hospitality in our hearts, a wonder takes place: those who

draw near to us perceive a mysterious Presence and perceive, without knowing this, a wind from heaven, which leaves those who do not believe, as well, thoughtful.

The Servant of God Paul VI turned to his friend Giuseppe Prezzolini, a non-believer, to have advice about the best ways "to enter into dialogue with those who were distant" in order to "make the Church credible for contemporaries". "Holiness", replied the Tuscan writer, "there is only one way. The men of the Church must be above all else good and have one purpose alone: to create good men. There is nothing that attracts like goodness because there is nothing else that we non-believers are so deprived of. The world is full of intelligent people: what is absent is good people. Forming them is the task of the Church: to re-attract men to the Gospel, everything else is secondary".

4. But how is it possible to open hearts to the flood of the goodness of God? What makes possible the encounter between our misery and the infinite Love of God? We are given the answer by the Gospel of the two blind men who, sitting by the side of the road, are the image of the poverty of the whole of mankind, and of our poverty as well.

The Blessed John XXXIII, when visiting the 'Bambino Gesù' Hospital on the occasion of Holy Christmas of the year 1958, drew near to the bed of a child who spontaneously reached out his arms to him and declared: "Pope John, I can hear that you are here, but I cannot see you…because I am blind!" The Pope caressed the child and with a start of Christian wisdom said to him in a low voice: "My child, we are all a little blind!" And he lowered his eyes so as not to show that he was weeping. "We are all a little blind!"

To encounter the Lord and His mercy we need humility: humility that is knowledge of our limits, awareness of our radical poverty, awareness of our blindness, and awareness that we all need to be saved.

The blind men of Jericho opened themselves to Jesus through the humility of a petition: "Lord, have pity upon us!" It was at that moment that there begun their healing: it began to start from their souls which were immersed in humility. The miracle of the healing of the blind was only a confirmation of this.

Blaise Pascal acutely observed: 'The last step of reason is to recognise that there is an infinity of things that go beyond it: it is weak if it does not manage to know this'. And Mother Teresa of Calcutta added: 'Humility is the most intelligent virtue because it throws us into the arms of Truth and of Charity'. For this reason, humility is indispensable not only to encounter to God but also to encounter our brethren: the person of pride is alone, dramatically alone, and is incapable of fraternity, because pride is a wall that separates you from everyone: from God and from men. On this point I would like to relate to you an episode that is truly illuminating.

Msgr. Loris Capovilla, who was the secretary of the Blessed John XXIII, confided to me what happened on the same day as the election of that Pope. When John XXIII went onto the balcony of St. Peter's Basilica for the first 'Urbi et Orbi' blessing he tried to see the people who thronged the square: he heard their voices but he could not see them because the floodlights of the various television channels prevented him from seeing beyond them.

At the end of the ceremony the Pope left the balcony and went into the Hall of Blessings. He stopped and declared: "The strong lights prevented me from seeing the people. I have learnt a lesson: if I want to see the faces of my brethren, the lights of pride must always be turned off".

To end, I hope that you will have such hearts: in this way you will truly be able to bend down before the others and you will also be transparent and thus allow the Light of God and the Love of God to pass through you. And thus you will see very many people healed: certainly in their souls, and, God willing, in their bodies as well. ■

Address of His Holiness Benedict XVI

Your Eminences,
Venerable Brothers in the Episcopate and in the Priesthood,
Dear Brothers and Sisters,

I offer you a warm welcome! I thank the President of the Pontifical Council for Health Care Workers, (Health Pastoral Care), Archbishop Zygmunt Zimowski, for his courteous words; I greet the distinguished speakers and all those present. The theme of your Conference – "The Hospital, a Place of Evangelization: a Human and Spiritual Mission" – gives me an opportunity to extend my Greeting to all the health-care workers, and in particular to the members of the Italian Catholic Doctors' Association and of the European Federation of Catholic Medical Associations, which has examined the subject "Bioethics and Christian Europe" at the Catholic University of the Sacred Heart in Rome. I also greet the sick people present, their relatives, the chaplains and the volunteers, the members of the associations, and in particular of the Italian National Union for the Transport of the Sick to Lourdes and International Shrines (UNITALSI), the students at the Faculties of Medicine and Surgery and those who are taking degree courses in the health-care professions.

The Church always turns with the same brotherly spirit of sharing to all who are suffering, enlivened by the Spirit of the One who, with the power of love has restored meaning and dignity to the mystery of suffering. The Second Vatican Council said to these people "know that you are not... abandoned or useless" (cf. *Message to the Poor, the Sick and the Suffering*, 8 December 1965).

And in these same tones of hope, the Church also reassures health-care professionals and volunteers. Yours is a special vocation that requires study, sensitivity and experience. Nevertheless, a further skill which goes beyond academic qualifications is demanded of those who choose to work in the world of suffering, living their work as a "human and spiritual mission". It is "the Christian science of suffering", explicitly pointed out by the Council as "the only one that can respond to the mystery of suffering" and of bringing to the sick "relief without illusion". The Council says: "it is not within our power to bring you bodily help nor the lessening of your physical sufferings.... But we have something deeper and more valuable to give you.... Christ did not do away with suffering. He did not even wish to unveil to us entirely the mystery of suffering. He took suffering upon Himself and this is enough to make you understand all its value" (*ibid.*). May you be qualified experts in this "Christian science of suffering"! Your being Catholics, without fear, gives you a greater responsibility in the context of society and of the Church: it is a real vocation, as has recently been witnessed by exemplary figures such as St Giuseppe Moscati, St Riccardo Pampuri, St Gianna Beretta Molla, St Anna Schäffer and the Servant of God Jérôme Lejeune.

This is also a commitment of the New Evangelization in the times of an economic crisis that are cutting funds for health care. In this very context hospitals and structures for assistance must rethink their role to prevent health, first and foremost a universal good to be guaranteed and defended from becoming a mere "product" subjected to the laws of the market, hence accessible to few. The special attention owed to the dignity of the suffering can never be forgotten, applying also in the

context of health-care policies the principles of subsidiarity and solidarity (cf. Encyclical *Caritas in Veritate*, n. 58).

Today, although on the one hand because of the progress in technology and science the ability to heal the sick physically is increasing, on the other, the ability to "care for" the patient, seen in his integrity and uniqueness, appears to be weakening. Thus the ethical horizons of medical science that risks forgetting that its vocation is to serve every person and the whole person, in the various phases of his or her life, seem to be dulled. It is to be hoped that the language of the "Christian science of suffering" – to which belong compassion, solidarity, sharing, self-denial, giving freely, the gift of self – become the universal lexicon of those who work in the sector of health-care assistance.

It is the language of the Good Samaritan of the Gospel parable, which – according to Blessed Pope John Paul II – may be considered as "one of the essential elements of moral culture and universally human civilization" (Apostolic Letter *Salvifici Doloris*, n. 29). In this perspective, hospitals assume a privileged position in evangelizing, because wherever the Church is the "bearer of the presence of God" it becomes at the same time "the instrument of the true humanization of man and the world" (Congregation for the Doctrine of the Faith, *Doctrinal Note on Some Aspects of Evangelization*, n. 9). "Only by being very clear that at the heart of medical and health-care assistance is the well-being of the human person in his frailest and most defenceless state, of man in search of meaning in the face of the unfathomable mystery of suffering, can one conceive of the hospital as "a place in which the relationship of treatment is not a profession but a mission; where the charity of the Good Samaritan is the first seat of learning and the face of suffering man is Christ's own Face" (*Discourse*, Visit to the Catholic University of the Sacred Heart, Rome, 3 May 2012).

Dear friends, this healing and evangelizing assistance is the task that always awaits you. Now more than ever our society needs "Good Samaritans" with generous hearts and arms wide open to all, in the awareness that "The true measure of humanity is essentially determined in relationship to suffering and to the sufferer" (*Spe Salvi*, n. 38). This "going beyond" the clinical approach opens you to the dimension of transcendence, for which the chaplains and religious assistants play a fundamental role. It is their primary task to make the glory of the Crucified Risen One shine out in the rich panorama of health care and in the mystery of suffering.

I would like to reserve a last word for you, dear sick people. Your silent witness is an effective sign and instrument of evangelization for the people who look after you and for your families, in the certainty that "no tear, neither of those who are suffering nor of those who are close to them, is lost before God" (*Angelus*, 1 February 2009). You "are the brothers of the suffering Christ, and with him, if you wish, you are saving the world!" (Second Vatican Council, *Message to the Poor, the Sick and the Suffering*, 8 December 1965).

As I entrust you to the Virgin Mary, *Salus Infirmorum* [Health of the Sick], so that she may guide your footsteps and always make you hardworking and tireless witnesses of the Christian science of suffering, I warmly impart to you the Apostolic Blessing. ■

THURSDAY 15 NOVEMBER

I. History and Mission

Opening Address by H.E. Msgr. Zygmunt Zimowski

H.E. MSGR. ZYGMUNT ZIMOWSKI
President of the Pontifical Council for Health Care Workers, the Holy See

'*Euntes docete et curate infirmos*' (Mt 10:6-8 – Go, preach and heal the sick) is the mandate of Jesus on which are based two of the fundamental and always relevant to our times activities of the Church: evangelisation and care for the sick. These are endeavours that are always conjoined, both in territories that are traditionally seen as being of mission and in specific institutions such as centres for care and, more precisely, hospitals. Today, above all in the economically advanced countries of the world, hospitals are authentic crossroads of cultures and religions, settings for the profound expression of healing, privileged places for the Apostolate of Mercy, as they were defined by the Blessed Pope John Paul II who in 1985 instituted our Pontifical Council *pro valetudinis administris*, and spaces for *preaching* and the *new evangelisation*.

This is the deliberate concordance of the subject of our twenty-seventh international conference, to which His Holiness Pope Benedict XVI wanted to give the title 'The Hospital, Setting for Evangelization: a Human and Spiritual Mission', with the Year of Faith, which was inaugurated on 11 October 2011, just after the end of the thirteenth Ordinary General Assembly of the Synod of Bishops, and with the fiftieth anniversary of the opening of the Second Vatican Council, which was characterised, amongst other things, by the promotion of an increasing involvement of the lay faithful in the life of the Church.

The three days of the meeting in the Vatican, two planned for the New Hall of the Synod and the third to be held in the Paul VI Hall, will be dedicated to the study of all the aspects of hospitals in their essence as privileged settings for the carrying out, both individually and collectively, of the mandate of baptism, proclaiming the Good News, and being able to recognise and encounter the Face of Christ and to imitate to the full the Good Samaritan of the gospel parable that bears his name.

A hospital is a reality of mission which is also a challenge for all the agents of pastoral care in health, both consecrated and otherwise, and constitutes a unique opportunity to adhere to the Word that was made man.

This is a journey that is almost impossible to make and maintain in a faithful way if one does not perceive an authentic vocation, if one is without faith in Man and Love-Charity, but also if one is without humility that is linked to an awareness of the human condition and the finitude of the scientific advances that have been achieved and which need to be updated because of their constant evolution and the advance of technologies. These are advances, and we state the point once again, which if they are not 'humanised', that is to say guided by ethics and by a Christian anthropology, run the risk of 'reducing' a patient to being a mere object of study and/or therapeutic treatment, and this is not to mention extreme cases where ethically wrong experimentation, or action for its own sake, are engaged in.

This, however, is something that can take place, to the detriment of respect for Life, from conception until its natural end, and of the patient in his being a person with a dignity and an experience that are specific to him or her and are unrepeatable. The 'Christian science of suffering', as the Council Fathers who met fifty years ago for the Second Vatican Council put it, is indeed 'the only truth capable of responding to the mystery of suffering' and capable of offering authentic 'relief' that is free of utopian solutions.

This is a cardinal reality that has to be addressed given the increasing tendency that exists to privilege management rather than the affective needs of patients.

On the other hand, given the increasing accessibility to information, which for that matter is information that is not always verified or verifiable, today it is an increasingly common fact that a sick person does not entrust himself or herself in a passive way to an institution or a medical doctor. He or she has the possibility, and wishes, to make his or her own choices, and to interact from the first verbal exchanges, and he or she is aware, or is convinced that he or she is aware, of what is needed and of the place from which this can be obtained. There

follows from this a greater role for medical doctors and institutions who, and which, have to be able to communicate in an effective way their ability to treat and to cure, abstaining carefully from provoking false illusions where physical recovery is in fact unobtainable.

Indeed, the substance of the relationship between a medical doctor and his or her patient is immutable. As was well illustrated by the Blessed Pope John Paul II, amongst other things the founder of our Pontifical Council, this is an interpersonal relationship of a special nature. It is, as the *Osservatore Romano* of 18 October 1998, reported, 'an encounter between a trust and a conscience', that is to say the trust of a human being marked by suffering and illness and who is thus in need, who entrusts himself or herself to the conscience of another human being who can take responsibility for his or her need and goes towards him or her in order to assist him or her, treat him or her, and heal him or her. This last is what a health-care worker is. For him or her a sick person is never only a clinical case but always a 'sick human being', towards whom should be adopted a sincere approach of 'sympathy' in the etymological sense of the term (from the Latin *sympathia*, the Greek συμπάθεια, a composite of σύν 'with' and πάθος 'affection, feelings').

It is specifically the relationship between a patient and a health-care worker, whether a professional or a volunteer, a religious or a lay person, that is indeed the principal common denominator that is to be found in the great polyclinics and dispensaries that are active in the remotest areas of the planet, and 'Western' hospitals and those that work in economically disadvantages countries.

We are referring here to nations that are characterised by poor economies where in a dramatic way there is a shortage of health-care institutions, in quantitative terms, that is to say their presence in local areas and access to them, because of the costs connected with diagnostic examinations and treatment, but also in terms of quality, because of a lack of equipment and of money by which they can be kept running. In addition, it is impossible for most of the health-care personnel to obtain full training or adequate professional updating.

We thus take this opportunity to express our solidarity and gratitude to all medical doctors, nurses and voluntary workers, and in a special way to those who are too often faced with a life that comes to an end because of the lack of a medical product.

Their frustration is often of a daily character, and yet with courage and determination they continue to assist in the best way possible all suffering people, without making distinctions based upon religion or ethnicity or origins, and they do this with what is available and above all with their love.

Pope Benedict XVI exhorts us in the following way: 'The Church's health care institutions and all their personnel should strive to see in each sick person a suffering member of Christ's Body. Difficulties of every kind rise up along the way: the growing numbers of the sick, inadequate material and financial resources, the withdrawal of support by organizations which had helped you for years and are now abandoning you; at times all this can give you the impression that your work produces no tangible results. Dear health-care workers, bring Jesus' compassionate love to those who suffer! Be patient, stand firm and do not lose heart! As far as pandemics are concerned, while financial and material resources remain indispensable, seek also constantly to form and inform people, especially the young'.[1]

The value and the profound courage that are demonstrated by health-care personnel who work in the most impoverished regions of Africa and of the other continents of the world must absolutely be helped because, as His Holiness Benedict XVI emphasised in *Caritas in veritate*, the encyclical at the centre of the 2011 edition of our international conference, 'the requirements of a development that respects human life do not only have a dimension that is within individual communities but also an international dimension. They need effective cooperation between the various subjects that act in the community of people where 'the principle of subsidiarity should be maintained strictly connected with the principle of solidarity and vice versa. This is cooperation that tends, on the one hand, to provide solutions to problems that cannot be solved within individual countries, and, on the other, to address the various needs with a shared vision. In response to these needs, therefore, human, economic and the most broadly material resources should be channelled and employed'.[2]

It is also of fundamental importance that Catholic health-care centres maintain their identities without compromises, welcoming everybody without, however, yielding to injurious forms of secularisation or relativism. Church health-care institutions, the Holy Father emphasised, although they should welcome suffering people without engaging in forms of discrimination, 'need to be managed in compliance with the Church's ethical norms, providing services which conform to her teaching and are exclusively pro-life. They must not become a source of enrichment for a few. The management of grant monies must aim at transparency and primarily serve the good of the sick. Finally, each health care institution ought to have a chapel, the presence of which will remind all who work there (management, staff, physicians and nurses), as well as the sick themselves, that God alone is the Lord of life and death'.[3]

This is an exhortation which at the level of fact concerns over 120,000 health-care institutions which work in the five continents of the world and which derive from the commitment of the great religious orders, such as those founded by St. John of God and by St. Camillus de Lellis, but also from the commitment of dioceses, institutes of consecrated life, and other religious and lay entities and men and women of good will.

An imposing network of charity, at the service of Love and *Salus*, which includes remote dispensaries and large metropolitan polyclinics because, as His Holiness Benedict XVI emphasised, 'Love – caritas – will always prove nec-

essary, even in the most just society. There is no ordering of the State so just that it can eliminate the need for a service of love. Whoever wants to eliminate love is preparing to eliminate man as such. There will always be suffering which cries out for consolation and help. There will always be loneliness. There will always be situations of material need where help in the form of concrete love of neighbour is indispensable'.[4]

We have this come this year to the twenty-seventh edition of our international conference which, as tradition has it, will being together personalities of an international calibre and over 650 participants who will come from more than sixty-five countries to represent the five continents of the world. On the screen we can see these sixty-five countries listed in alphabetical order.

During this inaugural day of the international conference, our deliberations will centre around the subject 'History and Mission', whereas tomorrow we will address the subject 'Ethics and Humanisation', before the subsequent subject of 'Spirituality and the Deaconate of Charity'. Numerous and distinguished speakers will make their own contribution and amongst these one may refer to Cardinal Jean-Baptiste Pham Minh Man, Cardinal Wilfrid Fox Napier, and Cardinal Willem Jacobus Eijk.

Various bishops and archbishops will make their contribution as well, starting with Msgr. Salvatore Fisichella, the President of the Pontifical Council for the Promotion of the New Evangelisation, and Msgr. José Luis Redrado, the former Secretary of our Pontifical Council.

We also envisage a paper by the Italian Minister for Health, the Honourable Renato Balduzzi; by Prof. Enrico Garaci, the President of the Advanced Institute for Health Care with its headquarters here in Rome; and Fra' Mario Bonora, a member of our Pontifical Council and the President of ARIS and of the Negrar Hospital of Verona.

Cardinal Angelo Comastri will lead the meeting of reflection and prayer planned for Saturday morning, at the end of which is envisaged an address by the Holy Father, Benedict XVI. There will also take part in this important appointment, which will take place in the Paul VI Hall and which will end our deliberations, those people attending the European Congress of Catholic Doctors FEAMC-AMCI, which is on the subject 'Bioethics and Christian Europe' and is currently being held in Rome. With them, taking part in the meeting, will be a very large number of sick people and those who accompany them, thanks to the efforts of UNITALSI as well, which well represents the multiple realities of national and international voluntary work that are involved in pastoral care in health.

To them and to all of you our welcome and our gratitude, as to many other people who because of reasons of time I cannot now refer to but to whom goes all of our gratitude for having welcomed our invitation, agreeing to interrupt their many daily commitments as pastors and agents of pastoral care, as medical doctors and as nurses, and as people of good will involved in improving the worlds to which they belong and improving themselves for the good of mankind. ■

Notes

[1] Cf. Benedict XVI, Post-Synodal Apostolic Exhortation *Africae Munus* n. 140.

[2] Speech of Archbishop Z. Zimowski to the conference on 'Respect for Life and the Development of Peoples', with reference to the encyclical *Caritas in Veritate* of Pope Benedict XVI, Wednesday, 1 December 2010, Rome, Catholic University of the Sacred Heart.

[3] Cf. Benedict XVI, Post-Synodal Apostolic Exhortation *Africae Munus* n. 140, n. 141.

[4] Cf. Benedict XVI, Encylical Letter *Deus Caritas Est*, n. 28b.

The Decree *Ad Gentes* in the Life of the Church Today

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We think it would be appropriate to share some of our pastoral experiences in applying the Decree Ad Gentes *to the life of the Saigon Archdiocese in the socio-cultural-economic-political context of the Socialist Republic of Vietnam today.*

1. The Situation

After 1975 the regime nationalised all health-care/educational institutions that belonged to religions. Saigon was renamed Ho Chi Minh City. In adopting the new name, the archdiocese lost nearly 400 health-care/educational institutions (elementary-secondary schools and universities, hospitals and dispensaries, charitable humanitarian care centres).

Two decades later, the authorities are promoting the new policy of 'socialising' educational and health-care services. A number of organisations, both of foreigners and of local lay people, and some Catholics as individuals, have begun to open new health-care/educational works. Even though up to now no permission has been given to open schools and hospitals, various Catholic institutes such as religious Congregations and parishes have been running nearly 300 new centres:

– Nearly 200 kindergartens, alphabetisation classes, professional training courses, hostels for migrant workers and students.

– Nearly 100 smaller centres which are called 'homes' and care for the poorest and most abandoned of patients, for elderly people, for the handicapped, orphans and abandoned infants – helping undesired newborn babies in 'family and life protection' programmes.

Furthermore, the archdiocese has engaged in pastoral care for Catholic health-care and educational workers (such as doctors, nurses, hospital employees, lecturers and teachers) by creating appropriate associations for them. These associations unify them so as to overcome various social abuses, promote education for poor and abandoned children, and give free health-care services to patients in the remotest and poorest areas. They thus offer a Christian witness of hope and love in the social context of the country.

2. Principle

The Catholic Church is missionary by nature, therefore it requests all Catholics to be aware of actively taking part in the Ministry of Mission. This is done through different formation and up-dating courses for priests, religious and lay people, and by being closely associated with the lay apostolic associations. The Church's leaders should pay due attention to:

– *Creating favourable conditions* for all Catholics so that they can be aware of the ministry that Jesus has given to the Church, which is proclaiming the Good News of salvation and spreading the Kingdom of God. They should be convinced that the ministry has its source in the salvific design of God the Father to save all people of the world.

– Giving all Catholics *the ability* to participate in this ministry together with their fellow countrymen by walking on the path and in the light of the Gospel, just as Jesus himself overcame many serious problems, wickedness and abuses in his human life, before reaching a new and fruitful life in God's Kingdom – a new heaven and a new earth full of the light of truth, justice, peace and love.

3. The Formation of Workers for Ministry

Offering conditions to all Catholics to renew their ways of living as Christians: they should overcome certain traditional repetitions as well as religion-keeping mentalities. They should be imbued with the Word of God, live in the light of Christ's love and truth, and themselves be evangelised first.

3a. *Renewing their spiritual lives*. The three main columns of a Christian life are: mortification – praying diligently and receiving the sacraments – and the practice of sharing with a charitable heart. But what is more important is renewing the ways of practising these, doing as Jesus did, following the teaching of John Paul II: overcoming the routine of the old man; letting oneself be transformed by the Holy Spirit so as to become an entirely new creature, following the model – Jesus; listening to the Word of God expressed in the Gospel and in the teachings of the Church, through social and historical events; and being faithful to Jesus in his path of salvific love.

3b. *Building up the Church solidly on the foundation of the Word of God*. All the faithful should be united in one soul and one heart in order to rebuild their families and their communities (whether religious institutions, parishes or ecclesial associations) on the solid basis of the Word of God so as to become:

– *Church-mystery*: a faith-sharing community that lives wholly love for God the Father.

– *Church-communion*: living perfectly fraternal love in unity as children of the one Father.

– *Church-mission*: opening up this fraternal love to all by compassionately sharing the gifts donated by God to their countrymen, to humankind at large, as brothers of the same family in the globalised world of today.

3c. *Transforming one's life by the Gospel*. The ministries of evangelisation and spreading the Kingdom of God require all members of the People of God to answer to the challenge of Pope Benedict XVI to evangelise their own lives, bringing the light and strength of the Word of God into their works and words, and to imbue all their activities (religious formation, Catholic education, pastoral care, administration…) with the values of the Gospel so as to become yeast and salt: Christ's light of truth and love in all situations of today's society. Furthermore, there should be initiatives in evangelising the various festivals of today's society, such as Woman's Day, Valentine's Day, Father's Day, and Mother's Day etc… introducing them to the Christian community programme.

In this way, the diocesan family will eventually become God's community, which humbly and with love serves the cause of life and of human development. This prospect of becoming witnesses to the Good News of life and love would certainly, little by little, blot out in the mind of many the image of a powerful Church, a fearful enemy, and thus would eventually make the Church a strong support to all men and women of goodwill in contemporary society.

4. The Personnel of Mission

Following Christ on the way of salvation. Creating favourable conditions for ecclesiastics, religious, lay faithful, adolescents, young people, families, medical

personnel, teachers, businessmen, intellectuals, professionals, immigrants: opening up and elevating their knowledge of faith and better pastoral care, giving them the ability to listen to the Voice of God in all walks of life, and following Christ on the road of salvation with four characteristics:

– Humbly inculturising themselves by sharing in all conditions of human life so as to offer to everyone love and peace.

– Engaging in services that bear witness to the Gospel of Love, by serving fellow human beings, in particular those in serious difficulty.

– Loving generously to the end, for the sake of human life and the human development.

– Opening up the road of renewal that leads to the source of life itself, the Risen Christ, to everyone.

Building up the fraternity that makes all humankind brothers. To promote solidarity that unifies all men – people of all walks of life – so as to bear witness to the Good News in their condition of life: in the context of the globalized world of today, there is a need to create bridges of communion between two local Churches, two nations, between religions... in order to share with each other the divine gifts received, and together be witnesses to the Good News of life and love which clears the way for the work of evangelising this very globalised world itself.

5. Missionary activity

Incorporation and participation. In order to be genuine yeast, salt and light for the world, the Christians should be associated more closely with the cultural-social life of the society around them by participating in all educational and health-care services that care for (in particular) those who are excluded by society itself, such as lepers, HIV/AIDS patients, elderly-handicapped people, orphans, and poor and abandoned children. Such actions will contribute positively to the building up of a civilisation of life and love in contemporary society

Dialogue and cooperation. Nowadays another means of missionary action is dialoguing and collaborating with all other members of the society in order to serve life better as well as to advance the human community: inter-religious, inter-cultural and inter-national actions are especially valuable. Patient dialogue and sincere collaboration respecting all human and religious Gospel values as well as sound humanitarian values that are founded in the traditional culture of the people would certainly make this society more and more sustainable and wholesomely developed.

6. Situation of the Diocese up to the Beginning of 2012

Population. The Catholic population of the archdiocese in 1998 was 520,000; in 2012 it is 680,000 in 200 parishes, out of a total of 0.8 million, the population of the city. That is not counting 150,000 out of the total of 0.2 million migrants students and workers. 90% of Catholic go to Mass on Sunday. Almost 100% of children study catechism in the parishes up to the time of receiving confirmation and even afterwards. Secular priests number more than 300, religious priests are also 300, and there are almost 6,000 men/women religious.

New parishes and mission outposts. During the last decade of the twentieth century, from the various charitable and social services in the remote areas of the city missionary outposts sprung up. Some of them, with a few hundred faithful, eventually became parishes, with priests and religious caring for both the bodies and souls of the poorer people.

Lay associations. In all 200 parishes there exist three pastoral institutions: (1) The Pastoral Council that has in total more than 5,000 members; (2) catechists, all volunteers: more than 6,000; (3) more than 1,500 choirs with a total of almost 30,000 choir members. There exist in the archdiocese 26 lay apostolic associations. Among them the most numerous is the Association of Christian Mothers which in 1998 had 4,000 members, but now in 2012 already has 24,000. Furthermore, there are other groups of lay people that spontaneously associate with one another in order to do social and charitable works to protect human life and promote development.

Centres for formation. At the present time the archdiocese has one Major Seminary that needs to be extended more in order to receive at least 300 candidates for the *priesthood* over the next ten years. Ten formation centres for men and women *religious*. As for the formation of *lay people*: in 2004, after getting back the compound of the former Minor Seminary that had been used since 1975 by the state as a College of Finance, the diocese has transformed it into a Pastoral and Formation Centre. Since 2004 this centre has opened yearly intensive courses for the updating of pastoral knowledge as well as faith-deepening studies, with no less than 6,000 students every year.

Furthermore, this Pastoral Centre frequently runs and organises:

1. Courses of specialised training for sixteen diocesan pastoral commissions (Liturgy, Sacred Music, Holy Scripture, Catechism, Vocation, Children, Young People, Family, Migrants, Catholic Education, Culture, Evangelisation, Caritas-Health Care, Interreligious Dialogue, Justice and Peace, Social Communication).
2. Meetings, symposiums, assemblies at national, inter-diocesan, inter-religious and FABC levels.
3. Festivals and celebrations with a congregation up to 10,000-15,000 participants, sometimes with both Christians and non-Christians.

PROLUSION

Hospitals: Settings for a New Evangelisation

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A Historical Memory

'The opening of a hospital, even though it is an event of importance for the art of medicine, does not usually provoke much positive interest in the general public, who vies away from such asylums of pain. Such, however, was not the surprise of His Excellency Msgr. Quigley, the worthy Archbishop of Chicago, when he was surrounded by a crowd of more than 4,000 people who had gathered around the chapel and the reception hall to hear his words! Other people, more than a thousand in number, were sent outside because of a lack of space and they had no hope that they would be granted access. Everyone agreed that never in the United States of America had so much enthusiasm been expressed at the opening of a hospital as was the case on that occasion. This was the day of the Lord, the work of the Lord… The medical faculty of the city classified our hospital as being one of the first order. And everyone is in agreement in saying that the charming position and the beauty of this institution make it the best hospital in Chicago'.[1] These are the words that Francesca Cabrini wrote to the students of the Institute of the Magisterium that had gathered together here in Rome to be informed about her intense activity and that of the Missionary Sisters of the Sacred Heart. The date was 5 May 1905. In recent days *L'Osservatore Romano* published this piece of a latter together with a fine piece of reporting to remember the first great American woman saint, the patron saint of immigrants, who engaged in work which is considered from the human point of view alone of absolute greatness. At the beginning of the twentieth century in Europe, the United States of America and Latin America she had already founded sixty-seven schools, works of care and hospitals. And if this was not enough, during that time she crossed the ocean at least twenty-four times. We could be astonished by the great missionary action of St. Cabrini who from a small village named Codogno was able bring her witness to faith as far as the Andes. However what was said in this letter has for us a fundamental importance. The reactions of people faced with certain situations were emphasised. She speaks about 'asylums of pain' which did not provoke much positive interest on the part of people. At the same time, however, there is mention of the originality that she had put into the construction of a new hospital: the choice of the location, the beauty of the buildings and the first-class equipment, which in contrary fashion provoked great enthusiasm in the local population. If to this one adds that this hospital was called by her a 'work of the Lord', and we well know that it was also the outcome of her personal holiness, then the mosaic is completed and allows us to the see the great works that believers are able to achieve when they allow themselves to be guided by the grace of the Father and in meekness to the action of the Holy Spirit.

In recent weeks the twelfth Ordinary Assembly of the Synod of Bishops came to a close. The subject that filled its intense days of work was the New Evangelisation and the transmission of faith. In a clear way there emerged an awareness that the new evangelisation is by now the journey that the Church intends to make over the next decades with hope and decisiveness, knowing that the path is the work of the Holy Spirit who always guides the Church in the events of history so that in history the Church can be the living sign of the presence of Christ. Awareness has grown that in the new evangelisation, as well, what should take pride of place is the person of Jesus Christ, the first evangeliser of the Father and His mystery, but at the same time this should be contained in our preaching which is always new because it is renewed by a faith that is incarnated in the various situations of history.

However, to think that one can give a clear and exhaustive definition of the new evangelisation is a temptation from which we should flee. Paul VI in his *Evangelii nuntiandi*, which is always of contemporary importance, warned about falling into this danger when he wrote: 'Any partial and fragmentary definition which attempts to render the reality of evangelization in all its richness, complexity and dynamism does so only at the risk of impoverishing it and even of distorting it. It is impossible to grasp the concept of evangelization unless one tries to keep in view all its essential elements'.[2] In the same way, in his address at the beginning of the Synod[3] Benedict reaffirmed in a very profound way: 'In every time and place, evangelization always has as its starting and finishing points

Jesus Christ, the Son of God (cf. *Mk* 1:1); and the Crucifix is the supremely distinctive sign of him who announces the Gospel: a sign of love and peace, a call to conversion and reconciliation'. And he immediately went on to specify: 'the *New Evangelization* [is] directed principally at those who, though baptized, have drifted away from the Church and live without reference to the Christian life…[it is needed] to help these people encounter the Lord, who alone fills our existence with deep meaning and peace; and to favour the rediscovery of the faith, that source of grace which brings joy and hope to personal, family and social life'.

As one can observe, evangelisation has always been of the nature of the Church and it is what makes the Church the Body of the Risen Christ and his presence in the world so as to be a mediation of his revelation. The new evangelisation is not something that is added from outside under the pressure of events but a feature of the very nature of the Church which emerges in a more evident way to achieve a renewed awareness of the mission that believers have to be witnesses to the risen Christ in a world that has radically changed its features under the pressure of secularism. The new evangelisation, therefore, is not a matter of placing in brackets a past that is always rich in testimonies that changed the world, but, rather, it becomes an opportunity for a serious examination of conscience in order to assess whether the faith of believers is still able to be as genuine and vivacious as it should be, or whether it is subjected to tiredness, obviousness, fear…all elements that are extraneous to faith and limit its sphere of action.

Amongst the *Propositiones* that were presented to the Holy Father as a first summary of the work of the Synod, one in particular bears upon the subject of the application of the new evangelisation to the field of pastoral care in health. It says: 'The New Evangelization must be ever aware of the Paschal Mystery of the death and Resurrection of Jesus Christ. This mystery sheds light on the suffering of people who can find in the Cross of Christ understanding and acceptance of the mystery of suffering that gives them hope in the life to come. In the sick, the suffering, persons with disabilities and those with special needs, Christ's suffering is present and has a missionary force. For Christians, there must always be place for the suffering and the sick. They need our care, but we receive even more from their faith. Through the sick, Christ enlightens His Church, so that everyone who enters into contact with them will find reflected the light of Christ. This is why the sick are very important participants in the New Evangelization. All those in contact with the sick need to be aware of their mission. We cannot forget when we build new hospitals to pay attention so that we do not lack a consoling and supportive environment and a place for prayer'.

One would not understand some of the points of this 'Proposition' if one did not refer to the rich teaching of the Church on suffering and illness in relation to the mystery of the Cross of Christ. This teaching is to be found in particular in the Blessed John Paul II. In his *Salvifici doloris* he wrote the following words: 'The theme of suffering… is a universal theme that accompanies man at every point on earth: in a certain sense it co-exists with him in the world, and thus demands to be constantly reconsidered' (n. 2).

The Meaning of Pain in the New Areopaghi

This observation allows us to set in motion a primary analysis of our subject. The gospel does not exclude any field of personal and social life. The Church, therefore, can forget no place reached by man and within which he gives practical expression to his personal existence. To every one of its contemporaries, the Christian community is called to being the word of the Gospel which gives meaning and saves. At the present time one often hears reference to the presence of the Church in the areopaghi that mark modern culture and offer spaces for preaching that were previously unknown. This is an important suggestion for the new evangelisation because it must be able not only to recognise these new settings but above all else find coherent forms by which to enter them. Opening towards these new forms, which remain fundamental, cannot lead to forgetting about the commitment that believers have always shown towards fields that are less exciting and often amongst the most forgotten, such as those that revolve around the great chapter of human suffering. The new areopaghi are by no means rarely marked by a wish to ignore or conceal these settings because they do not accept that man can experience weakness, after they themselves have had the illusion of his omnipotence. And yet specifically because of this and our love for the truth we must be able to bring to the new areopaghi the meaning of forgotten suffering and pain that is not talked about.

The fact that the Christian religion has as its specific feature the incarnation of the Son of God is not without consequences for the organisation of its personal and social life. If God enters history and takes upon Himself the criterion of participation in human life, then everything that the life of a person and the life of society which he or she lives involves becomes a space for the action of believers. Nothing is saved in that which was not taken upon by the Word of God. The incarnation of God commits the Church to entering the history of men and making them participants in a plan of salvation that is not only a future promise of eternal life but is also already, here and now, a change in, and transformation of, the present life. The miracles that Jesus performed, for example, did not only have the purpose of stressing his power over evil, over illness and over death. At the same time they were a prelude to proclaiming the concrete transformation of man. What there will be in the new times and on the new earth is made visible now through a change that the power of God works, if we abandon ourselves to Him in faith. The body will be

transformed and with it the whole of the creation. This idea has always found space to be specially listened to at the moment of the experience of suffering. The apostle said this in a peremptory way: 'When I am weak, then I am strong' (2 Cor 12:10). The moments of the weakness of man, therefore, can become a space to make evident the force of God, who from nothing brings everything to being.

It is the force of faith that has allowed down the centuries the transformation of pagan places – when a sick person was deceived by myth and by his ministers of his real condition – into centres of loving welcome where the sick person was directly taken care of. What paganism directed to the gods so that they would intervene in favour of the sick, Christians made become a setting for the direct role of the divine so that the sick could touch with their own hands the concrete nearness of God through the charitable hearts of their brethren. This is the first act of the new evangelisation which is imposed as an obligation so as not to forget the human condition in all its aspects.

Indeed, we are faced with the new evangelisation as a cultural expression that enters the formulation of a new anthropology of which the culture of our days has especial need. Directed as we are to give images and voice only to beauty to satisfy a by now evident narcissism, or to the right to be healthy so as to deceive ourselves as to an immortality that does not belong to us, the Church has as an obligation which is that of emphasising the dignity of human person in all of his or her expressions. There could never be a society worthy of that name if it imposed a culture which in the name of life and individual rights offered death as a condition for selection and discrimination. The dignity of the person applies because of the very fact that the person exists and bears the impress in himself or herself of the image of God. Every other manifestation that stopped at corporeal perfection alone and discriminated against other people on the basis of age, race and language should not find a place in our homes; and, even less, could it be an expression of the progress achieved over the centuries by civilisation. In the face of cultural forms that push towards an obsession with physical beauty to the point of being near to the ridiculous because of an illusion of being able to offer eternal youth through surgical action which brings out even more an old age that wants to conceal itself, it is important to pose the question of the meaning of life and its essence. Faced with a renewed pagan cult of the body we should nourish a greater critical sense that will allow us to restore to confused man the right meaning of things and the real measurement of his acts. This is a new evangelisation which brings a breath of oxygen by presenting the truth and by this fact also the freedom of every person against illusion and thus deception.

The Sick Person as the New Evangeliser

There are rich and intense experiences of new evangelisation that deserve to be participated in and lived. These allow it to be seen that the new evangelisation, beyond any form of rhetoric, involves not only those people who are called to be evangelisers of those people who suffer, but also, and primarily, makes sick people the protagonists of the new evangelisation when they are able to locate their illness and pain in the mystery of the Cross and the Resurrection of Jesus Christ. It was John Paul II who, once again, remembered this profound truth when he said: 'Dear brothers and sisters who experience suffering in a particular way, you are called to a special mission in the new evangelization and to find your inspiration in Mary, Mother of love and human pain. You are supported in this difficult witness by health-care workers, family members and the volunteers who accompany you on your daily path of suffering'.[4] The first evangelisers of hospitals, therefore, are the sick. They are called to take upon themselves awareness about, and responsibility for, the proclaiming of the good news of the gospel which saves, starting with their own condition. This is not without importance because it seeks to look with greater intensity and commitment at the formation of believers so that in these circumstances of suffering, as well, such experiences can be lived through in harmony with faith. One cannot improvise being evangelisers and one cannot give meaning to pain from one day to another. All of this requires a grounding that grows and matures with faith in the mystery of active and real participation in the mystery of Christ and the life of communion with him that is offered by baptism.

The journey of the Pontifical Council for Health Care Workers has for some time now made the New Evangelisation its priority choice. The multiple initiatives of which it is the promoter bear witness to this. One need only remember here, in this sense, the subject of the ninth World Day of the Sick of 2001 which was entitled: 'The New Evangelisation and the Dignity of the Suffering Person', when the Blessed John Paul II himself wrote as follows: 'Evangelization must be new – new in method and new in ardour – because so much has changed and is changing in the care of the sick. Not only is health care facing unprecedented economic pressures and legal complexities, but at times there is also an ethical uncertainty which tends to obscure what have always been its clear moral foundations. This uncertainty can become a fatal confusion, manifested as a failure to understand that the essential purpose of health care is to promote and safeguard the well-being of those who need it, that medical research and practice must always be tied to ethical imperatives, that the weak and those who may seem unproductive to the eyes of a consumer society have an inviolable dignity that must always be respected, and that health care should be available as a basic right to all people without exception'.[5] All of this is located even more directly in the specific concerns of our subject as a constant pathway that demonstrates the progress that has been achieved

and the great work that still has to be performed.

Hospitals allow a person to engage in a first basic experience: fear about the loss of a good that everyone sees as being fundamental. In these settings, an experience of limitations and of powerlessness which brings with it a form of incredulity that cannot accept that science and technology do not have limits, is not extraneous, if not to the patient then often to his or her family relatives. In the face of certain pathologies it is only with difficulty that people accept the answer that one cannot be certain. The mind immediately runs to alternative solutions and the illusion is reproduced through a search for new diagnoses and new therapies. If not in one's own country, then certainly elsewhere, in more technological countries, the solution will exist. Limitations and, even less, pain are not accepted. The mind prefers to follow the utopia of illusion rather than to surrender to realism. And yet illness is a true ignition key to turn on the mind which wanders in the search for better thinking, when, that is, it is not buried by the darkest pessimism. The experience of illness imposes on the person that he or she fixes his or her eyes on the essential which is often eclipsed by the ephemeral. In this process, however, it is important that nobody is left alone. Here is imposed the commitment to the new evangelisation which should form consciences in a pastoral action animated by enthusiasm which knows how to provide the company of faith. During these moments loquacious company is not required: what is needed is eloquent company. It is more effective when it is only company that is the presence of a heart that loves and for this reason is nearby, which takes part and has compassion, carrying the burden of the other person.

During an epoch when a sick person is solely entrusted to medical science, to technology and to a medical doctor, and however contradictory it might appear to a health-care institution which during rich moments speculates on his or her presence and during moments of crisis sends him or her immediately back home, faith must make people understand that there is a need for a more solid company that supports the person and knows how to provide answers that are sought for in vain elsewhere. A sick person because of his or her very sick condition personifies a request for help, for nearness, and for meaning. A new evangelisation that makes itself strong in the new means of communication: how can it forget that there exists silent communication, made up of cries from the heart that ask to be listened to because they impose the acceptance of questions that are often unanswered such as the courage to face up to a pathway of obstacles, the hope of winning and a refusal of resignation that has to be endured?

A hospital can be humanised when it becomes a place where one experiences that communion that overcomes loneliness, welcome which crushes self-interest, and readiness to engage in service which eliminates a folding in on oneself. A hospital is also a church of the sick. The words of Jesus to the Samaritan women return to us forcefully: 'the time will come when people will not worship the Father either on this mountain or in Jerusalem…by the power of God's Spirit people will worship the Father as he really is, offering him the true worship that he wants' (Jn 4:21-22). It is certainly the case that there are places that are consecrated because they are a sign of the sacred and a special relationship with God. But there are places that become sacred because of the celebration of the mystery of salvation that is worked through people. A hospital is one of these places. Celebrating the mystery of illness and salvation, of the weakness of the body and the strength of love, makes hospitals in themselves sacred places where silence dominates and where personal and intimate prayer prevails over the words of science. Here the sick person receives the visit of Christ the Eucharist which points out to him or her the true pathway of faith: this is not a conquest of man who searches for God but one worked by God who goes to that person where he or she lives and feels the deepest need. Here there receives greater meaning the celebration of the sacrament of reconciliation as a real space where in the weakness of one's own physical self one wants to hear the voice of mercy which forgives everything and which inculcates courage to look ahead with a serene gaze. Here the anointing of the sick has its privileged space because it brings us back to the value of the sacramental signs which are effective because of the presence of grace which is given and of faith which sees in them a necessary response. Anointing reminds us that we were baptised and confirmed in the faith and that our bodies are not extraneous to the body of the Son of God who transformed it into the glorious body of his resurrection. The experience of forgiveness that is achieved gives trust and what in the past was mediation of sin is now renewed by the true power of forgiveness that destroys everything to enable people to perceive the greatness of love which welcomes everybody and excludes nobody. Faith, that is to say, helps people to overcome the inevitable fears that everyone carries within them and, nonetheless, strengthens human weakness which cannot be removed, because we are all fixed in this terrain of the creation, but can be transformed into the light of the paschal mystery.

Conclusion

Just as a new evangelisation exists that belongs to the promotion and defence of an anthropology formed in the image of God, so is it necessary for the new evangelisation to take responsibility for entering the walls of very many places of suffering and pain in order to bring those words of hope that are to be found in the Gospel. Where else is a proclaiming such as this obligatory if not in those places where weakness is experienced and existential questions become stronger and the mind is more open to truth, in the same way as the heart is more ready to engage in welcoming? The following words of the Blessed John Paul II cam back

to us full of meaning and especial emotion: 'Every day I go on a spiritual pilgrimage to hospitals and treatment centres, where people of every age and social background live. I would particularly like to pause beside the patients, their relatives and the health-care personnel. These places are like shrines where people participate in Christ's paschal mystery. Even the most heedless person is prompted there to wonder about his own life and its meaning, about the reason for evil, suffering and death (cf. Gaudium et spes, n. 10). This is why it is important that the skilled and significant presence of believers should never be wanting in these structures'.[6] It is this pilgrimage at the bedsides of those who suffer that the new evangelisation must think of in order to restore confidence and courage to those people who expect from evangelisers words of hope so as to become, they themselves, new evangelisers.

Notes

[1] In *L'Osservatore Romano*, 13 November 2012.
[2] *Evangelii nuntiandi*, n. 17.
[3] Homily of His Holiness Pope Benedict XVI, 7 October 2012.
[4] 'Message of the Holy Father John Paul II for the IV World Day of the Sick', 11 Oct. 1995, n. 2.
[5] Letter of John Paul II to the Pontifical Council for Health Pastoral Care on the Occasion of the Ninth World Day of the Sick (Sydney, Australia, 11 February 2001), 18 Jan. 2001.
[6] John Paul II, 'Message of the Holy Father for the World Day of the Sick for the Year 2001', 22 Aug. 2000.

The Role of the Hospital in International Health-Care Policies

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It is a great pleasure to address this audience and to honour the long and noble history of work of the Roman Catholic Church in providing compassionate care for the sick and suffering. This is a tradition of enduring relevance.

Today, faith-based organizations provide the mainstay of essential health care in many parts of the developing world. In sub-Saharan Africa, for example, from 30% to 70% of all health care is provided by faith-based organizations.

The Roman Catholic Church has been a valued resource and partner for WHO, especially in providing care for people infected with HIV and tuberculosis. You procure medicines, deliver babies, and bring doctors and services to some of the most remote and uninviting corners of this earth.

I have a confession to make, as a young doctor specializing in paediatrics my first work was in a Catholic hospital in rural Ghana. The story there was a familiar one. The hospital was the place of last resort, where people went when they were desperately ill.

Early signs and symptoms were usually ignored, unless they occurred in young children. This I interpret as part of that universal desire of parents to do the best for their children, no matter how difficult and demanding. It was a good place to gain experience as a paediatrician, not just about diseases, but also about human nature.

In that mission hospital, transportation was a problem. Long waiting lines were a problem. Money was a problem. Stock-outs were common. The hospital was understaffed and we were all overworked.

But we did save lives. People came to the hospital in desperation, but also with great expectations, great hope. We tried our utmost not to disappoint them.

Paradoxically, in my country the people also associated hospitals with prestige. To be born in a hospital and to die in a hospital were status symbols. That meant that the family had money. It hinted at luxury.

Those early experiences were responsible for my decision to move from clinical medicine into public health. Many of the illnesses I saw could have been prevented or could have been treated much more easily had they been detected early.

I felt that, if health officials could address risks within the community, in collaboration with the community, hospitals would be freed to do a much better job.

Excellencies,

I have been asked to look at the role of hospitals from the perspective of international health care policies. Now that I have given you my prejudices from my younger years, let me give you my more mature views. The role of hospitals in the 21st century is not being properly exploited. We need to change some mind-sets and some policies.

The perceptions of hospitals and their place in international health care vary greatly, from OECD countries to low-income countries and communities.

Many see hospitals as wasteful, spending more money than they should. Far and away, hospitals consume the lion's share of health care budgets. Advances in medical technologies and devices are cited by many as a key reason for soaring health care costs. Some experts estimate that nearly half of the increase in health spending

since 1960 can be attributed to the growth of sophisticated medical technologies destined for use in hospitals.

Medicine is one of the few areas of technical innovation where new products are nearly always much more costly, most sophisticated, more difficult to use, and more likely to break down. This is certainly not the case with other areas of technology, like flat-screen TVs or computers and hand-held devices, where products keep getting easier to use and cheaper to buy.

Too often hospitals acquire the latest technologies without a proper study of the real benefits over existing technologies. In many cases, new technologies do not bring significant advantages for patients or improvements in health outcomes.

Hospital can also be dangerous. Worldwide, WHO estimates that nearly one million lives are lost each year because of errors during surgery. These errors occur in the richest as well as the poorest counties.

Hospitals can be hotbeds of infection. The SARS outbreak of 2003 was a disease primarily spread by sophisticated hospitals in wealthy settings.

Hospitalized patients may also be exposed to super-pathogens that have developed resistance to all mainstay antibiotics and, in some cases, to all available drugs.

In some developing countries, the spread within hospitals of highly contagious diseases, like tuberculosis, is a major problem. Hospitals can also be dangerous because of faulty equipment, substandard medicines, or inadequate numbers of appropriately trained staff. People go to hospitals to be cured, to heal, and not to be made even sicker.

Hospitals can be the sentinels of newly emerging diseases. Many new diseases, like Ebola haemorrhagic fever, first came to light because they were killing health care staff. Some were detected only when missionary doctors and nurses became ill and were air-evacuated to countries with the facilities to run comprehensive diagnostic tests and detect new pathogens. Lassa virus, for example, was first detected in 1969 in missionary nurses in Nigeria.

Hospitals are a mirror of how societies function, and are an essential element for defining the public trust in the functioning of the State and the society.

Hospitals have political implications which is seen by public reaction to the closing of small hospitals in France, the long waiting lists in the UK, and the Chinese State Council's concern about hospital reform**.** Politicians often promise to build hospitals as a way of winning votes, and not based on an assessment of real needs or consideration of recurrent costs. Once a hospital is built, even if it is underutilized and a significant drain on public funds, it is extremely difficult to shut it down, again for political reasons.

Hospitals can be dehumanizing. In their design, many hospitals show little respect for the dignity of human life. They are cold and sterile. People are treated like a collection of specialized body parts, and not as human beings with a soul and spiritual needs. There are often no inviting spaces for family members to gather. Friends and family may bring flowers, but much else in the environment is colourless and depersonalized.

On the positive side, hospitals are social institutions**.** When access is fair, and not dependent on ability to pay, hospitals can contribute to social cohesion. Having a well-functioning hospital can be a community's pride and joy, as well as a lifeline.

Hospitals are also often a stimulus for spiritual thinking, an interface between bodily ills and higher values and that deep human need for compassion. To repeat the title of one of your presentations, hospitals are the "custodians of life". They can be a cause for celebrations, of births, cures, and dignified deaths.

Hospitals are hope. Where there is health, there is hope. There is a new breed of thinking in public health. It is this: poor people deserve the very best health care available because they have been given so little else in life.

Excellencies,

The first decade of this century saw some stunning improvements in world health, especially for those diseases that keep people anchored in poverty and put a brake on development.

The epidemics of AIDS, tuberculosis, and malaria peaked and began a slow but steady decline. The number of deaths in young children dipped below 10 million for the first time in almost six decades, and continued to drop, each and every year. Deaths linked to pregnancy and childbirth also began to decline after decades of stagnation.

This is progress, impressive progress, but it is by no means a victory. All of these achievements have been rendered especially fragile by another set of events during the first decade of this century. In fact, that decade may very well go down in history as the time when nations came face-to-face with the perils of interacting in a world of radically increased interdependence.

Since the start of this century, the world has been beset by one global crisis after another: a fuel crisis, a food crisis, a financial crisis, and a climate that has begun to change.

These crises are revealing the dark side of living in a closely interdependent and interconnected world. As the past decade has shown, the consequences are highly contagious, quickly moving through the international systems that bind countries together.

The consequences can also be profoundly unfair. Developing countries have the greatest vulnerability to adverse events and the least resilience. They are often hit the hardest and take the longest to recover.

Globalization produces numerous benefits, but it has no rules that guarantee the fair distribution of these benefits. Today, the international systems that govern trade, capital markets, and business relations have more power than a sovereign government to influence the lives and opportunities of citizens, including their chances to enjoy a healthy life expectancy.

Unfortunately, equity is rare-

ly an explicit policy objective in the way these systems function. As a result, the world has become dangerously out of balance. Differences, within and between countries, in income levels, opportunities, life expectancy, health outcomes, and access to care are greater today than at any time in recent history.

The difference in life expectancy between the richest and poorest countries now exceeds 40 years. Annual government spending on health ranges from as little as $1 per person to nearly $7,000. A world that is greatly out of balance is neither stable nor secure.

And there are other ominous trends, again linked to the world's unprecedented interdependence. All around the world, health is being shaped by the same powerful forces.

Universal trends, like urbanization, population aging, and the globalization of unhealthy lifestyles, have sparked a sharp increase in chronic diseases, like heart disease, cancer, and diabetes.

Long considered the close companions of affluent societies, these diseases now impose around 80% of their burden on low- and middle-income countries. In these countries, people fall ill sooner, get sicker, and die earlier than their counterparts in wealthy countries.

Mounting evidence shows that obesity and diabetes, strongly linked to unhealthy diets, have reached epidemic proportions in parts of Asia, where the loss of traditional diets has been especially rapid. But no part of the world is being spared.

These trends have enormous implications for hospitals and health budgets. The costs of chronic care for the growing number of people with noncommunicable diseases are simply not affordable. They break the bank. In most low- and middle-income countries, patients with diabetes, who live on less than $2 a day, need to spend between 25% and 50% of their monthly income to buy one vial of insulin from a private pharmacy.

Late last year, a study concluded that technologies for the treatment of cancer now carry costs that are unsustainable, even in the wealthiest countries in the world.

WHO estimates than more than 35 million people worldwide are living with dementia. This number is expected to double by 2020 and more than triple by 2050. Already now, nearly 60% of the burden of dementia is concentrated in low- and middle-income countries.

The cost of caring for dementia is expected to rise even faster than its prevalence, making it important that societies are prepared to address the social and economic burdens caused by this condition. The costs are already staggering. In 2010, the total estimated worldwide costs of dementia were $604 billion.

Excellencies,

All these point to a number of conclusions:

– People want to live, long and healthy lives.

– Many people will have chronic illnesses and more than one disease at a time.

– People want to have a say in what affects their lives and that of their families.

– People want to be treated as human beings, with dignity and delicacy.

– People want a reduced risk of disease, effective medicines and technologies, and reliable health authorities.

– Hospitals can play a big role in this.

For hospitals to fulfil this role paradigm shifts are needed to ensure:

– emphasis on care of acute episodes of disease, to the emphasis of care through the continuum of life;

– responsibility for individuals, to responsibility for health of defined population;

– care must be people-centred;

– services are as close to home as possible;

– hospital environment is as homely as possible;

– success is measured by the capacity to increase hospital admission and capacity to maintain people health;

– the objective of a hospital is to fill beds and to give appropriate care at appropriate levels.

Some of these shifts are already happening.

In this new century, industrialized countries are trying to reduce their reliance on hospitals, having realized the opportunity cost of hospital-centrism in terms of effectiveness and equity, and the need to make them more fit for humans. Yet, many low- and middle-income countries are creating the same distortions. The pressure from consumer demand, the medical professions and the medico-industrial complex is such that private and public health resources flow disproportionately towards specialized hospital care, at the expense of investment in primary care and in the human dimension of care. National health authorities have often lacked the financial and political clout to curb this trend and achieve a better balance. Better balanced, and integrated, health systems will require much better collaboration between authorities and the hospital establishments; pressure from patients and populations is increasing and may help force such collaboration.

Hospitals must become much more people-centred and caring. They need to accept responsibility for prevention and health promotion, and not concentrate exclusively on cure.

People associate hospitals with hope and healing. These expectations need to be shaped in ways that make patients partners in safe-guarding their own health.

The Roman Catholic Church has much to offer in reshaping hospital environments and value systems. Hospitals are not profit centres. They are custodians of life, and that includes its spiritual dimension.

As I conclude, I come back full circle to an early conviction that changed my career. If health officials could address risks within the community, in collaboration with the community, hospitals would be freed to do a much better job. Again, the Roman Catholic Church is well-positioned to undertake this kind of community engagement.

Recommendations and Perspectives on Pastoral Care for Health-Care Workers in *Africae Munus*, the Post-Synodal Apostolic Exhortation of Pope Benedict XVI

H. EM. CARDINAL WILFRID FOX NAPIER, O.F.M.
Archbishop of Durban, South Africa, Member of the Pontifical Council for Health Care Workers

"Today more than ever, the Church is aware that her social doctrine will gain credibility more immediately from witness of action than as a result of its internal logic and consistency" (Blessed John Paul II, *Centesimus Annus*, n. 57).

"Be patient, stand firm and do not lose heart!". These are the words addressed to healthcare workers in the continent of Africa by our Holy Father, Pope Benedict XVI, in the post-synodal document, *Africae Munus*.

They are important words because there is so much that might cause us to lose heart. Indeed, if we had not been sustained by our faith in the Lord Jesus, we would not have been able to remain engaged as a Church in providing health care in many parts of our continent. Our position in the "thick of the fight" and amidst many serious challenges does sometimes prevent us from seeing how far we have come and how effective our work is in reality.

In May 2009 the Pontifical Council for Health Care Workers, in conjunction with AISAC (the International Association of Catholic Health Care Institutions), convened a workshop in Rome ahead of the African Synod. That workshop put forward recommendations concerning health issues in Africa which it intended as a resource and framework for understanding Catholic healthcare as a means of reconciliation, justice and peace. We will look at three of these as a way of expanding the points raised by the Holy Father in *Africae Munus*. What are those points?

1. Conforming to Church Teaching

In his exhortation the Holy Father emphasizes the need "to form and inform people, specially the young" when fighting the pandemics present in African countries (and here he was clearly referring to the TB and the HIV/AIDS pandemic). He specifically drew the attention of bishops and healthcare workers to two important issues, namely, the need i) for healthcare institutions to provide services which conform to the Church's teaching and are exclusively "pro-life", and ii) for an increased emphasis on transparency and ethical norms in their work, so that funds would be used primarily to 'serve the good of the sick'.

A Culture of Life versus a Culture of Death

The Church's healthcare institutions and community workers in Africa serve most often in the poorest and most deprived communities, and in regions where disregard for the law and for the rights and dignity of the person is often manifest. "A model of society appears to be emerging in which the powerful predominate, setting aside and even eliminating the powerless: I am thinking here of unborn children, helpless victims of abortion; the elderly and incurably ill, subjected at times to euthanasia; and the many other people relegated to the margins of society by consumerism and materialism. ...This model of society bears the stamp of the culture of death, and is therefore in opposition to the Gospel message" (John Paul II, *Ecclesia in America,* 63).

The Church through its bishops needs to ensure that healthcare workers not only understand what it teaches in its pro-life approach but also that this approach is adopted and actively practiced in our Catholic health facilities. We must not fail to support them in their stand against the modern "culture of death" which makes the life of every person subject to political or ideological whims and convenience, and is often promoted by governments and donors. The result is that workers are put under tremendous pressure to conform to these whims or else forfeit the funding which they so desperately need. We believe that bishops have the obligation to speak up in defense of these workers at all times and to support them through loving and focused pastoral care (care for the carer, to be specific).

Pastoral Care for Carers

This Council has as its goal the appropriate and dedicated provision of pastoral care for those involved in the care of the sick and dying. Because by its very nature their work puts them in daily contact with illness and death, healthcare workers themselves stand in real and urgent need of pastoral care, spiritual healing and guidance. This could take the form of spiritual retreats, days of recollection and time to reflect and meditate – to look into their hearts to discover there, and draw on, those deep-seated values and beliefs that are needed to inspire and

guide them in their life and work.

The AISAC workshop, mentioned above, noted the lack of pastoral care programs and people dedicated to pastoral service in our institutions. Given that the African peoples generally associate spiritual care with the healing process, it is important that health workers are well prepared and trained so that the health care they give can draw strength from the liturgy and prayers which are part of the pastoral care available to them. The liturgy in particular is a sacred moment, especially when it celebrates our reconciliation with God and with our brothers and sisters, and gives true meaning and value to suffering and solidarity.

2. Transparency and Ethical Norms

I come now to the second point made by the Holy Father, the need for an increased emphasis on transparency and ethical norms in our work, with funds primarily used to "serve the good of the sick".

"The support of the health institutions of the Church in Africa requires an awareness of the practice of management (stewardship) and a new internal and external partnership that will ensure the future sustainability of services and finances" (recommendation by the Pontifical Council and AISAC to the African Bishops, 2009).

Because healthcare workers in Catholic facilities serve people of all beliefs, races and cultures, their work gives them a unique opportunity to bear witness to the Gospel.

That is why their actions will need to demonstrate a commitment to transparency and accountability which is sorely lacking today, where in many instances it is "every man for himself" and "anything goes as long as I am not caught".

"Christ alone can free man from what enslaves him to evil and selfishness: from the frantic search for material possessions, from the thirst for power and control over others and over things" (John Paul II, Homily, March 1, 1998).

Being a Good and Faithful Steward

In *Africae Munus* Pope Benedict refers specifically to the need for accountability. Many good individuals and organizations contribute generously to the Church's healthcare. So, especially we in Africa must show good stewardship in the use of resources as a way of acknowledging that all resources come from God and so must be used for His glory and the common good. Such a responsible stewardship of resources will involve advocating a just and equitable healthcare system through which every person is assured basic health care and in which the good health of every member of the community is fostered.

Therefore all administrative boards and management structures must ensure that wise and prudent financial decisions are taken in handling public and donor funds. Accountability challenges us to provide credible information that clearly demonstrates our relevance, our efficiency and added value, our observance of relevant legislation, and the ethical conduct of our boards, management and staff.

Recommendations therefore include a) the establishment of good governance through well-appointed and responsible boards, and b) the regular provision of financial information not only to the local Bishops' Conference but also to the local public health authorities and especially to donors.

Promoting Justice while Caring for the Sick

Finally, one of the most important recommendations to the African Synod dealt with the promotion of justice through healthcare. So often it is the victims of injustice that are brought to our hospitals, dispensaries and clinics for assistance. A famous example is Steve Biko's doctor who was the first to speak out about the unjust treatment that he was receiving at the hands of his jailors.

Healthcare workers are obliged to bring to the attention of the authorities any cases of injustice that they may encounter in their work. As well as bringing relief or justice to the victims, such action will demonstrate the spirit of true justice and fairness which is the mark of the Christian.

This makes it all the more incumbent on us to make sure that the Church cannot be accused of pointing out the wrong that others may be doing while ignoring what is wrong in our own facilities. Consequently, it is necessary that we provide healthcare workers in our institutions with salaries and working conditions that are in keeping with or even better than those of government. Charity must never be an excuse for allowing situations of injustice to exist.

It would seem appropriate that while African bishops take advantage of every opportunity to "promote initiatives in defense of justice" jointly in their countries, they should at the same time ensure that their own institutions reflect true justice in regard to working conditions, as well as an equal and fair distribution and use of resources.

3. A Bishop Responsible for Pastoral Care in Health

The final recommendation of the Pontifical Council together with AISAC was that, with the support of the Council, each Episcopal Conference should nominate a Bishop responsible for coordinating appropriate pastoral care in each health region, as well as conducting necessary negotiations with government authorities regarding health care.

True pastoral care for our healthcare workers affirms, promotes and dignifies their work, grounds it in God and gives it true value. At the same time it inspires workers to regard their work as service rendered to Christ through all that they do for "the least of his brothers and sisters". ■

Hospitals: Temples of Humanity and Crossroads of Peoples

H. EM. CARDINAL WILLEM JACOBUS EIJK
Archbishop of Utrecht, the Netherlands

The Church encounters first of all people to whom it transmits the Christian faith in churches during various kinds of different liturgical celebrations, confessions and other pastoral encounters. However, outside churches there are also places of encounter, especially as regards people who never go to church. This is true of many non-Christians or non-Catholic Christians who do not attend our churches but also of Catholics who never practise their faith or practise it very little. Hospitals are, without doubt, such places of encounter. A hospital chaplain or a parish priest or a vice-parish priest who visits sick people from his parish who have been admitted to hospital will also find there Catholics who perhaps never go inside a parish church.

A hospital, as well as being a place of encounter of non-Christians and Christians, is also a place that offers an opportunity to meet people who at times are more open to the Gospel than is usually the case. Although it is obvious that evangelisation and – in Western Europe – re-evangelisation concern all human beings, both the healthy and the sick, the rich and the poor, the elderly and the young, experience in general suggests that existential crises are often valuable moments of reflection about the meaning and the purpose of life which can open the soul to Christ and to his Gospel. A pastoral encounter with a patient in a hospital is thus, not rarely, very productive in spiritual terms.

In addition, a hospital can be an excellent setting in which to express human and Christian charity in a very intense way. In his motu proprio *Porta Fidei* the Holy Father stresses that to achieve a productive re-evangelisation witness to charity is required: 'Faith without charity bears no fruit, while charity without faith would be a sentiment constantly at the mercy of doubt...Through faith, we can recognize the face of the risen Lord in those who ask for our love. "As you did it to one of the least of these my brethren, you did it to me" (*Mt* 25:40)' (*PF* n. 14).[1]

In contemporary hospitals, above all in hospitals in the big cities, one can encounter because of the globalisation of the world in addition to indigenous patients also the representatives of many peoples and races, if not, indeed, of them all. This was also my experience during the time that I worked as a medical doctor in the hospital of the University of Amsterdam at the end of the 1970s.

All in all, one can describe hospitals as temples of humanity and crossroads of peoples.

A Look Backwards

From a look backwards it is clear that hospitals worked from the outset as temples of humanity and crossroads of peoples. One should also observe that hospitals as we know them were an 'invention' of Christians. The Roman Empire had military hospitals which offered emergency aid and rehabilitation for sick or injured soldiers with the primary purpose, if not the only purpose, of making them return as soon as possible to active military service. For this reason, the treatment these hospitals offered had utilitarian motivations. Christians after the Edict of Milan of the year 313 of the Roman Emperor Constantine had an opportunity to express themselves publicly and to found hospitals in order to implement the ideas that they had as regards sick people. These hospitals, which Christians founded during the second half of the fourth century, were the first to offer medical care, including long-term medical care, to sick people, and to poor and oppressed people who were ill who not able to pay for their treatment.[2] The foundation of these hospitals was the consequence of a radical change that was promoted by Christianity as regards the social position of sick people and the organisation of public health care.[3]

Christians began to see disinterested care for the sick as a task that was inherent in the imitation of Christ, primarily because of the analogy that exists between the redemption of man by Christ and the healing or curing of a sick person. This led a number of the Fathers of the Church to bestow upon Christ the title '*Christus Medicus*'.[4] This analogy was compelled by the numerous healings worked by Jesus and reported in the gospels. Another very important factor was that Jesus himself identified with human beings who lived in poverty: '"Come you that are blessed by my Father! Come and possess the kingdom which has been prepared for you ever since the creation of the world. I was hungry and you fed me, thirsty and you gave me drink; I was a stranger and you have received me in your homes, naked and you clothed me. I was sick and you took care of me, in prison and you visited me"' (Mt 25:34-36). This provided those who loved Jesus with the opportunity of engaging in concrete acts of charity towards him, amongst other things through caring for the sick, thereby recognising in them his face. A icon for all those who work in health care was the Good Samaritan of the parable that carries his name (Lk 10:25-37).[5]

All of this stimulated Christian physicians, but also Christians in general, to care for the sick with charity and compassion. Since God showed us His love for us in an unlimited way in the incar-

nation of His Son and in the sacrifice of His Son on the cross, care for the sick could also take the form of a sacrifice by treating them without asking for payment in return. The icons of this are the martyr saints, Cosma and Damian, whom we are told by tradition were physicians in Syria who treated their patients out of Christian charity and charged no fee for their services. This could even involve the sacrifice of one's own life in looking after sick patients who were afflicted by the plague, which was something that involved the risk of being infected by this disease which was often fatal. We are told about a number of saints who treated people afflicted by the plague in a generous and heroic way, amongst whom were St. Catherine of Sienna (1347-1380) and St. Aloysius Conzaga (1568-1591).

After the decline of the Roman Empire, the monasteries of Western Europe offered free hospitality to travellers in their guest accommodation and this included medical care and treatment for those that were ill. Thus these buildings providing guest accommodation were literally temples of humanity and crossroads of peoples. For more than five centuries the guest accommodation of monasteries constituted the only organised medical care in the West.[6] Although from the point of view of contemporary medicine the level of medical science and the methods that were applied to heal the sick were of a very low level, and many medicaments and surgical techniques of antiquity had been lost, the deep Christian motivation for taking to heart the efforts of the sick remained.

In parallel with the birth of cities, from the twelfth century onwards communes built large city hospitals. Innocent III (1198-1216) stimulated wealthy Christians to found these institutes in every city. The hospital of the Holy Spirit in Sassia in Rome, which he himself founded, was the model for these city hospitals.[7]

Modern hospitals, which have made a clear distinction between medical care and pastoral care, arose in the eighteenth century. However, those hospitals which had a Christian identity conserved the gospel motivations of the origins. In recent decades, in expressing and implementing the Christian ideals of integral care, that is to say medical, human, psychological, social and spiritual care, in hospitals above all in the Western world, today a large number of difficulties and challenges are encountered, and to this subject I will return later in this paper.

An Intrinsic Evangelisation

A hospital as a temple of humanity and crossroads of peoples is a setting to the utmost for evangelisation. The reasons lie in the analogy, which I have already mentioned, between redemption and healing, which was emphasised by Jesus himself, and the fact that care for the sick is a special form of human and Christian charity.

One should avoid giving the impression that one is dealing here with a technique to win over souls. This would be the case were one to impose the Christian faith on patients within the context of medical care or if this care were to be offered only on the condition that the patient converted to Christianity. This would be in contradiction with the Christian faith itself which requires that a person makes a free choice for Christ and his Gospel.

Medical care, where the patient is left free, without forcing him or her, or putting him or her under pressure, to become a Christian, is an act whose moral object is good in itself. If carried out with a good intention, medical care is, of its essence, an act of charity. This is expressed in deeming the 'visit the sick' the fifth of the seven works of corporeal mercy (derived from Mt 25:35-36 and Tb 1:17). Care, if carried out without impositions or without concealing one's own Christian beliefs, is, in addition, in itself an act of evangelisation.

A very fine and expressive exploration of this from the point of view of theology and of spirituality is offered to us by St. Camillus de Lellis (1550-1614). Favi calls his theology of the care of God a 'lived theology'.[8] St. Camillus, who was wounded as a soldier on the battlefield, suffered from an incurable and festering wound until his death at the age of sixty-four. As a patient and a worker in the hospital of St. James of the Incurables in Rome, he saw how care for the sick during his epoch was defective. The conditions at the level of hygiene were miserable and the nurses were on the whole unworthy people, often being prisoners, and they had no training for their work or any dedication to it. In order to improve care in hospitals, St. Camillus founded the Order of the Ministers of the Sick, now known as the Order of Camillians, whose members – both priests and brothers – devoted themselves entirely to care for the sick and to pastoral care for the sick. His theology of the care of God was developed in part on the basis of his theological studies within the context of his priestly formation, and above all on the basis of what happened to him as a result of his experience of his own illness and the way in which he himself and others were treated in his hospital.

After his conversion from being a wild and violent man, a slave to gambling, into an ardent follower of Jesus, and transfigured by his experience of the concern of God during his illness, St. Camillus discovered that a sick person was 'the altar of the exercise of his baptismal and ministerial priesthood', as Favio put it.[9] Subsequently he developed a Christocentric vision of himself and his neighbour which made him perceive in a new and practical way the inalienable value of every human being even if sick. St. Camillus saw a sick person as a '*sacrament* of the encounter with Christ and thus a way of access to God and perceived and experienced how "with the incarnation the Son of God after a certain fashion united himself to every man"'[10] Because of his or her suffering a sick person offered a place of experiencing the kenosis of Christ in his incarnation and cross. St. Camillus started from tradition in recognising in a sick person the face of the suffering Christ[11] but he added to this the analogy be-

tween the above-mentioned identification of a sick person with Christ and Christ's presence in the sacraments. Apart from the face of Jesus, St. Camillus found in the face of a sick person also the face of merciful God who redeems and makes participate a human being in His intra-triune life. Experience of the contemplation of the suffering of Christ in a sick person 'becomes a place for calling on solicitude for man, for revelation of his mission and for care for the needs of humanity. Such care refers back to the concern with which God Himself through Christ bent down before the frailty of humans in order to transmute it into a way of hope'.[12] Care for a sick person thus became 'witness to the concerned presence of Christ the Good Samaritan of humanity' and at the same time the area of encounter with Christ who 'serves, cares for and heals a sick person with the maternal tenderness of God through the solicitous action of a Minister of the Sick'.[13] Solicitude towards sick human beings, seen in this way, was seen as analogous with the sacramental presence of Christ and as a form of extension and implementation of his salvific-healing mission.

I would like to point out two special outcomes of the spirituality of St. Camillus. First of all, the spirituality of St. Camillus, in adding to recognising the face of Christ in the face of a sick person the analogy of this identification of a sick person with Christ through his sacramental presence in the Eucharist, offered a bridge by which to connect to each other the deaconate and the liturgy, especially through the sacrament of the Eucharist, where Christ is present, in his suffering, in his death and in his resurrection, amongst us in the forms of bread and wine. Like many Christians in secularised society, Christian workers in the field of health care also encounter difficulties in practising their faith in their daily lives. The possibility of connecting the deaconate with the liturgy makes those health-care co-workers who take this spirituality as a point of departure able to integrate their faith and their personal relationship with Jesus in a very direct and productive way in their care for sick people.

Secondly, the spirituality of St. Camillus for health-care workers prefigured in a certain sense the Second Vatican Council and its Christological anthropology. The Second Vatican Council, in pronouncing on human affairs, was also profoundly Christological. The Son of God, who became man, took on our humanity and our human condition, as a result of which in Christ there is a fundamental unity of all human brings, both Christians and non-Christians. Thus the Second Vatican Council said in *Gaudium et Spes*, the Pastoral Constitution on the Church in the modern world, that: 'The truth is that only in the mystery of the incarnate Word does the mystery of man take on light' (n. 22).[14] By his incarnation Christ does not only reveal God, he also reveals man to himself. In the mystery of the incarnation there expires the dualism of a natural morality and a supernatural morality. A hospital, in performing its Christian mission in implementing the deaconate of charity towards sick people, at the same time thereby bears witness to a profoundly human charity and a charity that is profoundly Christian.

The theology that was lived by St. Camillus of the relationship between the person who looks after a sick individual, whether a medical doctor, a nurse or a pastor, and the patient himself or herself, implied for the former a very beautiful and profound form of spirituality. This spirituality can awake in such workers an approach of solidarity with the suffering individual and an empathetic concern for him or her in the context of authentic Christian charity, despite his or her wealth or lack of wealth, origins, the people or race to which he or she belongs, and his or her religion. One understands that this spirituality is of value also for medical doctors, nurses or pastors in their extramural contacts with sick people. However, this spirituality of St. Camillus, except where it is developed specifically in a hospital setting – and it could not be developed but in this way – is expressed in a much stronger, more intense and more productive way if it is offered in an organised and systematic way by a health-care institution rather than by an individual. Thus the Christian deaconate of charitable concern has, inside hospitals whose workers are sincerely committed to implementing it, a great evangelising strength.

The Contemporary Challenge of Maintaining Hospitals as Temples of Humanity

After the middle of the nineteenth century and above all since the 1930s medical science has undergone an unprecedented advance. There is no longer an absence of hygiene. There are numerous medical products and techniques that make it possible to cure many illnesses and relieve many troublesome symptoms in an effective way and for which there was no remedy in the not very distant past. The diagnosis of cancer is no longer a 'death sentence' although there remain today many incurable illnesses. This advance of medicine is a reason for gratitude. However, this does not remove the fact that illnesses, and especially grave and chronic illnesses, are also often a source of suffering. Although we no longer have in our hospitals the dramatic conditions that St. Camillus witnessed when he was alive, today, as well, many sick people suffer physically, mentally, socially and spiritually. There will always be sick people who are abandoned by their family relatives. Today as well, and perhaps more than was the case in the past, sick people struggle with anxiety and with the question of the meaning of suffering and then the question of the meaning of life.

However, over recent decades certain developments have taken place which should be observed and these concern contemporary hospitals. They make the deaconate of Christian charity rather difficult to live. These developments undoubtedly exist despite a progress which should undoubtedly be appreciated. They are threats which should not be un-

derestimated to hospitals being temples of humanity.

First of all, secularisation does not halt at the threshold of hospitals. As Benedict XVI observed: 'This secularization is not only an external threat to believers, but has been manifest for some time in the heart of the Church herself. It profoundly distorts the Christian faith from within, and consequently, the lifestyle and daily behaviour of believers'. [15] When a large part of the workers in a hospital no longer share the Christian faith, including its moral demands, it will become more difficult to express the deaconate of charity on the basis of faith in Christ and thus of the spirituality described above, which is the foundation of a profoundly Christian solicitude. This, without doubt, weakens the evangelising witness of hospitals.

However, even where all the workers are convinced Christians, contemporary culture in large hospitals, and especially in wealthy countries, makes the practice of the deaconate of charity, which is based upon a personal and living relationship with Jesus, difficult. This culture is characterised by a depersonalisation that attacks people.[16] Various different causes lie behind this depersonalisation.[17] We see manifested a strong tendency to see professional skills and expertise, and this applies to medicine as well, unilaterally as mere technical ability. This creates an atmosphere in which the expression of emotions, an element that is indispensable in human relationships, is almost the object of suspicion. The obligation to confine oneself to an approach of mere technical ability forces medical doctors or nurses to conceal that they are people with religious and ethical beliefs, their own characters and their own feelings behind a mask of professionalism. This phenomenon is strengthened by exaggerated autonomy, as a result of which there is a tendency to leave the ultimate decision to the patient, and this is a decision to which the healthcare workers must conform.

A second factor is advanced specialisation: a specialised medical doctor or nurse is inclined to focus his or her attention on that organ, on that part of the body, or that physiological system that concerns his or her special competence. In this way he or she runs the risk of losing the patient as a human person, in his or her, totality from sight.

A third factor relates to the consequences of the introduction of the free market economy into health care in order to control costs. This has transformed hospitals into institutes that are subject to a managerial approach: in order to calculate and control the costs of medical diagnosis and care and treatment, the management uses protocols where, for example, the time that is necessary to perform certain actions is prescribed and this is done without reference to the personal condition of the sick person involved. This makes it difficult to spend more time on a person who needs such time, and as a result the culture of a hospital becomes depersonalised. In addition, the introduction of the free market economy implies that the patient, often seen as a 'customer' or even as a 'consumer', engages in a contract with those who come to his or her aid. This contract assumes that both parties have an equal position, which in reality they cannot have. The position of the party that provides aid and the position of the party that asks for aid are very different from each other. The contract does not take into account this diversity of the parties involved. Health care, unilaterally guided by a free market economy, is directed more towards healing as a product than the sick person himself or herself who needs to recover. Economic values thereby take the place of human values. John Paul II pronounced on this development in the following way: 'Here we find a new limit on the market: there are collective and qualitative needs which cannot be satisfied by market mechanisms. There are important human needs which escape its logic. There are goods which by their very nature cannot and must not be bought or sold. Certainly the mechanisms of the market offer secure advantages: they help to utilize resources better; they promote the exchange of products; above all they give central place to the person's desires and preferences, which, in a contract, meet the desires and preferences of another person. Nevertheless, these mechanisms carry the risk of an "idolatry" of the market, an idolatry which ignores the existence of goods which by their nature are not and cannot be mere commodities (*Centesimus Annus* n. 40).[18]

The depersonalisation caused by the factors that have just been listed is a serious obstacle to care based upon a Christian faith that is lived. Over recent decades a significant number of nurses, after they finished their studies and began to work, have felt disappointed and by no means a few of them have decided to look for another profession or another job within a hospital. Many of them, not finding in hospitals a culture in which they can work according to their expectations, have the impression that they cannot live what they see as their original vocation.[19]

One disturbing question is that in the Netherlands most of the people who are responsible for pastoral care in hospitals, and they are for the most part lay pastoral workers with a pastoral mission entrusted to them by their diocesan bishops, are forced by managers to conceal their specifically Christian and Catholic contribution behind a mask of professionalism. Indeed, they do not care for the Catholic Christians of their hospital. The management indicates to them those departments, for example of internal medicine, of neurology or of surgery, where they have to attend to all the patients who need them, independently of what religion they may belong to: Christians of various denominations, Muslims, Jews, Hindus, Buddhists or non-believers. The patients of other departments who want to have contact with a pastor of souls who belongs to their religion can obtain this through a written request. In this field use is made of the technical professional competence of a pastoral worker in the area of techniques of conversation and their the ability to assist people who are in a state of crisis or who have to struggle against bad news

as regards the prognosis for their illnesses. However, a pastoral worker must keep quiet about his or her own beliefs, which, in reality, concern the essence of his or her mission. This does not make it easy to give to pastoral care for the sick a real Christian character and prevents witness to faith in Christ by those who have received a pastoral mission.

Conclusion

The profound spirituality that was from the outset the basis of care for the sick and was enriched over time by people, and by Orders or Congregations that dedicated themselves in particular to this kind of task, is a very valuable fruit of faith in Christ. There are, however, a significant number of challenges in the contemporary culture of the world of health care in general, and in hospitals in particular, to making this fruit shine forth. In the studies of the spirituality of health-care workers and – not least of pastors of souls in hospitals where such studies are an ongoing task – one should devote especial attention to the possibility of working with this spirituality in the contemporary world of health care for the benefit of our sick people. This is a '*conditio sine qua non*' to be able to assure that hospitals remain temples of humanity and crossroads of peoples that are inspired by Christian ideals relating to care for the sick.

Notes

[1] Benedict XVI, "Motu proprio Porta Fidei (11 ottobre 2011)," AAS 103 (2011), n. 11, pp. 723-734.
[2] A.S. Lyons and R.J. Petrucelli (reds.), *Medicine: an Illustrated History* (New York, Abrams, 1987), p. 272.
[3] H. Sigerist, *Civilization and Disease* (Chicago, University of Chicago Press, 1943), pp. 69-70.
[4] H. Schipperges, "Zur Tradition des 'Christus Medicus' im frühen Christentum und in der älteren Heilkunde," *Arzt und Christ* 11 (1965), pp. 16-19.
[5] W.J. Eijk, 'The Good Samaritan is the Greatest Justice', *Dolentium Hominum* 15 (2011), n. 1, pp. 64-68.
[6] A.S. Lyons and R.J. Petrucelli (eds.), *Medicine: an Illustrated History*, pp. 276, 283-291.
[7] *Catholic Encyclopedia*, 'Innocent III'.
[8] J.M. Favi, 'San Camillo de Lellis, "teologo" della premura di Dio', *Camillianum* 9 (2009), n. 25, pp. 57-78, quotation p. 57.
[9] *Ibid*., p. 65.
[10] *Ibid*., p. 69.
[11] S. Cicatelli, *Vita manoscritta di S. de Lellis, scritta prima della morte di questo*, p. 54 (edition by the *Curia Generalizia dei Chierici Regolari Ministri degli Infermi*, Rome, 1980).
[12] J.M. Favi, 'San Camillo de Lellis, "teologo" della premura di Dio', p. 70.
[13] *Ibidem*.
[14] Second Vatican Council, 'Costituzione pastorale *Gaudium et Spes*', *AAS* 58 (1966), pp. 1025-1115.
[15] Benedict XVI, 'Discorso ai Partecipanti all'assemblea Plenaria del Pontificio Consiglio della Cultura (8 marzo 2008)', AAS 100 (2008), pp. 245-248, quotation p. 246.
[16] J.J. Zealberg, 'The Depersonalization of Health Care', *Psychiatric Services* 50 (1999), n. 3, pp. 327-328.
[17] B.M. Ashley, J. Deblois, and K. O'Rourke, *Health Care Ethics. A Catholic Theological Analysis* (Washington D.C. Georgetown University Press, 2005, 5th ed.), pp. 204-205; A. van Heijst, 'Burn-out, een teken aan de wand?' in J.P.M. Lelkens, J.A. Raymakers (eds.), *Economisering en vertechnisering van de gezondheidszorg* (Bunnik, Stichting Medische Ethiek, 2006), pp. 117-129.
[18] John Paul II, *'Litterae encyclicae Centesimus Annus* (1º maggio 1991)', AAS 83 (1991), p. 843.
[19] S. Hewa and R.W. Hethrington, 'Specialists without Spirit: Crisis in the Nursing Profession' *Journal of Medical Ethics* 16 (1990), pp. 179-184.

The Hospital of the Holy Spirit in Sassia: its History and Mission

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On the banks of the Tiber, in the heart of the city, is located the Hospital of the Holy Spirit in Sassia, the oldest hospital in Rome and amongst the oldest in the world.

During the first imperial age, in this area were to be found the *horti* of Agrippina where tradition located the villa of the favourite granddaughter of Augustus. Indeed, under the hospital, beneath the 'Sistine wards', remains were discovered in *opus mixtum* as well as floor mosaics of the first half of the second century AD, together with the remains of plastered and painted walls that certainly go back to the first century AD.

In these places, which correspond to the *ager Vaticanus*, was located one of the most important *scholae peregrinorum*: that of the Saxons. The *scholae*, ever since the fist centuries of the Christianity, were used for the accommodation of pilgrims who came from the remotest regions of Europe to the Eternal City to visit the tombs of the Apostles Peter and Paul and to venerate the relics of the first Christian martyrs.

The four *scholae* referred to by the *Liber Pontificalis* (of the Franks, of the Frisians, of the Saxons, and of the Lombards) were within the Leonine wall and accommodated travellers and pilgrims belonging to these peoples. In addition to residential houses they contained shops and taverns, places for the sick and hospitals, as well as a church and a cemetery to give a Christian burial to those people who died far from their countries. They had their

own *militiae* which they mobilised to defend the city.

The *schola Saxorum* was founded in about 717 AD by Inna, the King of Wessex who, on the occasion of his visit to Rome, had a building made to accommodate the sovereigns, nobles and ecclesiastics who came from far off England. Next to it was the Church of St. Mary in Saxia, with attached to this a hospital (*hospitium peregrinorum*) and a cemetery. This hospital (or *xenodochium*) was enlarged by King Offa of Mercia in 794.

Throughout the High Middle Ages the *schola Saxonum* expanded in the area of the Borgo (from the English term 'burg') and the importance of the hospital also grew before its decline after 1000.

It was precisely the area of the old hospital that King John of England, after returning from the Holy Land, gave to Pope Innocence for the building of a new hospital.

Lothar of Segni, who became Pope in 1198 with the name of Innocent III, was one of the great Popes of the Medieval period. During his long and controversial pontificate – he died on 16 July 1216 – he was responsible for memorable constructions such as the Hospital of the Holy Spirit in Sassia which was a model for similar institutions throughout Christendom.

One night this Pope had a dream (the life of Innocent III was full of prophetic dreams) in which an angel commanded him to build a new and large hospital for the city: this was built at the point where his mule knelt down, that is to say in the area of the hospital of the Saxons.

The building work was carried out very quickly and paid for by the Supreme Pontiff with the alms of the faithful '*pro salute animae*'.

By a document of 19 June 1204 (*Inter opera pietatis*), Innocent III entrusted this institution to Guy de Montpellier and his brothers ('*Guidoni … eiusque fratibus*') and laid down the Rules of the Order of the Holy Spirit.

Recent and accredited studies have ascertained, in opposition to certain doubts that arose in the past, that Innocent III followed the building of the hospital and paid for it, that he established the rules for its management and how it should work, and that he then entrusted it to Guy de Montpellier.

This last was an aristocrat and Templar knight who had always dedicated himself to care for the sick. Since 1170 he had established in his city of Montpelier an Order of Hospital Brothers and had built a hospital named after the Holy Spirit: in the above-mentioned Bull of 1204 he was referred to as '*fundator hospitalis Sancti Spiritus Montepessulanis*'.

In 1198 he was in Rome where he had two hospital houses. The Pope, who knew him and appreciated his works which offered care and assistance, by an act of 10 December 1201 granted to him the Church of St. Mary in Saxia and the adjoining hospital which had just been built or was being built where at one time the ancient hospital for pilgrims ('*hospitalitas Anglorum*') had been located.

Another document, in addition to the above-mentioned Bull of 1204 which contains the articles of the *Regula*, is of fundamental importance – the '*Ad commemorandas nuptias*'. This laid down that every year the Pope, accompanied by Cardinals and canons, would go on a procession from St. Peter's Basilica to the hospital where in memorial of the wedding of Cana there would be distributed meat, bread and wine to three-hundred patients and another thousand needy people from every part of the city (which at that time had a little less than 30,000 inhabitants). This act was intended to emphasise the caring function (in the broadest sense of *caritas*) of our hospital which for the first time was called *hospitale Sancti Spiritus in Saxia*.

Of fundamental importance in knowing in a detailed way about the type of care that was provided by the Hospital of the Holy Spirit is the *Liber Regulae*, of which we have various manuscript codices and various printed versions from the modern age.

The oldest and most representative codices, not only from an archival point of view but also because of its splendid miniatures, are to be found in Italy. One, from the fourteenth century, is kept in the Vatican Library, in the Borghese Section (amongst the documents that Cardinal Borghese managed to move from Avignon to Rome). The other – and this is the one that will be drawn upon in this paper, is at the present time to be found in the State Archives of Rome and comes from the archives of the Hospital of the Holy Spirit. It is in a Gothic script, with illuminated headings, and was drawn up, according to the most recent and accredited analyses, at Avignon roundabout the middle of the fourteenth century. It is attributed, because of its stylistic and iconographic features,

Pope Innocent III

Guy de Montpellier

to the *atelier* of the Master of the St. George Codex.

The *Regula* was approved definitively by Gregory IX in 1228 and affirmed the following fundamental principle: 'the patient is the master and he who assists him is his servant'. Within this general rule, some distinctions were made as regards the approaches to be engaged in towards patients: towards the poor, '*libenter ed caritative*' (willingly and in a spirit of charity); towards religious, '*benigne, quasi servus Dei, et caritative*' (with affection and willingness to help, as is appropriate to a servant of God, and in a spirit of charity); and towards the rich and the powerful, '*speciale hospitium et reverenter serviatur* (they should be served with a special willingness to help and with reverence). The three adverbs *libenter, benigne* and *reverenter* express clear differences in terms of social class and treatment: they also express the spirit of the times and the special features of the place but also the practical necessities connected with the working of the institution and its survival, given that admission, care and treatment were free.

The people who needed to be admitted arrived at the hospital or were taken there (others were picked up in the streets, once a week, by a kind of ambulance cart) and left their belongings in a special office. They had to undress before they were assigned a bed and had to engage in confession and take holy communion. Dressed in the special clothes of the hospital, they lay in their beds assisted by the *confratres*. The sisters had the task of changing the bedclothes once a week, if they were dirty, and to wash the feet of the patients every Tuesday and their heads every Thursday.

There is no reference in the *Regula* to physicians, surgeons or apothecaries. One may assume that the brothers had special health-care knowledge and experience and that the sisters and the servants made their contribution to the usual practices involving care and assistance.

The presence of physicians in special cases cannot, however, be excluded, as is borne out by documents of the same period in relation to other hospitals (Santa Maria Nuova in Florence, Santa Maria della Scala in Sienna).

But hospital health care was not the only task of the Hospital of the Holy Spirit. The Rules of Innocent III of 1204 had declared expressly: '*reficiuntur famelici, pauperes vestiuntur, necessaria ministrantur infirmis*' (the hungry will be fed, the poor will be clothed, and the sick will be given the necessary treatment and care). In addition, Pope Innocent III, though the creation of the 'wheel for the foundlings', sought to provide care to newborn children whom inhuman mothers, prostitutes or of other kinds, used to abandon or even to throw into the waters of the River Tiber.

The 'Constitution' of Innocent III had an influence on health care in Europe for a number of centuries until the fifteenth century and beyond. Indeed, many hospital institutions adopted the Rules of the Hospital of the Holy Spirit.

The 'wheel' for the foundlings

During the 'captivity of Avignon', for about seventy years, a decline was witnessed, not only of the city of Rome but of all health-care institutions of the city, including the Hospital of the Holy Spirit. The old building constructed during the twelfth century by Marchionne di Arezzo was by now dilapidated, the internal organisation of the hospital was in a state of ruins, and the income of the hospital was at a low level and insufficient.

Eugene IV (1383-1447), amidst the stormy events of his pontificate, had an opportunity and the time to rebuild the hospital from its foundations, to fill its empty funds by an income that was paid directly by the Pope, and to restore its operations by giving new strength and vigour to its religious Order. He created, according to the customs of the time, the Brotherhood of the Holy Spirit which was made up of lay people who were rather well-off and to whom 'indulgences' were granted: in the *Liber Fraternitatis* were written the names of the brothers who had made over funds or left legacies to the hospital.

Nicholas V and Callixtus III were other Popes who dedicated themselves to the Hospital of the Holy Spirit during this troubled period. But the Pope who was responsible for a decisive turning point in the reconstruction of the Hospital of the Holy Spirit was Sixtus IV. Francesco della Rovere was Pope from 1471 to 1484 and his pontificate has received from historians rather controversial judgements. As regards the sub-

The Sistine Hospital

The wards

ject of this paper, he reconstructed *ex novo* the Hospital of the Holy Spirit which had been destroyed by the disastrous fire of the Borgo of 1471. He involved in this project 'skilled architects' whom he called to Rome from all parts of Italy. The building work was completed between 1477 and 1482. The façade was renewed (this is a façade that appears in the painting 'The Temptations of Jesus' by Botticelli in the Sistine Chapel and in the seventeenth engraving by Giovanni Battista Falda), the two huge wards with at their centre the dome cladding were created, and the buildings for accommodation and the services were restored. It was an authentic 'city of the sick', an ideal setting for conjoining religious piety with the mechanisms of healing.

The home of the sisters

The sixteenth century witnessed extraordinary events. The Catholic Counter-Reformation and the Council of Trent established new rules for hospitals and for all care-providing institutions, more rigid regulations as regards the way they worked and were managed, more careful administrative controls, and a greater level of technical/health-care qualifications.

But at the same time a new religiosity pervaded the whole of the sector, worked an evolution from within, shook consciences and transformed institutions. John of God, Filippo Neri and Camillus de Lellis were expressions of this deep renewal at the level of mentalities and customs. The Hospital of the Holy Spirit received the last two – Filippo Neri and Camillus de Lellis – into its wards amongst the patients, and gave them the rudiments of the art of medicine and placed them in contact (an organised contact) with pain, illness and death.

Over the next two centuries the Hospital of the Holy Spirit was a forerunner of the transformations that were underway in the field of treatment and care for sick people.

Alexander VII established a 'small hospital for the wounded', a sort of emergency department that was open day and night to deal with the victims of brawls and attacks which at that time in Rome were very frequent.

Once again under Alexander VII, in the year 1644, Commendatore Vai laid down that every Thursday the managers of the hospital – the administrators, the medical doctors, the apothecaries, the ecclesiastics and the other 'officers of charity' – were to meet in the room containing herbal remedies to discuss the problems and the needs of the moment. And periodic meetings of this kind were also established subsequently. The presentation of tables, information and comparisons attested to engagement and study in the correct management of an institution, and this was important not only at the level of health care and assistance but also at the level of the economic-financial context of Rome and Lazio.

In the middle of the seventeenth century the Hospital of the Holy Spirit had acquired a striking size: in 1657 4,014 sick people and 932 foundlings entered the hospital and a year later 6,505 sick people and 1,101 foundlings (by means of the special wheel) crossed its floor. In 1625 on one day alone there were 1,587 people in the dining hall, and of these 380 were patients, 118 were children, 560 were spinsters, and there were also friars, sisters, men and women nurses, servants and people who worked in various jobs for the hospital.

The institution enjoyed immense prestige, not least because of the 'value of the men great in medicine, surgery and herbal medicine' who worked in it. Amongst these there was Giorgio Baglivi, a man of an open mind who was ready to use in the treatment of sick people all the new developments, such as music therapy, which in our hospital achieved incomparable heights. When Cardinal Juan de Lugo introduced in Rome the elixir of China, a new miraculous medical product against fevers, the sisters of the

St. Filippo Neri

Giovanni Maria Lancisi

Hospital of the Holy Spirit made a concoction of exceptional efficacy which was extremely useful in countering malaria, which at that time was very widespread in Rome and its hinterland and came from the Pontine marshes.

Between the seventeenth and the eighteenth centuries there emerged the figure and the work of Giovanni Maria Lancisi, a medical doctor of mercy and a scientist of exceptional value. He taught at La Sapienza but argued that the teaching of the traditional texts of Galen, Avicenna and Mesue the Elder was insufficient in the training of a good physician: theoretical teaching had to be conjoined with direct examination of the sick. And the Hospital of the Holy Spirit provided all the elements for this operation which in the future would undergo a major development.

He transferred teaching to inside the hospital and still today, at the Historical Museum of Health-Care Art, is kept the teaching chair from which he taught at La Sapienza. The remains of the anatomical theatre are also kept at thus museum: the obstetric waxes of Manfredini (1785), the little skeletons of the *monstra*, and the anatomical models – all elements that were useful in the preliminary teaching of medicine.

The Popes of the Restoration dedicated especial care to the Hospital of the Holy Spirit. Later, Pius IX added a '*pars nova*' to what was still, legitimately, the hospital of the Popes: this new wing was used as a military hospital for the treatment of the sick and wounded of the French contingent stationed in Rome.

When in 1870 Rome, after the breach made in Porta Pia, was annexed to Italy, the situation of our hospital was aligned with the health-care legislation of the new State and the Hospital of the Holy Spirit became (was considered) one of the many hospitals of Rome.

There thus ended at this moment the special character of a hospital (a place for admission and care) in which faith and reason, piety and science, relics from the past and hopes for the future, found their most complete synthesis for many centuries. ■

Bibliographical Notes

On questions of a general character, only some essential recommendations for the history of hospitals, see, for everyone, the old but always valuable A. PAZZINI, *L'ospedale nei secoli*, (Orizzonte Medico ed., Rome, 1958); for the history of Roman hospitals A. CANEZZA, *Gli Arciospedali romani nella vita cittadina, nella storia e nell'arte* (Rome, 1933); and for juridical-institutional questions cf. E. NASALLI ROCCA, 'Il diritto ospedaliero nei suoi lineamenti storici', *Biblioteca della 'Rivista di storia del diritto italiano'*, vol. XX, Milan, 1956.

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In part some of the research of Enzo Bergami and A. F. La Cava on the *Liber Regulae* has been superseded; still valuable are the studies of Bergami in the internal regulations of the hospital (E. BERGAMI, 'Influenza del regolamento dell'Ospedale di Santo Spirito nella evoluzione della sanità in Italia', in *Atti e Memorie dell'Accademia di Storia dell'Arte Sanitaria*, 1, 1989.

Of very great interest for the history (but also for the present state of the buildings and the frescoes) of the whole historic site of the Hospital of the Holy Spirit are the *Atti del Convegno Internazionale di Studi* (Rome, 15/17 May 2001): *L'antico ospedale di Santo Spirito. Dall'isitutzione papale alla sanità del Terzo Millennio*, 2 vols. (Il Veltro ed., Rome, 2002).

The move from papal Rome to the troubled post-unification period is described very well in the recent S. MATTONE, M. MONGARDINI, and M. SCARNO', *L'Arcispedale Santo Spirito in Saxia* (Aracne ed., Rome, 2011).

The Historical Genesis of Hospitals

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1. Introduction

I think that one should approach the subject that on this occasion I have been asked to address with reference to its broadest definition. This is something of which I have practical knowledge given that I have had the possibility of knowing about *many hospital institutions* in various parts of the world. I have not been a person dedicated to the *field of history*: I have been much more directed towards the *management of the people* who go to make up hospitals, both the users and the professionals, and I have done this with a specifically pastoral outlook because I am a Brother of St. John of God, a priest.

On the other hand, seeing the programme of this *international conference*, with subjects based upon what is covered by the title, everything in my paper will be about the action of hospitals, their professional, human, and curative (on many occasions) action, or action involving accompanying when treatment cannot be given, and always with evangelising action according to the context or the creed of the people involved. The title of my paper is 'the historical genesis of hospitals'.

2. The Contributions of Antiquity

As it is impossible to engage in an exhaustive study, I will offer a trajectory with various dates *as testimony*. In antiquity there was overall action which was reflected in *religious or cultural traditions* which were different from those to be found in the Bible.

Ancient India: its data tell us about certain centres where medicines were distributed and which had personnel who were trained in treating sick people.

The Egypt of the Pharaohs: sanctuaries existed where sick people who were seeking help could reside and there were 'physicians' who practised magic.

Ancient Greece: in its temples there were kinds of private clinics with the best physicians who lived there so that they could examine those who asked for their help and also rest. Later they treated people in halls where the '*incubatio*' took place: a series of therapeutic sleeps and baths, physical exercise and diet. These temple were places of pilgrimage.

Ancient Rome: sorts of military camps were created for wounded soldiers. In Italy the great landowners began to construct buildings that they called 'hospitals' in order to keep their slaves in good health.

None of these four peoples had hospitals for the poor and the sick. The spirit of antiquity towards the sick and the needy was *not based upon compassion*. The custom of helping people in need to a great extent began with *Christianity*.

3. The Light that Came from the Word of God and Steadily Grew in the Church

The traditions of antiquity addressed the subject of evil and illness and the reason for their existence. The most known and most profound tradition is that of the *Bible*. Illness, suffering and death were the outcome of sin and as a consequence they were a *punishment of God*. We find ourselves in very precarious and primitive contexts and ones with few foundations in knowledge about reality. The Creation myth by which the appearance of man and woman in history is explained has needed theological explanation during the modern era. The knowledge of Job, that he was just, took place during a time when because of illness and calamity he and his family were seen as sinners. This was something that he did not accept and against which he fought with resistance and cries of protest until there came, through nearness to God, proof of his goodness.

In this context, *more than places of care* there were social attitudes that promoted the distancing of sick people from cities and towns: lepers, the mentally sick, the obsessed etc. were led to live in fenced off areas where very little was done to heal them. More than care and treatment, they received *exclusion*, which for certain categories of sick people has continued until the present day.

The Bible offers us accounts of initiatives that were taken to help infected people. We have a description of *the healing of Naaman the leper* who came from Aram to Israel and was sent by the prophet Elisha to the River Jordan (2 Kings 5:1-15). Them there is the healing of the *paralytic at the pool of Siloam* by Jesus (Jn 9: 1-12), a pool that had a curative power when the waters moved. Chapter 38 of *Sirach* engages in a *praise of the physician* and his learning; it speaks about medicines and the prudent man who knows how to use them, and also about the healing power of the spirit of God and the need for prayers for healing.

In a progressive way the word of God illuminates us about the reason for evil in history and the action of God and men in favour of others, above all in the case of those in need. Four characteristics are emphasised: a different view of sick people; a way of engaging in human relationships which is based on love; a broadening of care for the incurable and the dying; and the appearance of organised care for the whole of the population.

Modern hospitals have their origins in the houses for the sick and in the hospitals that were built by

the *Catholic Church* during the Roman Empire. Christianity asked its faithful to help the sick and those in need. The principal consequence of this change in values was the appearance of organised care for the whole of the population and this led to the creation of the hospital as a specific institution.

4. The Historical Evolution of Hospitals

During the fifth century the *Christian Churches of the East* created charitable institutions which were later called 'hospitals'. The authors of greatest authority see the Hospital City of St. Basil as the first hospital in history. In 370 he founded in Caesarea an establishment for sick people who were treated and cared for by physicians and nurses. *St. John Chrysostom* did the same later in Constantinople. St. Basil was the first to begin by fusing two genuinely Christian institutions, namely *a monastery and a hospital*, and this union was consolidated in the West by *St. Benedict of Norcia*.

We are provided with the first information about the appearance of various centres in the West at the end of the fourth century and during the fifth century by St. Jerome. Subsequently, *St. Benedict in his Rules* spoke in chapter 36 about how sick brothers had to be cared for, about how illness had to be experienced, and about behaviour towards those people who cared for the sick. Chapter 52 refers to guests and defines the character of hospitality. A proliferation in infirmaries stands out.

The Byzantine hospitals were a natural and immediate development of the work of St. Basil and his successors. They began a trajectory of care that was increasingly marked by the use of *scientific medicine* and then by Hippocratic-Galenic medicine. The Byzantine model of hospitals was transferred to the medieval and modern Islamic world. It was also transferred to the Christian and Roman world starting in the twelfth century.

Between the eighth and the thirteenth centuries *Islamic hospitals* received from Christianity their idea of a hospital as such, a fact that it is advisable to know about given the increasing interreligious component that we have and because of the importance that our Islamic patients have today for us.

During the *medieval period* the word 'hospital' began to be used and every category of hospital appeared, developed by the military Orders during the crusades. But there were also civil and episcopal hospitals in the cities which were really such, as well as hospitals of the nobility for pilgrims and hospitals for the crusaders which then became of general use, for lepers, the mentally ill, and so forth.

With the *hospitals of the Renaissance* there began the secularisation of hospitals, structures which had previously been organised by institutions of religious character. This was the natural consequence of a *secularisation of society* which led to a greater involvement of public authorities, which promoted them and controlled them. The municipal and state authorities allowed hospitals to be their own responsibility. The state began to take responsibility for what was is known as *public welfare*. A specifically hospital architecture appeared and there was also the presence of *specialised hospitals*: for the contagious, incurables, convalescents, lepers, the mentally ill, etc.

5. The Increase in Autonomy

From roughly the middle of the seventeenth century onwards, hospitals entered their stage of development when their control by the state increasingly grew to the point of placing them at the service of its political, economic and military goals. This approach led to the *replacement of motivations and goals based upon charitable criteria*, as had been promoted by the Church, by a search for greater efficacy in the achievement of ends. Medicine was like this in a decided way and this was then promoted by Enlightenment thinking. *General hospitals began* and these have continued until today.

The secularisation of hospital welfare continued through an increase in the control exerted by the state and because of the policy of the state of reducing and concentrating services and centres as part of a project of greater institutional rationalisation. This was achieved by strengthening the quality of care within the public domain. Vitality was lost and difficulties appeared as regards the appreciation of care provided within the context of so-called charity.

The *Enlightenment* had the virtue of giving a decisive impulse to the medicalisation of hospitals and to converting them into places where scientific medicine and its academic acquisition increasingly developed. *The dark side*, however, of this stage lay in the fact that advances in the organisation of hospitals and in medical science were not accompanied by a better and more worthy and more attentive care for those patients who had been admitted to hospital.

During the eighteenth century changes in scientific ideology accentuated the importance of empirical studies and the production of knowledge on the basis of observation of the facts. After the *French Revolution*, medical doctors in these countries began a new strategy of professional and social progress through what was generally called 'observation medicine'. With the notable number of patients that could be obtained in hospital wards, medical doctors had an opportunity to observe from the outset the individual development of illnesses and the diagnoses of many more patients than was the case in their private practices.

The increasing presence of doctors and surgeons in European hospitals made these institutions increasingly attractive as places for the instruction and training of physicians. *Special teaching halls* were looked for where lecturers and assistants, followed by their students, made regular visits to patients. The teaching of education became more active.

Hospitals during the nineteenth century present a paradox as regards their historical evolution: *at a scientific level they were praise-*

worthy but at the level of care they were deplorable. Medical doctors came to be seen as authentic scientists but in the same institutions hospitalised patients became *a higher field of scientific observation*, but this was done with the most crude enlightened despotism and the conditions offered by hospitalisation were often below the minimum necessary for elementary human decency and dignity.

6. Hospitals for all Social Classes

The last years of the nineteenth century can be seen as the moment when the evolution of hospitals received a new impulse which continued into the first half of the twentieth century. The form this took was as follows:

There was a move from charity to insurance against sickness – for the first time in history hospitals were used to diagnose and treat patients from all social classes. In 1882 insurance against sickness at work was introduced for employees and their family relatives, with a concomitant expansion of the market as regards health because this included medical treatment, the costs of medial products, and admission to hospital. Medical doctors and insured workers had a duty to decide between the need to treat the patient and his or her capacity to work. The medicalisation of medicine had arrived.

Hospitals functioned according to the needs of the urban and industrial context – the new mission of hospitals was the result of a convergence of ideologies, political strategies and welfare needs. Religious values and donations to charity still had an important role to play at the beginning of the twentieth century because the needs of economic development based upon capitalism indicated that the health of workers in the industrial world was of great importance both for the state sector and for the private sector. Urbanisation advanced at an accelerating rhythm. In addition, industrialisation created a new panorama of occupational illness and also ones caused by accidents.

Hospitals became the first and most important health-care resource – with the incorporation of scientific medicine hospitals were transformed into institutions of primary reference. Thanks to diagnostic and therapeutic procedures such as radiology, electrocardiograms and clinical laboratories, the ability to produce diagnoses greatly improved. Hospitals increasingly concentrated on the treatment of acute illnesses. A new generation of vaccines and therapeutic chemical substances improved the chances of success in the battle against certain illnesses. With anaesthetics and antiseptic procedures, hospitals were transformed into the most important centres for surgery.

New occupational illnesses – to treat patients, hospitals absorbed more and more generations of women nurses who came from the middle classes and who had been trained with educational programmes based upon the model established by Florence Nightingale (1820-1910). These hospital women nurses took the place of the religious personnel who by tradition had provided service to patients. The women nurses of Florence Nightingale were transformed into valuable assistants of the medical profession in the provision of care and treatment to patients.

Hospitals as centres for research and specialisation and medical teaching. During the second part of the twentieth century hospitals were transformed into the primary laboratories of medical doctors. Their objectives, which included specialisation, training and research, were transformed into institutional priorities. Hospitals underwent a major development in specialised care with the creation of clinical departments and an increase in the number of medical students.

Other aspects of the new hospitals. After hospitals were transformed into a point of preferred attention for the application of scientific principles in medicine, *new ethical problems emerged*. The processes of the medicalisation of life increased the level of life experiences. *Birth and death*, which previously had been events that took place at home, now took place in hospitals. From the beginning of the nineteenth century a *depersonalised approach to illness* influenced the nature of the relationship between medical doctors and their patients because professionals played a central role in successfully solving the diagnostic problems of human pathologies. The moral authority of medical doctors, which had hitherto been based on personal qualities, was now based on scientific competence. Clinical experimentation became aggressive and abusive because of the few guarantees that existed to safeguard patients.

7. The Presence of the Church during this Whole Stage

The Church has had, and has, a preponderant role in the provision of health care for the good of patients. Many Hospital Orders came into existence, amongst which that of the Brothers of St. John of God which was approved in 1571 by Pope St. Pius V and that of the Fathers of St. Camillus, the Ministers of the Sick, which was approved by Pope Gregory XIV in 1591.

There were a large number of religious foundations for women which consolidated the very important role of the presence of the Church in hospital care.

The action of the Church has been to do good to others, relying in turn upon the support of governments in those areas where foundations were made, and also upon the support of the local population, solving the health-care and social needs of very many people through the major sacrifices of people who joined these institutions, following the spirit of the men or women founders.

In the spirituality of these institutions the paschal mystery of Jesus Christ, who took on suffering of a redemptive character for other people, as well as the approach of the Good Samaritan who was sensitive and compassionate towards the wounded man he encountered on the road, were very present.

8. Observations

History tells us that the Church created care centres and has had a decisive influence on their development over the last six hundred years, from St. Basil until the present time.

Starting with the modern era, hospitals moved from being the responsibility and property of the Church to belonging to various secular institutions, and this underlined the power of political authorities, and, later, of medical culture and medical science.

This has not been an impediment because until now the Church has continued to pay preferential attention to hospital institutions. The proof of this is to be found in:

a. The large number of religious Orders and Congregations which from the sixteenth century onwards have had as their charism the provision of a service of care and of pastoral care in hospitals, and the foundation of their own institutions to express this hospitality.

b. The foundation of hospitals in lands of mission, from the sixteenth century onwards as well, as action inseparable from the evangelising work of the Church. According to the latest data provided by the Holy See in the *Annuarium Statisticum Ecclesiae*, there are 120,826 Catholic healthcare structures in the world and of these 5,236 are hospitals in the true sense of the term.

c. The number of hospital foundations which are still owned by diocesan churches.

d. The number of hospital beds at present provided by the institutions of the Church in the various sectors of health care, amongst which beds for psychiatric cases without which, in by no means few cases, the adequate provision of secular health care would not be possible.

e. The active and productive contribution of contemporary hospitals to new and pioneering initiatives such as ethical committees, palliative care units, units for people with brain damage, etc.

f. The agreements and understandings with public authorities and private health-care bodies to provide Catholic religious assistance services in hospitals.

g. For this reason one should state again vigorously and clearly that the Church must be faithful to her Tradition and for this reason must give to hospitals the attention, the people and the pastoral instruments that they need today; the Church must be faithful to Jesus Christ, the Good Samaritan and Physician for all people; the Church must maintain her faithfulness and make hospitals a fundamental instrument of encounter with sick people, their family relatives and those who work in them providing care; in dioceses people should know about and appreciate more the efforts made by Catholic hospitals to meet the new challenges of hospital care and to form with them closer relationships of pastoral cooperation; and given secularisation there is a need to review and renew the doctrine of Catholic hospitals (Spain 1981).

9. Conclusion

In this technical, secular, plural, scientific world the Church of Christ, the Good Samaritan, must act in the world of health and health care in the way that has always characterised her, doing good to others, especially when they are most in need.

The Church must do this being aware of the global world in which she lives with its cultural diversities, being in mind the constancy of gospel principles, amongst which the great mercy of Jesus Christ towards those who suffer, with whom he identified, as is expressed in the account in chapter 25 of the Gospel of St. Matthew of the Final Judgement.

The contemporary context is the outcome of a secularisation that in some aspects is exaggerated but which in others has been necessary, and we must strive to be light and salt of the earth through witness, knowing how to welcome, illuminate, respect and accompany every situation of suffering and death in our apostolic activity, in the belief that God saves, in addition to everything that we can achieve.

Centres of care are universal centres for all people and although they are the work of Catholic institutions we cannot force their users or the professionals within them to adopt our beliefs. We must always be evangelisers through our lives and we will do this to the extent that we embody the Gospel in our religious experience lived in the sacraments and in service.

We are given a great deal of light by the Second Vatican Council, as indeed was the wish of that Council, the fiftieth anniversary of the beginning of whose synodal assembly will take place over the next few days. With prudence but with audacity we must look to the future with hope so as to bring that light that centres of care and hospitals need today, with the sensitivity of their professionals, with support for life and with dying with dignity, so that they are truly places of evangelisation, because of the deeds we engage in and where they are performed.

We trust that during this year of faith that we are living through and the Synod of the New Evangelisation whose celebration we are now ending, these two events will be a stimulus for us and as we have been reminded openly on various occasions our faith should be united to works of charity, especially for those who suffer because of illness or marginalisation. May they help us to be a solidarity-inspired and renewed presence of Christ that is not alarmed but, rather, illuminates, and like Christ knows how to say things that are clear, are alive with transparency; and a presence that proclaims a year of grace for everyone, shares life with the least and with sinners, and always tries to bring a message of salvation for everyone!

May we do this through our presence in hospitals which are places of physical and moral healing; may we accompany the pain and deaths of people; may we make these institutions forces for humanisation where people in their own way encounter the mystery of the one God, a healing presence in our lives!

I will end this paper of mine with a quotation from a paper given by H.R.E Msgr. Zygmunt Zimowski, the President of the Pontifical Council for Health Care Workers,

at the recent Synod for the New Evangelisation. He reminded us that 'pastoral care in health has a field of action which has many detailed and complementary expressions which go from *hospitals* to relationships with the various professional figures of the health-care world; from personal encounter with people marked by the mystery of pain and from dialogue with their families to pastoral care in parishes etc. In practical terms *hospitals* must be seen as privileged settings for evangelisation because where the Church becomes a 'bearer of the presence of God' she is transformed at the same time into an 'instrument for the true humanisation of man and the world' (Congregation for the Doctrine of the Faith, 'Doctrinal Note on Some Aspects of Evangelisation', n. 9): an evangelised hospital is 'a place in which the relationship of treatment is not a profession but a mission; where the charity of the Good Samaritan is the first seat of learning and the face of suffering man is Christ's own Face' (Benedict XVI, Address to the Catholic University of the Sacred Heart of Rome, 3 May 2012). ■

The Centuries-Old Religious Role of the Sisters of Charity of St. Jane Antide Thouret in Roman Hospitals

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Introduction

The historical outline in this brief survey brings out a fine feature of the civil, social and ecclesial history of Rome and takes us back to the flow of the river of love for our suffering neighbours which led my religious family to take root in Rome and to make its mission of charity always contemporary, in line with the charism of the founding Mother, St. Jane Antide Thouret.

Our sister wrote: 'if suddenly one could reveal to human eyes all the tasks of heroic education, now enveloped in a dear and sweet silence, carried out by all the male and female religious Congregations, we would be certain that Rome is not only '*Caput mundi'* and the capital of Italy but also, and above all else, the capital of Charity' (Raffaella Perugini, *La nostra stella, Rivista trimestrale delle Suore della Carità,* 1962*).* We agree with her and we thank the Lord for the incalculable number of people that have been met, loved and healed, to whom we have sought to bear witness to the tenderness, the gratuitousness and the liberality of God the Father who is near to those who suffer and in a particular way to the sick, to the poor and to children.

The boundaries within which we travel on our journey through time are those of the city of Rome in the years that go from 1844 to today. We are the Sisters of Charity of St. Jane Antide Thouret, our Founder who in 1799 in Besançon, in France, created our Congregation which then soon spread to nearby Savoy and Switzerland. Its arrival in Italy goes back to the year 1810. She swiftly answered the request to care for the poor of the city of Naples which was made by the Empress, Madame Letizia, the mother of Napoleon Bonaparte, who had entrusted the Kingdom of Italy to his brother-in-law, Murat.

Hitherto the Congregation has reached thirty countries in the world. 'Love Jesus Christ, love and serve the poor, who are his members, express to them the love of the Father' *(RdV 1.1.1.)* is a charism that in the sight of God – 'God alone' is the motto of the institute – embraces the pains of the world: poverty as regards bread, health, culture and freedom. This is the charism of charity which is always of contemporary relevance and importance and which through the untiring and audacious work of the Sisters of Charity, and their lay friends, seeks to be, today as well, a propulsive centre of evangelisation and service.

Our Founder stayed in Rome during her trips from France to Naples which took place on a number of occasions and for almost two years between 1818 and 1820 when she sought pontifical approval for the Rules of the Congregation. At that time the organisation of care was the task of the government and the pastoral care of the Supreme Pontiff himself through the work of a chairman of a committee responsible for various institutions. Thus she nourished the wish to make herself available to the Pope for a service of charity. She made this request a number of times in letters that she sent from Naples between 1824 and 1826, the year of her death. Because of the interceptions of the letters and because of a lack of understanding between certain Cardinals and officeholders of the Vatican, nothing

came of this. But there would be a flowering of works of charity in Rome later on.

The First Call of the Sisters of Charity to Rome

Eighteen years after the death of our Founder, Sister Rosalia Thouret, her niece and secretary, who at that time was the Provincial Superior in Modena, after receiving a request from Pope Gregory XVI, responded to that request for a service of charity with two communities at the Hospital of the *Holy Spirit in Sassia*, in agreement with the General Superior Sister Guinevere Boucon. The service began on 23 September *1844* with six sisters. In what spirit? The same as that of the Rules written by the Founder: the mission of charity is 'to do in part what the Saviour of the world came to do on earth, to work to establish the Kingdom of God' (S.G.A. *Discorso preliminare alla Regola)* with the ecclesial definition that was so dear to her: 'I am a daughter of the holy Church, be the same with me' *(S.G.A., Circ. 11-4-1820).*

The sisters were entrusted with the *Conservatory for Unmarried Women* for young women rejected by their families and by society, and the *Orphanage for Abandoned Children*, which were both connected to the hospital. The reception was good but immediately the two communities had to deal with a confusion that had spread to all levels: the economic, the organisational and the moral. However, the sisters *managed to unite in love and with this widespread energy soon the atmosphere was marked by calm, order and respect*.

Two years later (*1846*) it was once again Pope Gregory XVI who through Msgr. Morichini, the Director of the Pontifical Charitable Works, made a second pontifical request, this time for the running of the *Refuge for Penitent Women* in *Piazza Santa Maria in Trastevere*, where what was proposed was a work of rehabilitation and mental and physical care for young women who had emerged from the most squalid experiences, troubles and rebellions. What was the therapy for these problems? The sisters found it and implemented it: calling on the young women to be involved in work, the acquisition of a sense of responsibility, and with the wish to acquire a more luminous identity. Their approach was marked by great welcome and friendliness, the wealth that they had available. The inhabitants of the neighbourhood did not forget this…

In the history of Italy and of Rome, *1848-49* was a moment of revolutionary movements and riots which wanted to overturn the existing political regime. They were moved by liberal anti-clericalism and by the dream of a new political order. The unity of Italy was wanted, even to the detriment of the Papal States. The secularist climate and the establishment of the Mazzinian Republic in Rome brought about the distancing/expulsion on the grounds of public peace on 23 February 1849 of the sisters and the religious of St. Camillus de Lellis, who had recently arrived in the capital city. Pope Pius IX himself was forced to flee to Gaeta.

Once the republic had fallen the Pope returned to Rome and called back the Sisters of Charity. H.E. Msgr. Carlo Luigi Morichini was chairman of the committee for charity, which also had lay members. In *1850* he established another community in the Hospital of the Holy Spirit to which he *entrusted the nursing care provided in the Sistine Ward*. Later, Pius IX invited the creation of a novitiate in the buildings of the same hospital and this was inaugurated on 2 January *1852*. These communities were at the service of the poor, their needs and their health, in a climate of relationships which were always marked by affection and an educational purpose. After assimilating the spirit of the Founder, the primary purpose of the sisters was that of bearing witness to faith and charity even in the most difficult places, such as the psychiatric wards of Via della Lungara and those for people with bad sight.

But at the Hospital of the Holy Spirit the Waters did not Calm

In *1860* Pius IX asked Sister Caroline Chambrot, whom he himself appointed Superior General, to look for another location in Rome for the novitiate and to move the general curia there from Naples. The political, social and strongly anti-clerical climate was heavy and lucidity was required so as not to succumb, as well as prudence in order to defend the young aspirants against complications, dangers and confusion. On 13 June *1869* an act of a public notary was drawn up for a building in the north-east part of the Aventino which was surrounded by land and a large garden. Here, after this transfer took place, young women were received and given formation so that they could be ready for the mission of charity as a response to the appeals of the Vatican, the town council of Rome, some noble families and benefactors for the provision of care to the sick and the education of young people in schools, orphanages and conservatories.

St. Agostina Pietrantoni at the Hospital of the Holy Spirit: a Martyr to Charity

In *1882* a young woman called Livia Pietrantoni arrived at the generalate house: 'one of those little and humble sisters of whom one can ask anything, especially what one cannot ask of the others, with the certainty of a 'Yes' which comes from the heart and awareness that only in this way can one express gratitude to God for being called and to the Congregation for being accepted'. (Perugini, *Storia della provincia religiosa di Roma*, 1989).

In *1884* this young sister was invited as a nurse to the Hospital of the Holy Spirit, first in the department for children and then in the ward for tuberculosis patients. Prof. Achille Ballori, a grand master of the freemasons, was the director of the hospital. He ordered all of the crucifixes in the wards to be removed, sent away the chaplains, the Conceptionist Fathers, and had hung in the Sistine Ward a slogan in square letters – 'Freedom of Conscience'. While waiting to send away the sisters as well, he prohibited them from speaking about God to the patients. It was in this climate that Agostina worked.

She served the sick whom she defended saying that they were not bad but only suffering. Her motto was 'For the Lord everything is not very much' and she was told that she had to take some rest. Having contracted tuberculosis she wanted to stay in the ward so that another sister would not become ill, and she went on with her service always smiling, full of care and without tiring. Her nursing style of life may be codified in ten rules for behaviour in a hospital environment: her decalogue. She revealed all her awareness that she was serving the person of Jesus Christ in the sick, the importance of the delicacy of small acts of kindness, the search for better care even to achieve a little relief, and caring accompanying until the final encounter with God.

Agostina died one morning, stabbed by a patient whom she had cared for in her ward and who had challenged her the whole time. The day was 13 November *1894* and she was thirty. She was in time to forgive the murderer who himself subsequently converted. Because of her virtuous life Agostina was beatified on 12 November *1972* as a martyr to charity, in the words of Pope Paul VI, and canonised on 25 April *1999* by the Blessed John Paul II. Since 29 April *2003* the Italian Bishops' Conference, through the Vatican Congregation for Worship and the Sacraments, has issued copies of the decree that declares her Patron Saint of the Nurses of Italy, when this is requested by medical doctors, nurses, volunteers, patients and various kinds of associations.

The Journey towards Other Hospitals and Places of Care, Assistance and Treatment for those who Suffer

In the meanwhile, governments and town councils during the second part of the nineteenth century became increasingly aware of their duties within society towards those who could not take care of themselves. A sick patient moved away from his or her village in order to obtain treatment in a city if he or she did not want to stay at home and die: families were forced to work hard and could not look after those of their members who fell ill. Hence the advance of the social need to open a large number of hospitals with large structures or small centres for treatment, and the constant requests made to our Congregation for hospital sisters for the sick and the elderly and for sisters involved in education for girls and young people.

A hospital that has left a deep mark on the memories of the Romans is the hospital founded in 1400 and called the *Hospital of St. Mary of Consolation*, which is under the Rupe Tarpea at the foot of the Campidoglio. This place enjoyed great popularity together with the Hospital of the Holy Spirit. The Sisters of Charity entered it in *1871* and remained there until *1936*. The Superior, Sister Loreta Marcoz, called the 'veteran' by Dr. Alessandro Canezza, is remembered with veneration. She died in the hospital in 1928 after 38 years of untiring service to the sick.

When in *1930* the Hospital of St. Camillus was opened, the Hospital of St. Mary of Consolation remained an emergency unit for a few years. Today the building is the headquarters of the High Command of the Municipal Police of the Campidoglio.

In 1870 some sisters of the Hospital of the Holy Spirit were called by the military section of the chief of the occupation of Rome after the storming of Porta Pia in order to care for the wounded of the Italian army and the papal soldiers in the district known as Gianicolo. The sisters hurried to help. They had to dress wounds but they were also engaged in listening to the problems of these soldiers, listening to them, and alleviating their longing to be with their relatives who were far away.

The Queen of Italy, Margherita of Savoy, had been the classmate of Sister Loreta Marcoz, the General Councillor and Superior at the Hospital of St. Mary of Consolation. Once the Queen came to Rome the contacts were re-established between the two friends and the custom was established of visits to the generalate house and the various charitable works that the Queen supported. It appears that she was very much inclined to works that helped the very poor. In *1875* a *home for blind poor people* was opened: it was named after the Queen and financed by legacies given by aristocratic families who were connected with the royal family. Its task was to provide accommodation and care to blind poor people. This home was made a charitable institution by the royal decree of 18 April 1875 which approved its statutes. These statutes were subsequently modified. The service of this home ended after the Second World War because the funding had come to an end. The town council of Rome took it over and fused it with the Institute of Sant'Alessio sull'Aventino. Today it operates elsewhere with approaches in line with existing laws and regulations.

The relationship between Pope Pius IX and the Sisters of Charity was a special one. He had known the communities of the diocese since when he had been Bishop of Imola. He was on very good terms with some of them and in particular with the vicar general, Sister Irene Buzio, whom he called his most tender daughter. She had asked him to be a missionary in India. 'My daughter, your Indies are at the Hospital of the Holy Spirit', was his reply. And it was precisely in this hospital that this sister engaged in a hard struggle to defend the patients and the sisters from the attacks of anti-clericalism, violence, and abuse of power. Unfortunately, she witnessed the martyrdom of one her daughters: Agostina Pietrantoni.

The Military Hospital at Celio

In *1871* the sisters were at the military hospital, which had previously been a pontifical hospital, at the Hospital of the Holy Spirit which was transferred to the area of Santa Maria Maggiore and , later on, to the Celio Hospital, *the military polyclinic that was built between 1885 and 1891*. Here still today a community provides service in some parts of it. This military world dear to our Founder as well is especially sensitive to the presence of the sisters. Here the illnesses of young recruits or of men who have served the State with honour and dedication are treat-

ed. Here a delicate nearness to the wounded or the mutilated, those who have been in war, humanitarian or cultural missions in various countries of the world is needed. Here the coffins of the victims of attacks, wept over by relatives, are received as a work of mercy that the sisters have often engaged in recently because of acts of terrorism or deleterious events in the places where the various missions have been carried out.

Linked to the Celio Hospital is also the *Cecchignola*, a military nursing home, in the neighbourhood of Laurentino where another community worked from *1954 to 1991*.

Care for the Elderly, Teenage Mothers, Orphans and Abandoned Children

To go back to the chronology, in *1875* the town council of Rome wanted a home for poor and sick elderly people at *San Gregorio al Celio*. The Sisters of Charity agreed to serve them. A little later there was the transfer to the Umberto I Home, in San Cosimato, in Trastevere, where other sisters of the Order were already working. They remained there until *1958*.

The Savetti Maternity Ward

The town council of Rome, through the ONMI (the National Work for the Protection of Maternity and Children), in *1887* had already asked for a kind of assistance that have never before been entrusted to the Sisters of Charity: nearness to, assistance to, and care for, teenage single mothers. There were two hundred of them in the Savetti maternity wards of *San Francesco a Ripa,* in Trastevere, and they stayed there until *1956*.

Their task was to help these young women to defend their health, to appreciate life through motherhood, to and to lead them to look to the future with positive intentions as regards self-fulfilment and a positive and effective reintegration into society.

The St. Mary of the Angels Orphanage for Girls

And in *1894* four sisters were sent to run the *St. Mary of the Angels Orphanage for Girls* in the *Palazzo delle Terme di Diocleziano*, near to the central railway station. In *1896* another eight sisters for boy orphans were sent to Via XX Settembre and then to the *Istituto San Michele*, on the right bank of the Tiber, which had been founded in the seventeenth century by Pope Innocent XII to take in and help poor people, young people and elderly people of the Papal States. After the building was purchased by the state railway company, the girl orphans were sent to the *Istituto San Michele* where the sisters had already been providing a service to elderly and sick people since *1898-99*. The orphanage was in existence until *1960*.

When the Fascist government in 1938 wanted to turn the *Istituto San Michele* into an institute of art, all the sections were transferred to the neighbourhood of *Tormarancia*, in *Garbatella*, where the sisters remained until *1994* to take care of elderly and sick people and children who were in difficult situations. The elderly were then taken in at San Cosimato in Trastevere. But there were very many of them: a very large number of individuals who lived alone, had been abandoned and in bad health but who next to the sisters found warmth and recovered a meaning to their lives.

The Provincial Foundlings Hospital

In *1896* there was a request to establish a provincial *foundlings hospital* in Rome. This was after the revolving wheel in which babies were placed at the Hospital of the Holy Spirit so that they would be taken in was abolished. The idea was to create a work independent of the hospital which would also take in single teenage mothers. The central buildings were four in number: in the district of Gianicolo, on the basis of the illnesses from which the children suffered: in Via Poerio, Via Garibaldi, at the Fontana Paola, in Via Fratelli Bandiera and in Via Pamphili where in *1955* the central building was established with about fifty sisters who were nurses. With the passing of time in this institution there also worked sisters who were paediatric nurses and sisters who were social workers who had above all the delicate and complex task of arranging adoptions. Laws transformed this institution for the immediate taking in of children with difficulties. Today it is directly managed by the town council of Rome according to new rules. The Sisters of Charity left this service on 28 February *2002* after dedicating all of their efforts to making up for parental absence with tenderness, dedication, smiles and medical care and treatment.

The Treatment of Infectious Diseases

At the end of the nineteenth century infectious diseases were spreading. In Rome a centre for those suffering from them was in operation from *1884* onwards in Aventino but in *1896* the Governor of Rome called the Sisters of Charity of Santa Sabina for all emergencies. They were ready to give themselves and were always full of courage, Nothing stopped them, and nothing frightened them during the cholera outbreak of *1910*, the measles outbreak of *1910*, and the meningitis outbreak of *1920*. It was the boldness learned from St. Jane Antide that animated them.

The Lazzaro Spallanzani Hospital

The Hospital of Santa Sabina was closed in 1936 when the *Lazzaro Spallanzani Hospital*, which specialised in infectious diseases, began operations. All of us know how high the level is of this hospital and how it is in the forefront as regards scientific research, the treatment of infectious diseases and the fight against AIDS. Still today, a community of Sisters of Charity works here providing a nursing service, together with a service of social assistance for drug addicts and people who are terminally ill with AIDS, and as workers in the chaplaincy.

A Nursery School and Centre for Single Teenage Mothers

In Rome, *from 1901 to 1927*, the Sisters of Charity worked in

the 'Maternal Home' named after Princess Iolanda of Savoy who, like Queen Margherita, was very sensitive to the world of the needy, the poor and the abandoned. And in *1902* five sisters were sent to a work that looked after children without a family, the so-named 'Home of Providence' which was located between Via Salaria and Via Arno. This was the first nucleus of a large complex. The next year, indeed, because of the interest in the project of Princess Mary Massimo-Colonna, a nursery school for single teenage mothers was annexed to this institute and this was entrusted to four Sisters of Mercy. This work was completed in *1925* with the St. Anne Maternity Clinic which had eight sisters. A certain Sister Maria Borghi dedicated to this work of Via Amo her fine capacities for human relationships and she left upon it an impress of intelligent solidarity with the poor, with children, with their mothers, with medical doctors and with the civil and religious authorities.

The sisters left the whole of this service in *1977* when the medical team of the clinic openly declared its support for abortion and began to receive from other hospital mothers who did not want to continue with their pregnancies.

The Umberto I Polyclinic

In *1905* the *Umberto I Polyclinic* was born in the neighbourhood of San Lorenzo. It was Prof. Achille Ballori himself who had so opposed them at the Hospital of the Holy Spirit who asked for the Sisters of Charity. Forty-eight sisters were immediately sent to the various departments of the hospital. With the opening of other departments and specialist clinics, the sisters would come to number 112. In *1933* the sisters also began to work in the *dental clinic* of Eastmann (they left in 1975). In *1957*, with another twenty-four sisters, the IA university surgery clinic was opened within the polyclinic and was named after Prof. Pietro Valdoni, a great figure of modern surgery with whom the Sisters of Charity had a special relationship, as they did with Prof. Paride Stefanini and other professors with whom the sisters were able to work in an excellent way in the practice of medical and surgical science for the benefit of patients. In *1961* the sisters joined the university *obstetrics clinic* and in *1965 its eye clinic*.

One cannot but record the productive effects and the efficacy of this very capillary presence. These were years that were full of good because of the dedication of the sisters, their concern, and their cooperation with the consultants and with the personnel so that everything worked to the benefit of the patients, around whom out of faithfulness to their profession and their charismatic mission revolved all the reasons for being and acting of each sister and the community as a whole. Unfortunately, the community left service at the polyclinic on 14 November 2011 because of a lack of turnover of its members.

On the Hospital Trains

One of the first tasks of the Superior General, Sister *Anna Lapierre* (1915-1936), was to take to heart the organisation of the presence of the Sisters of Charity near to those who suffered because of the war. During the Great War of *1915-1918* the sisters worked very hard to care for the wounded, the mutilated and the sick. They left for the fronts and as soon as the sisters had returned from the first expedition on hospital trains of 1915, Mother Anna organised, together with the sisters of the Province of Rome, nursing care in four hospital trains which left for the central railway station on 15 January 1917, the most disastrous year of the war, for the Russian and French fronts. In each train there were four sisters: the mission of eight of them lasted for the whole year; another eight returned home after two years.

The Prevention of Tuberculosis

The first decades of the twentieth century were marked by the discovery of the tuberculosis bacillus by the scientist Robert Cock. The hope that such a disease could be cured became more felt and more pressing because it was spreading with greater facility through increased contacts that were generated by progress and social emancipation.

The Sisters of Charity were called in Rome, as had already happened and would happen elsewhere, to provide their service in a work of a new social kind: *the prevention of tuberculosis*.

One aspect of the therapy was prevention in the case of children in families where there was a case of infection. Very many of them were removed from the terrible action of the disease and placed in institutes where the air was healthy, and their food and hygiene were attended to. One of these preventive institutions was in Rome, the Queen Helen Residential School, in Via Ferruccio, half way between the Basilica of S. Giovanni and the Basilica of S. Maria Maggiore. It had fifty girls between the ages of two and fourteen. The sisters went there in *1912* and remained there until *1963*.

The honorary president was the Queen of Italy and the executive president was her lady in waiting, Countess Guglielmina Campello-Buoncompagni, who was very present in the life of the school. Very poor children and orphans went there.

In Rome were created:

The Marchiafava Institute

This was the 'Marchiafava' anti-malaria sanatorium institute which was created in *1918* with its central buildings in S. Egidio, in Trastevere, which derived from a section of the *Hospital of S. Sabina* and was to begin with only for malaria patients but was later dedicated to the prevention of tuberculosis. A marble commemorative stone at the entrance to the building, which today is a museum, records the date when the sanatorium was dedicated to Dr. Ettore Marchiafava, a distinguished doctor and a senator of the Kingdom of Italy, as well as being an expert on malaria, and in 1918 the head of the commission of the town council of Rome for hygiene. These were years when malaria caused many victims amongst the workers of the

Roman rural region. In 1925 he organised the first international congress on malaria. He was also the Vice-President of the Italian Red Cross and the promoter of numerous initiatives for the protection of hygiene and the treatment of people with tuberculosis. At this sanatorium the young people remained on average for two months and were entrusted to the care and treatment of the medical doctor of the governorate and the Sisters of Charity, who were called the Sisters of St. Vincent de Paul before the canonisation of the Founder. In the institute there was also an orchard/garden and a small school. When the hundred plus children afflicted by malaria decreased in numbers to the point of disappearing, the service of assistance continued with a children's and vaccination clinic. The Sisters of Charity left this service in *1963*.

Another work of the period immediately following the First World War (1919) which Mother Anna Lapierre undertook for the Province of Rome was that named after the person who originally proposed it, 'Gina Mazza', and this was for women who *had previously been in prison*. The house was at the corner of Via Monte Farina and Via del Falco near to St. Peter's Square in the Vatican. In *1926* it moved to Monteporzio, near to Rome, and the sisters left it due to incompatibilities with the management.

The 'Maraini' Institute

From *1920* onwards the 'Maraini' institute for prevention took in breastfed children who were the children of mothers with tuberculosis and it was therefore a kind of preventive nursery. The sisters were entrusted with a group of wet nurses who had an urgent need to be trained in a sense of responsibility and personal morality in their service to those poor children. Theirs was a very delicate task and the sisters with discretion and patience managed to have a certain comforting impact on them all. The management of the institute made an assessment and also entrusted to the sisters the days and the care of the children, which had previously been entrusted to lay personnel.

If one goes through the names of the sisters, and those who knew them when they also looked after disabled children, there comes to be invoked the witness of a service under the banner of charity, sacrifice, forgetting about oneself, prudence and hard work. It was the primacy of love and the Kingdom of God that guided their work.

The Vittorio Emanuele III Permanent Anti-Tuberculosis Residence at the Lido of Rome

The town council of Rome well knew the capacities of the Sisters of Charity who were working in the institute. Therefore in 1920 they entrusted them with the permanent residence in Ostia where in addition to health care the children were provided by them with nursery and elementary education and gymnastic activity which took place on the beach in front of the institute. Roundabout *1932* there emerged the plan for the union of the new building with the pre-existent one through an underground passage under Viale della Marina so that the children would not have to cross the street. The old building was then used exclusively for accommodation with balconies overlooking the sea and fences around the beach. The children reached the number of five hundred and there were thirty sisters involved in education, nursing and general services. During the summer the work and the number of sisters increased with other groups of children, the children of state employees, and guests to take the sea air and swim.

The home/school of Ostia was a model as regards organisation, the readiness of the personnel to help and the availability of resources, and hygiene and discipline. It was often a place of visits and study for Italian and foreign figures who wanted to learn about modern works for the provision of care to children. This home began to decline in the 1970s: the town council of Rome had other urgent needs as regards social policy. Care to families was provided by means of other instruments. By degrees, both because of the neglect of the management and because of a shortage of sisters, the institute moved towards closure and this took place in the year *1983*. The certainty remained that the work of the sisters had sowed in the hearts of very many girls and boys love of a healthy life, serenity and hope for a more welcoming and supportive world.

The Day Home for the Prevention of Tuberculosis

The day home for the prevention of tuberculosis, conceived and created in 1920 by the municipal government of Rome, had its buildings first in Via Galilei and then in Via Ariosto, within the large complex of the Hygiene Office. In this home, as in all the others, the children not only received care and treatment but also had available an internal primary school: a nursery school and elementary classes which were taught by the sisters. In 1951 the children were transferred to Villa Glori, which was fused with the day institute which was already located there. Since 1988 the complex of the day home is today the location of the Casa Famiglia di Villa Glori, run by the Roman Caritas for the provision of care to people with AIDS, and which arose from the idea of giving back to the park its function of being a place of collective memory and of social aggregation and solidarity.

The Opera S. Vincenzo for Children without Families and Abandoned Children: 1921

The San Vincenzo Institute for children from the foundlings hospital and for other unfortunate children without families owed its existence to Countess Anna Alberghetti-Merolle, an elderly lady in waiting of the court of Queen Margherita of Savoy. It was located in Monteverde, in Via Federico Torre, and was admired by various agencies because of the values of humanity and charity that were implemented within its walls. Four years after its creation, this house became the responsibility of the Children's Nurseries of Rome. The Sisters of Charity left the service in 1956 because the

provincial council was not able to provide replacements.

Casa Vittoria

Another request came from the governorate of Rome on 13 September 1929. Mussolini wanted to clean up the streets of Rome and free them from beggars, former prisoners, people who had come out of lunatic asylums and hospitals and had no home, no families and no jobs.

In Via Portuense there were the buildings of an old workshop for the production of oils for eating, where the comestibles arrived from San Cosimato. This place was called the 'beggars' centre' and later the 'beggars' asylum'. In 1970 it was called Casa Vittoria in honour of Sister Vittorina Tudini, a Sister of Charity who was decorated for her merits at the Theatre of the Opera of Rome and who dedicated her entire life to those abject people and for whom shacks gave way to pavilions in the greenery with suitable arrangements and with shared buildings which were centres for aggregation.

The town council of Rome followed this institution attentively but the daily devotion of the sisters who worked in it as nurses and as co-workers for the various services went well beyond what the internal rules required. It was said that if for some absurd reason all the works of the Province of Rome of the Sisters of Charity were to end, this work in Via Portuense, in line with what the Congregation upholds, should be the last to disappear…

The Hospital of St. Camillus

After the First World War had come to an end and while a violent epidemic was devastating Europe, the decision was taken to build a new hospital complex on the outskirts of the city of Rome. The area of Vigna S. Carlo in Monteverde, held to be one of the healthiest in the city, was decided upon. After the project had been approved, on 28 April 1919 the building work began. Because of a lack of funds the work was suspended for a number of years and was only begun again in September 1927. Twenty-five months later, on 27 October 1929, the hospital was solemnly inaugurated in the presence of Benito Mussolini and took the name of the Hospital of the Littorio. At the time of the inauguration about a thousand beds were ready and operational. It should be realised that the departments of Marchiafava and maternity (1935) and the heart centre (1957) were not finished. The staff was made up of eighty-six medical doctors, four pharmacists, 194 nurses, sixty sisters who later became eighty, two chaplains and 105 auxiliaries. Later, following a referendum organised by the Pius Institute of Hospitals of Rome amongst the health-care staff, on 20 October 1946 the hospital changed its name to the 'Hospital of St. Camillus', and its inauguration took place on 24 November 1946.

We can read in the newspaper *Il Quotidiano* of 27 November 1946 the following words: 'The large hospital of Monteverde Nuovo, previously of the Littorio, has been given, as we reported, by a unanimous wish of the health-care personnel, the patients and the nurses, the augural and holy name of Camillus de Lellis, the precursor of the Red Cross, the reformer of hospital care'. This general recognition of the saint – which joined others that in the past Rome had given him as a sign of perennial gratitude and admiration – took place at the same time as the centenary of the canonisation of Camillus de Lellis.

The Sisters of Charity joined the Hospital of St. Camillus, being wanted and proposed by the consultants who had known or experienced their hard work and the spirit with which they worked in other Roman hospitals. The pastoral care in health was carried out in cooperation with the Camillian Fathers, the Ministers of the Sick, with whom there had always been nourished an understanding, a unity of intent, generous dedication in favour of suffering people admitted to hospital and their family relatives, dialogue with medical doctors, and practical cooperation with all the personnel. This service ended completely in the year 2005.

The Residential School of St. Vincent de Paul for Nursing Sisters and Ward Sisters

Just a few notes on the residential school for nurses named after St. Vincent de Paul. Training in nursing for the sisters at the beginning of the twentieth century depended on direct practice in wards and the experience developed with older sisters, together with some summary knowledge of anatomy, medicine and emergency aid. It happened afterwards that the directors of the hospital themselves created an examining board when training took place outside. In other cases theoretical training took place privately and the exams were taken at the prefecture of the nearest city, with the authorisation of the Ministry for Internal Affairs or the High Commission for Public Hygiene and Health Care.

But new scientific research, the advances in medicine and surgery, new therapies and the large number of people admitted to hospital led the sisters to have a more suitable training to carry out their mission with sick people.

It was the Congregation itself which took responsibility for establishing a residential school for professional nurses and ward sisters. With the agreement of the health-care authorities the Hospital of the Holy Spirit in Sassia was chosen as its location because the support of a hospital was required. The inauguration took place on 6 February 1933. Its management, apart from a very short spell, was always in the hands of the Sisters of Charity. Attended by a large number of Sisters of Charity, because of the pressing requests it was also opened to other religious Congregations (at least thirty in number) and to lay women. At the level of facts, the training that it provided was always excellent. In 1974, although it was at a high point in its existence, this school was closed because of new economic burdens which could no longer be met and which had been imposed by the laws on non-state nursing schools.

For the Sisters of Charity the Hospital of the Holy Spirit has always remained a point of affectionate reference because it was

from there, for the Church, that there began the Roman life of the Congregation; in this hospital remains the presence and the sacrifice of St. Agostina who watches over the hospital world, medical doctors, nurses, staff and patients.

I think it is incumbent upon me to remember His Eminence Cardinal Fiorenzo Angelini, President Emeritus of the Pontifical Council for Health Care Workers and before that Auxiliary Bishop of Rome from January 1977 to February 1985, the delegate for religious assistance in hospitals and places of health care in the capital. His rigour and his tenacity always saw him present, a participant, attentive to the quality of service for the sick and to the beauty of the charism of St. Jane Antide Thouret.

The Gold Medal for Public Health Care

During the history of our Congregation we have received numerous awards for the apostolic action of our sisters with the sick in Italy, in Europe, in the East and thus also in Rome. One example amongst many brings out the shared intentions and actions, albeit in diversity, of religious Orders and Congregations of different inspirations: on 23 July 1963, in the chapter hall of the general curia of the Fatebenefratelli, on the Tiberine Island, the Hon. Angelo Raffaele Jervolino, the Minister of Health, officially awarded the gold medal for public health care to the Hospital Order of St. John of God, to the Order of the Ministers of the Sick, to the Company of the Daughters of Charity of St. Vincent de Paul and to the Congregation of the Sisters of Charity of St. Jean Antide Thouret, in the presence of prelates and civil servants of the Ministry for Health.

These four religious Orders have in common the fire that burns in hearts, the fire that becomes love and concrete action for our brethren who are in pain: 'This event seeks to place in their due light the high human and social merits of four religious families… The Republic of Italy commends most solemnly and confers a most sought-after distinction…may the voice of admiration and gratitude comfort you during hours that are not easy and continue to support you so that you can write new luminous pages of your history, which are already rich in immortal glory!' (Vita ospedaliera, August 1963, monthly review of the Fatebenefratelli – Province of Rome).

Thirty Years of Nursing Service at the Central Clinic of Roman Prisons

In response to a request made by the Ministry of Justice, from 1979 onwards the Sisters of Charity were a part of the infirmary of the prison of Rebibbia and the central clinic of the prison of Regina Coeli. These are communities that remained outside the prisons and nursing sisters who worked eight-hour days, always ready to act in the medical centres, in the operating theatre or during admissions to hospitals, in full harmony with the chaplains, medical doctors and prison police. Their withdrawal from this activity due to a lack of replacements took place in the year 2010.

The Service for Drug Addicts

In the large hospitals of Rome the sisters by degrees left the general services to lay people and remained as ward sisters or professional nurses in a few departments. In the meanwhile the new signs of the times were studied and it was asked to which answers and which challenges should be given priority.

In 1978 a sister was as the service of drug addicts at the SAT (service of social assistance) in the clinic for drug addicts of the Hospital of St. Camillus. This was a matter of forming relationships at a human, health-care and legal level with drug addicts, with their families, with therapeutic communities, with tribunals, with the local health units and with the various offices involved in the recovery of the victims of drugs.

In 1984 two sisters were at the CEIS (Italian Centre for Solidarity) of Don Mario Picchi with precise roles and tasks connected with the welcoming, the accompanying and the recovery of drug addicts.

Since 1989 a sister has worked at the Spallanzani Hospital for drug addicts, terminal AIDS patients and their families. In the same hospital other Sisters of Charity provide their service at the side of drug addicts and those afflicted by various infections. Thus services continue today with six of them, of whom two are at the side of sick people as volunteers.

We can understand the delicacy with which relationships at a human level and a Christian level must be nourished with sick people and how much pastoral passion is needed to accompany them during the final passage of life, above all if they are young.

At the Nursing Home of the Jesuit Fathers

For we Sisters of Charity to be at the side of sick or dying priests or religious is not a unique experience of its kind in other parts of Italy. Thus the answer was in the affirmative when we were asked to provide nursing at the nursing home for elderly and sick Jesuit Fathers at the House of Jesus: to be with them, to be concerned about their diagnoses, their medicines, their natural or artificial alimentation, their physiotherapy, to give a caress or smile to those who have dedicated their lives to the Church in terms of culture and evangelisation. The testimonies to beauty, delicacy, serenity, and the bearing of pain which the Fathers are capable of have become precious pearls of appreciation of which has no limits. Since 1980, when we began, we have reached the month of March of this year, when the Fathers were brought together at the General Curia of Pizza Borgo Santo Spirito and we greeted them!

Conclusion

The whole of this holy story, threaded through with humanity, gospel tenderness and social contributions, makes us praise the Lord, for the grace of 'Romanity' as well, in the sense of the place and the ecclesial awareness of our service of charity which continues, in addition to some places in the historic centre, also with Cari-

tas and parishes on the outskirts of Rome, as evangelisation and human and spiritual mission.

We feel emotions of nostalgia for this past of so much work in Rome. We are certain that the future will not cancel the past. Today we feel that we are involved in a process of transformation that is closely bound up with the world. Hence the analysis, the discernment and the choices that lead to a search for a new deaconate of charity! This for us means adhering to history which moves us towards new international and multicultural relationships, towards new forms of poverty, and towards a new style of life that is an alternative to that of contemporary society which strongly feels a crisis of values and of resources and which has the sensation that nothing can be retrieved.

We believe and we hope that this front of death, of an end, contains those seeds of life that only love of charity for God and for our brethren is able to generate. It is on the beauty of charity, our fourth vow, that we want to stake ourselves, in our time as well, seeking to recognise what should be transformed and what is already full of the future, of life and of hope for everyone!

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On the Pathway of Learning and Charity: the Human and Spiritual Accompanying of Medical Students

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From the beginning of their university courses, young medical students find that they have to address a large number of existential and symbolic breaks which can make them, in personal terms, more frail, or then deviate them into the practice of a materialistic and dehumanised medicine. First isolated from their families, they are then left to themselves, at times without reference points, in an adventure that takes place on the frontiers of life and death, in a universe that is in a pedagogic way totally dominated by science and reason. They then discover the uncertainty, the doubt and the suffering that are brought by their first patients whom they encounter when they are still incapable of alleviating their pain because their knowledge is just beginning. Following the initiation of carrying out of a dissection, they finally engage in the concrete experience of nearness to death, which is a source for them of fundamental questions about the meaning of human life, the reality of transcendence, and the relevance of faith.

All of these breaks are equally life events where their older colleagues can guide them in their spiritual journey, being supports as regards identification and bearing with them a Christian message which, later on, will be of fundamental importance for their personally expressed medical practice; for the ethical choices that they have to make at the bedside of their patients; for the singularities of human relationships; and for the different therapeutic options that modern medicine offers from the moment of the conception of life until its final point.

Although belonging to a society that has become at the level of daily life modern, secular and multicultural, the Catholic University of Louvain (UCL) remains faithful in each of its teaching and research missions to Our Lady of Wisdom, under whose protection the Church has placed our *Alma Mater* ever since its foundation in 1425. It is within the context of a proposal involving the rooting of Christian roots that we therefore strive, with humility and perseverance, to perform the duty of framing our students during the existential trials of their long academic pathway. The encounter with death during the dissection courses, which are indispensable in acquiring intimate knowledge about the human body, form a decisive part of the events that are a foundation for their becoming aware of the value of life and of the respect that its mystery inspires. It is, therefore, at the heart of this intense emotional loss that we hope to anchor their primary ethics and direct their spirit to the meaning of self-giving and respect for the other.

Incarnating Death so as to Consecrate Life

Dissecting a dead body, violating the skin of its surface, and separating its structures in the wise tangle of muscles, intestines, vessels and nerves, is an initiating trial that prefigures the medical mission and the curative activity that will penetrate and invade the flesh of patients in order to offer them relief for their maladies. This exercise leads many of our students to have silent admiration and wonder. For those who live in faith, this secret enthusiasm, this respect that is faithful to the wishes of the deceased to be a source of knowledge beyond the shadows, is transformed into a natural act of prayer and an action of grace. However, there are a large number of students who experience these febrile feelings in a confused way, with a certain sense of guilt, a source of doubt or a strengthening of the materialistic beliefs of those who do not share in hope. In order to offer a spiritual anchorage for these deeds carried out on dead bodies and the fragile human feelings that they generate, the lecturers and the chaplains of the Faculty of Medicine every year invite the students at the end of this first exercise, and roundabout All Saints Day, to meet at a Mass where they encounter the families of the people they have dissected. From this meeting, from which each student emerges with a heavy and uncertain heart, an incredible light is born. Readings and the Gospel are shared. In silence, the families call to their deceased loved one whose body is absent from its grave, like that of Christ at Easter, simply saying his or her name. The students answer and the emotion, each time, fills the assembly, creating a communion. From both sides of the window of the invisible, each person touches the soul of the other. The families of the deceased discover generous young people who, far from being neglectful, nourish a respectful and infinite gratitude for the gift they have received and feel, by way of gratitude, that this is something that they should take advantage of when they are at the bedsides of their future patients. The students see the faces of the deceased with whom they have come into contact alive in the looks, full of tears, of the relatives who loved them and who resemble them. Dissection, one of the most coldly material and transgressive of medical rituals thus becomes, nobly, a Eucharist. And without difficulty it then becomes possible for us to make our students understand that the broken body under their arms, armed with forceps and knives, is not divided but multiplies, inasmuch as it generates in their expressions and their spirits, though what we call metaphorically 'The Miracle of the Multiplication of Bodies', a living knowledge that overcomes death and which will be through them an inexhaustible source of benevolent care for the living.

In the golden book of this annual ceremony, amongst innumerable testimonies, the family of a deceased woman, who had offered her body to science, wrote as follows to the students: 'Here is our mother, in her body deteriorated by old age and by illness, our 'good' mummy…Please, treat her with respect, sweetness and tenderness…May she bring answers to your endless questions. This was her dream: to serve, to love, to give without asking anything in return…if, thanks to her, you can find out how to relieve suffering, this will make her happy! Know simply that her brain was nourished on the writings of Theilhard de Chardin, and the good words of all her children and grandchildren to whom she taught faith in eternal life…That her eyes admired with the same enchantment, without limit and without usury, all the wonders of nature, from the noblest to the simplest and the most imperfect…That her lips unceasingly sang of her joy to be alive and whispered the most tender words of encouragement, consolation and love, not only to us, her family, but to all the sick people that she met during the long hours that she helped them in the hospital. Therefore, when you open her noble body, draw on it with generosity: it is filled without end with an unshakeable trust in the beauty of life and in the benevolence of God'.

The students answered this wonderful and sensitive message in the following way: 'To give one's body, after death, so that others may live: does this not perhaps mean, if we consider the matter in its true light, to take part in a community of life that goes well beyond death? It means to prepare oneself to live better, inasmuch, as Spinoza said, 'a free man thinks of nothing less than death and his wisdom is a meditation not on death but on life'. The blessed living, in offering their moral clothes to the unknown, have defeated death well before it takes them away! Love, Christians say, is stronger than death. Is there a finer illustration of self-giving that that of abandoning, as Christ did, not only one's own life but also one's own death to others? If our body is the temple of our spirit, if our eyes are the look of the soul, then this deed which in appearance is as foolish as that of the Cross, is nothing else but the best way of being alive amongst the alive…May these few words that we address to you, dear family, being you comfort and above all hope in the pain of the mourning that you are experiencing. In the heart of your good mother we have found a thousand thanks and we do not doubt that in the secret of the stars, which she has certainly been amongst, she is watching over each one of you and is waiting for you, at the end of your silent journeys which lead to her. Keep alive in yourselves the memory of her smile and be certain that, in the silence of our respect, every vow of hers and every wish of hers has been humbly honoured'.

To parents who have lost a child at birth the students offer a white sheet of paper on which, with emotion, they put a coloured print of the feet of that child. Thus, at the other extreme of existence, this trace of an ephemeral passage on the earth indicated that the world conserves in memory of that child a indelible sign of the moving on of every life, albeit fleetingly, in the human community. To embody death spiritually, means to consecrate human life in the clinical practice of our future medical doctors. We hope in this way to ensure that in their daily

experience the prospect of the ineluctable deaths of their patients is no longer lived as a failure from which to flee through being absent or something which is reduced to the use of technical equipment. If they have understood everything that is intertwined with this mystery that edifies, then perhaps later they will decide to accompany it with sweetness and patience. 'Nothing troubles you, nothing frightens you', wrote St. Theresa d'Aville, 'everything passes, only God remains. Patience obtains everything'.

Drawing Near to and Living Suffering in Order to Learn Mercy

After the experience of nearness to death, the encounter with human suffering and the feeling of injustice that accompanies it are the second interior test that the young future medical doctors have to address. Faced with the challenge of those who treat, who have to heal a malady, comfort suffering flesh and relieve pain, science teaches students reasoned recourse to an arsenal of medical or instrumental techniques, the choices about which have to be thought through. The treatment that is proposed must be based upon a real analysis of the situation of the patient and the therapeutic choices that derive from this are naturally deduced from the so-called objective elements – which are often in code – of the medical picture. This kind of normative reasoning, which is specific to evidence-based medicine, has today been imposed as the golden rule to follow in every medical action. It is certainly very useful and performs an indispensable guiding role, not to speak of its being a protective barrier, and thus prevents, through guidelines that are approved by one's peers, those therapeutic adventures that are the most damaging for the patient. But to place a cold analytical distance between the patient and his or her medical doctor dangerously compromises the human relationship on which are based the generosity and the benevolent attention that are indispensable to the act of care. A cancer patient, for example, is no longer a suffering person. His or her clinical sheet is organised by now into stages indicated as being from 1 to 4 according to a classification of T (for tumour), N (for nodules) and M (for metastasis). The higher they are, the more the illness has advanced and the prognosis is unfavourable. The forms of treatment that are chosen depend on these degrees and follow rules from which it is not at all easy to distance oneself. The same occurs in the majority of almost all other illnesses which are enclosed within the reductive framework of a factual analysis and the therapy that has been imposed. In these schemata of normative forms of treatment, the human dimension of the patient and his or her illness is often seriously compromised. In becoming a science, contemporary medicine partially divested itself of its soul. In being voluntarily made autonomous by the *principle of benevolence* – which is now seen as a obsolete residue of the medical paternalism of the nineteenth century – it has become material at times to the utmost, forgetting that before being a science it was an art. 'Be unemotional!, we were constantly enjoined by a great American teacher when a decision had to be taken about an operation to be imposed upon a patient with cancer of the face that would have disfigured him. As regards medical treatment and care, he was right. As regards the form of the holistic approach to the patient we continue to think that he was wrong. To add emotion and compassion to the mutilating act that has to be engaged in out of duty takes nothing away from its efficacy or the ability to do it perfectly. Now, what shared suffering often brings to this act is priceless for the patient who through simple facial expressions or a hand placed on his or her hand perceive the benevolent care of this communion with his or her pain. Intuitively, in the ingenuousness of their youth, our students feel this easily: like Simon of Cyrene they are ready to offer their shoulders to carry a cross.

Their posing of questions in the face of what is at stake in a benevolent medicine derived from the art of healing that is opposed to a rigorous and factual medicine that is increasingly governed by science, is, however, such as to send them off course in two opposing directions. The first sees them take refuge too often in the dogma of a normative and materialistic medicine. This tendency becomes so accentuated that in the current economic framework the constrictions of economic returns are often added – reinforcing it – to the pragmatic pathway outlined by scientific reason. The dehumanisation of the action of treatment is unfortunately the price to pay for this loss. The second pathway is that where, dominated by affection, the medical doctor is made extremely fragile by a sensitivity shared with the suffering of his or her patient that dwells inside him or her, and to such an extent that every therapeutic choice becomes for the medical doctor an insurmountable source of dismay and doubt. There derives from this a paralysis at the level of decisions that can lead to a pre-judging of the patient and even, out of inertia, to a deflection of the medical doctor into alternative practices that are without any scientific foundation.

Teaching the middle way to our students is not at all easy. But the essential reference to humanity and to Christian values is a powerful good in an educational initiative that goes beyond the simple transmission of a *savoir faire* and reaches the teaching, through silent example at the bedside of the patient, of a *savoir être*. Through an identification with his or her teacher, the young trainee learns above all else that the destiny of the medical doctor is located, with sweetness, in an ideal of struggle against suffering and against the injustice of illness. As is the case with everything, this duty to struggle to raise up a weakened patient from his or her wounds is situated in the immediate continuity of the knightly values of the Christian West of which St. Martin of Tours was a hieroglyphic witness. Those who fight cannot hope to be spared all wounds: in agreeing to receive them and bear them they share in the dignity that they

restore to those to whom they provide medical treatment and whose wounds are eliminated: 'The true measure of humanity is essentially determined in relationship to suffering and to the sufferer. This holds true both for the individual and for society', writes His Holiness Benedict XVI in *Spe Salvi*. To paraphrase the Holy Father we could add: 'A medicine that does not manage to accept suffering people and which is not able to contribute through compassion to ensuring that suffering is shared and also borne inwardly by those who treat is a cruel and inhuman medicine'.

To prevent this lack we should educate people in contact with the emotions that are provoked by suffering Otherness, the look of the heart at what we call *the visible and invisible presence of the Figure of Christ* in the experience of a sick person: in the daily life of a hospital the examples of this are innumerable and it is enough to pay attention to this for the young student to discover empathy, compassion and also *mercy*, a value that we consider to be essential. The question that the person who provides treatment is constantly invited to pose to himself or herself is thus the following: 'do you see the invisible image of Christ in the features of the person who is suffering in front of your very eyes?' This image is tenuous, certainly, like the impress of the face of Jesus left on the veil of Veronica; but for those who agree to allow themselves to be inhabited by his persevering presence it is the foundation of ethics that are safe and lasting. And it is starting from this that the pathway of the therapeutic choice, if it shows itself to be outlined, is imposed on the evidence in the face of the question that follows the previous one and provides the answer to it: 'do you see the work of God accomplished under the deeds of your hand which medicates the flesh and the spirit of this wounded body?' Faced with personal powerlessness in relation to every situation of incurability, a young medical doctor in the end will have, like his older colleagues, the ultimate experience that, in the sense of loss that will undoubtedly invade him or her as regards the other that medicine can no longer help, abandonment to Providence through prayer transcends the act of treatment and provides it with a human density that is irreplaceable. According to the epitaph of Paracelsus, *all medicine is love* and, when it can no longer offer healing. it can always still give, with mercy, love and compassion. This effort, however, requires a fundamental humility as was observed by Ambroise Paré, a surgeon to four kings of France and the inventor of bindings for vessels, in his famous motto: 'I have treated, God has cured'.

In a personal capacity we do not hesitate in individual conversation to bring to our students the testimony that prayer has often come to our help in the riskiest surgical situations and that abandonment to God or the holy protection of the Virgin Mary has allowed our hands to save many patients who were condemned. To give an example of this, some months ago we tried to save the foot and the leg of a little girl aged six which had been accidentally cut by the blade of a lawn mower. After hours of microsurgery, all the attempts to re-establish the blood flow, which was necessary to the survival of the limb, had failed. The young student who was my assistant during the operation, a frequent attendant of the Mass to which I referred above, watched me with consternation repeat gestures of hopelessness. A pause then opened up in our exchange of looks. A momentary break in the operation gave way, in the silence of us both, to prayer. After the silent saying of the filial prayer, the surgical clamps were removed from the foot of the girl: she had regained life. When a few weeks later she asked us how she could thank us for having saved her leg, we answered her simply that she should express her gratitude to her mother in heaven because without her benevolent help it would not have been possible to overcome the impossible. 'We must pray as though everything depended on God and act as if everything depended on us', wrote St. Ignatius.

Founding Research and Progress on the Duty of Humanity

To consecrate one's life to the bedside of a sick person so that humanity and transcendence dwell in, and relieve, interior suffering, just as clinical therapy itself relieves or eliminated physical pain. To embody death so as to accompany it and not flee from it or bring it on. To fight against the evil that weakens the wounded flesh and not to bend but to persevere. To act in all things with compassion and mercy. To remain humble beyond one's knowledge and to dare to offer one's own powerlessness to what overcomes us. These are the guidelines for spiritual conduct that we propose to our students to be integrated into their future medical practice so that, beyond the competence that is offered, it has real added human value which, *in the end*, will be its fertility. All of these precepts, absorbed by sensitive hearts, shape their daily lives. But are they enough to illuminate the existing pathway that constructs the future of medicine according to scientific advances?

Medicine is a science that is in perpetual movement. Progress is a part of its essential duties. One cannot accept the perennial failure to understand the mechanisms that govern certain illnesses, or are powerless in terms of treatment in face of others, as an inevitable fact. It is therefore right to investigate on a molecular scale, until the infinitely small, the little mechanisms of life so as to understand them and treat their failings, in the same way as it is legitimate to explore a dead body in order to alleviate the suffering of the living. The noble task that medical research sets itself is to push beyond the limits of knowledge and at times the limits of the possible so that all the resources that life itself and the world that surrounds us offer can be rightly utilised to treat illness and *restore to man his autonomy and his integrity*. Pushed as far as the use of the multiple potentialities of primary cells, this logic, however, is not without its risks. Indeed, it threatens to close up scientists within a dehumanised materialism com-

parable to the situation of medical doctors who are prisoners of the narrow and reductive corridors of evidence-based medicine. Scientific progress, which lives through the objective and symbolic transgression of the barriers of knowledge, must therefore be tempered, in the nascent spirit of young researchers, by its own ethics founded upon the same universal values as those referred to above in order to make them the reference point for choices as regards therapy.

Our university has always resolutely adopted the duty of progress. From its foundation onwards, André Vésale established the bases of modern medicine and surgery at the price of a fundamental overturning of anatomical knowledge. In the same way the presbyter Lemaître, father of the theory of the Big Bang, defined the physical limits of the universe. Nearer to us in time, Christian de Duve, who won the Nobel Prize for medicine, described lysosomes. This past of ours obliges us to assist our patients to the best of current knowledge but also to contribute to creating, for their salvation, new knowledge or knowing how to act that conduce more to *their dignity*. Transgression is not excluded from this duty, on the condition that it is based on man, faithful image of the Creator, and does not pursue other ends than the retrieval of his humanity. In no case can the principle of precaution be opposed, as an obstacle of inertia, to the carrying out of this imperative duty. Our journey was thus long when, on the constant lineage of our research on the development and nature of the human face, destiny called us to think about, conceive and then carry out with our students the first face transplant ever implemented in the world. The idea of having to engage in this innovative action was imposed on us by the evidence and also, we would have to say, almost by *illumination*. Previously frightened by such an undertaking which required us to go and remove from a clinically dead woman her life features before death carried them away, even though with the intention of restoring a human appearance whose wounded face had become a cranium, we understood, in the shelter of reflection, that this symbolic gesture was not a work that was pretentious: it was humble. Where our experience had taught us, indeed, that all of our surgical art was unable to reproduce the genius of nature and thus of the Creator, we had to accept, with modesty, that only a loan from that genius would have been able to advance our art, benefiting our disfigured patients alone. Heaven, in which we believe, inspired us in this noble experience: *to treat means to experiment*, wrote Vésale. And it then guided us with benevolence on the unknown pathways of creation and discovery. For every story shared in faith *the visible and invisible faces of the gospel* are discreetly revealed to us, constituting after a certain fashion, during the course of our scientific and spiritual journey, the chapters of a gospel until the stations of a Good Friday. A morally inconceivable and technically improbable operation became a *Eucharist*. From a broken body, shared on the first Sunday of Advent, was born, for the patient who received the transplant, a new life. The act of taking or receiving the face of a dead person was inhuman. The act of giving one's own face, this part of ourselves that we hope will survive in the memories of those we have loved, was superhuman. But also human, profoundly human and rooted in Christian hope, was the act of agreeing to be, with one's own hands, the humble ferryman of this mysterious exchange in which was worked, like a transubstantiation, a symbolic passage of life from one human being to another. The initial experience of this re-figuration, repeated about thirty times by us and by many other medical teams in France, Spain and the United States of America, forms a part today of common surgical practice: by now accessible to everyone, it has but one noble mission – to restore, in those who have been gravely wounded in their faces, the essential image of the human whose face they bear, the mirror of the soul, the *transcendence of the visible*.

Whereas the great majority of our colleagues of the medical world were amazed by the fact that we did not attribute this technical advance to science alone, to our purported intelligence and to our collective talent – 'Why such Christianity?' (one of them, indeed was indignant that in a scientific film on the event we associated a discreet sound of Lauds with the filming of consequences of the face transplant), our students, instead, easily understood that this adventure, about which we gave them testimony, had for us an ethical and spiritual dimension that was deeply anchored in respect for otherness and the human. This fact is for us a real source of enthusiasm, encouragement and hope. The hospital in which we have chosen, through our curative mission, to perform our duty as Christians, remains, through the human suffering that constantly calls on our consciences that bend over the destinies of those who have been made frail by illness, a perfect setting for *humanisation and embodied evangelisation*. The hold that reason and science have today over life and the decisions of people responsible for treatment do not necessarily render their hearts arid, hearts which remain ruled by sensitive souls that aspire to *charity*. Even if the young medical doctors of future generations will never be able to abandon the irreversibly established normative constraints of an evidence-based medicine, which in philosophical terms derives from the *post-humanist* current of thought, we continue to believe with trust that, in the face of the duty to create new knowledge at the boundaries of what constitutes the essence of life, they will understand, from a new *transhumanist* philosophical perspective, that science is work that certainly elevates the human spirit but which also draws near the attentive soul to God. 'A little science', wrote Pasteur, 'distances from God, but much science leads back to him'.

Medical progress will thus remain a gift from heaven, a grace which, through a beneficial, charitable and merciful will, brings Christ to the side of the bed of every patient.

Military Hospitals and the Evangelisation of Peace

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Apparently, to speak about military hospitals and peace could seem to be a contradiction. However, during this paper I will try to illustrate how in war territories and wearing a uniform one can also engage in 'evangelisation', bearing witness to one's love for God and one's brothers and sisters.

Operations in the Field

In missions in the field medical officers and the nursing staff of the *Carabinieri*, in addition to assuring health care for the military personnel on service operations, also engage in the following activities:

– Intelligence (study of the environment and the health-care structures of the local area, endemic diseases).

– Health care for the civilian population (mobile clinics and medical visits at home for the population, visits to support the local hospitals).

On these occasions medical doctors have an opportunity to visit a very large number of people, men, women and children, and to enter into contact with a reality which is particularly painful but which fills the days of each one of us, we medical doctors, with very high moral and professional meanings.

Professional – but even more human – contact with these populations that are devastated by war and hatred can certainly be an excellent opportunity for evangelisation for Catholics such as ourselves, above all because of the fact that most of operations in the field are in nations whose official religion is not Catholicism.

Military Field Hospitals

We will now consider some examples of Italian military field hospitals in the various theatres of operations where our country is involved in peace missions, namely Afghanistan, the Lebanon, Chad, Iraq, East Timor, Kosovo and Bosnia.

As you can see a military field hospital has different names according to its role at the level of admissions and surgery (Role 1, Role1 plus, Role 2, Role 3) and it is organised with a waiting room, an emergency aid section, medical sections, a surgery section, an analysis and x-ray laboratory (including TC), and an admissions and treatment room. As you can see from the pictures, this is a hospital that is fully equipped at a clinical and surgical level and this means we can carry out surgical operations of a certain difficulty and importance. Here are some pictures of surgical operations.

The Mobile Clinic

The *Carabinieri* in particular, in addition to their normal ambulances which are able to reach the most severe and difficult terrains, also have a mobile clinic and a mobile telemedicine centre. These are two very fine vehicles that I have worked with on various occasions, for example in Nassirya, in Iraq, and also during aid missions for the civilian victims of earthquakes in my homeland, Italy.

The mobile clinic provides services relating to cardiology; otorinolaringoiatry with audiometry and endoscopy; gynaecology; eye-care; and a laboratory for analyses.

In the telemedicine mobile centre there are the same services and the possibility of sending to Italy from abroad the results of various clinical tests carried out by paramedic health-care staff and having them referred to military hospitals that are located in Italy.

As you can see from the pictures, through these mobile clinics, used for example as you can see in Iraq, we have reached the smallest villages in order to provide them with our services (the mobile clinic, medical examinations, vaccinations, etc.).

Evangelisation

But what has all of this got to do with the 'evangelisation of peace'? The important thing, it seems to me, is to see how things are done; that is to say how our activity as medical doctors in these special areas and in war situations is engaged in. If what we do is only done out of philanthropy or to respect the rules of our commission and to carry out the simple tasks of our work, then we cannot speak about evangelisation! But if in every thing we do, and if in the people we help and treat, we see the face of Christ, then the situation changes.

My personal experience has taught me that even with the great difficulties due to differences of religion, if the person who is in front of us realises that what we do we do with love and with passion then we manage to make a breach even in the hardest hearts and to enter into harmony with the most hostile and difficult people as well.

For example, the photographs that you will are of an autopsy that I carried out in Nassirya after the killing of an Iraqi interpreter following a violent exchange of small arms fire. The fact that I washed, cleaned and then dressed the bloodied body of the dead man

in the presence of a large number of his family relatives, as well as the respect that I demonstrated towards their relative, enabled me to touch and work with the body of a Muslim and even to be invited to take part in the funeral.

We can see another way of evangelising in these photographs: creating nursery schools for children and orphans; making a crib and a Christmas tree; creating school classrooms and providing exercise books, coloured pens, and toys for children; and going to orphanages and prisons to treat people and distribute food. And doing all of this after being attacked with mortars or having gone through an exchange of small arms fire and making people understand that our passion for our work as medical doctors and our love for our brothers and sisters is stronger than the fear that grips you while they are shooting at you and while you see a fellow countryman wounded or dying.

Another fine picture that I always bring with me to meetings of this sort is the following: you can see a group of Iraqi women dressed in black veils with their faces completely covered. Next to them in the street there are two girls who are about ten years old and who are wearing aprons that we Italians gave them, and they are carrying exercise books and other books under their arms and are going to school! This image is apparently normal and banal but we should remember that we are in a fundamentalist Muslim place where women, and that includes girls, must always be covered and absolutely must not go to school. Through these little things, as well, one can achieve evangelisation and peace. Women of all peoples, and above all Muslim women, are a fundamental channel for evangelisation and peace between peoples.

Lastly, you can see here some small churches built by members of the armed forces with the help of military chaplains and in some areas (Chad, East Timor) with the help of missionary priests who work in those local areas. Bearing witness in a kind but decided way to one's faith is a sign of evangelisation and of witness for these local peoples as well.

These last photographs, on the other hand, are of the Patriarchate of Pec, in Kosovo. One can see this very beautiful and enormous mulberry tree: it has shared roots but the trunk has divided in two, one towards the east and the other towards the west. According to tradition, the splitting of the trunk took place when the schism took place between the Church of the East and the Church of the West. The branches, however, go back together and intersect and this is the hope that we Christians have: to return to Unity in Christ.

To end this paper of mine, I would like to quote the words of Paul VI who on Sunday 17 May 1964, during his visit to the Military Hospital of Celio in Rome, although he stressed the need for lasting peace between the peoples of the world, also made the following statement: 'the Pope is an admirer, from this point of view, of the soldier; he knows what the human organisation of a military unit, of an army, is; how much expenditure of moral energies, of high concepts it brings with it. One need only observe how great and human is the phenomenon of *command*, which is matched by the phenomenon of *obedience*; what discipline means, what the fundamental canon of military life is: that of *offering one's own life for the good of others*. Sacrifice… having this energy of military men of knowing how to use the energy and the fullness of moral manliness which the soldier makes his own and professes for good, for faith, for charity and for civilian life as well'.

I offer this conclusion from what emerges from the pictures that we have seen and my experience as medical officer, taking up the words of the prophet Isaiah. We must hope and believe that 'swords will be made into ploughshares' and we must work so that every civilian and military hospital takes this fecund opportunity to achieve brotherhood between the peoples of the world, spirituality and evangelisation.

The penultimate picture is for those of us who have fallen and bore witness through their lives to their love for their sisters and brothers, and the last image is for our protector, the *Virgo Fidelis*, and the prayer that every day in Italy or in the field the *Carabinieri* address to Mary: in this prayer peace, love and brotherhood are talked about, not war.

Prayer of the Carabiniere

Most Sweet and Glorious Mother of God, our Mother,
We Carabinieri of Italy,
To you reverently raise our thoughts,
With trusting prayer and fervid in heart!

You who our legions invoke,
Comforter and protector,
With the title 'Virgo Fidelis',
You accept all of our supplications for good,
And give vigour and light to our country.

You accompany our vigilance,
You advise us on what we should say,
You animate our action,
Your sustain our sacrifice,
You inflame our devotion!

And from one end of Italy to another,
You provoke in each one of us,
The enthusiasm to bear witness,
With faithfulness unto death,
To love for God and our Italian brothers and sisters.

Amen!

Hospital Management Between Rationalisation and the Defence of the Right to Health

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Good afternoon your eminences, excellencies and invited guests. It is a pleasure to be here. The Pontifical Council for Health Care Workers International Conference is always a thought-provoking and exciting gathering. It is important work that is done here. All the discussions center on thoughtful reflection of the increasingly complex challenges that we face in health care today.

The theme of this Workshop is "The hospital, a place for evangelization: a human and spiritual mission." My particular topic is 'Hospital Management: Between Rationalization and the Defense of the Right to Health'. As the United States Bishops state in their Pastoral Letter on Health and Health Care, "From the earliest traditions of the Church to the present day, the mission of evangelization to which Jesus sent his followers has included healing as a major part." In Luke, Jesus says, "Into whatever city you go, after they welcome you... cure the sick there. Say to them, 'the reign of God is at hand" (10:8-9).

As I began to reflect on the task before me, another scriptural passage came into my mind, the Gospel of John, Chapter 15, Verses 1-5: "I am the true vine and my father is the vine grower. He takes away every branch in me that does not bear fruit, and everyone that does he prunes so that it bears more fruit... I am the vine, you are the branches; whoever remains in me, and I in him, will bear much fruit, because without me you can do nothing." If we are to bear fruit we must remain in Christ, and the vine must be trimmed of its withered branches. if the healing ministry of the Church is to bear fruit it must remain in Christ, remain true to its Catholic identity. Likewise, if a health care system, particularly the fragmented system of the United States, is to bear fruit, we must trim away and burn the withered branches that result in waste, inefficiencies and sinful social structures that prevent the fulfillment of the right to adequate health care for all.

There is little doubt that the health care system in the United States is in need of such attention. At this time, the United Sates is still the only wealthy, industrialized nation which does not ensure that all its people have 100% coverage or 100% access to high-quality, cost effective health care. While the recent passage of President Obama's Affordable Care Act will expand both private and public insurance to many of those individuals who currently do not have adequate coverage, it will not fix all of the problems. The social injustice that has resulted from the failure to recognize and respond to the right of all people to adequate health care has taken its toll on the American system. Barriers to access experienced by the uninsured and underinsured in the United States have contributed to poor overall health outcomes. According to the World Health Organization, the United States health care system is highest in cost, and still, the U.S. system is 37th in overall performance and ranks 72nd by overall level of health.

Compared to ten European countries, the United States has a much higher prevalence of cancer, heart disease and stroke in its population 50 years of age and over.

Moreover, there are significant discrepancies in health related outcomes for racial minorities in the U.S. As reported in 2011, the age adjusted mortality rate for African-American males is 942.6 per 100,000 lives, while it is 744.7 for white males. So too, as reported on the 2011 national cancer institute fact sheet, while the incidence rate of breast cancer is higher among caucasian women than for African-American women (132.5 vs. 118.3 per 100,000), the death rate is much higher for African-Americans (33.8 vs. 25.0 per 100,000). These discrepancies reflect injustices and sinful social structures that will require more than simply expanding insurance coverage to correct.

While expanding health insurance coverage is a starting point, there are many additional efforts that must be undertaken in defense of the right to health care. Being of the created world, we have no choice but to recognize and call others to accept the reality that if all persons are to have access to some health care, no one can have access to all available forms of care. Whether you call it the transformation of health care, health reform, or maybe even rationing, one of the most important tasks leaders of the Catholic health ministry in the United States can undertake is to rationalize the delivery and financing systems.

There are two ways to conceptually understand the term 'rationalization'. One way which we rationalize is to devise self-satisfying but incorrect reasons for our behavior. This type of rationalization already occurs far too frequently in today's health care system. The other way, in which I use for our purposes today, is to make rationale or structure according to principles of reason. In the context of the healthcare system, then, this means restructuring or redesigning the delivery and financing processes to create a coherent system that is ordered – not according to the constraints of markets, the demands of politics or even the needs of health care providers – but according to

the needs of persons who come to us for healing in its fullest sense, caring for their body, mind and spirit. Only by eliminating the inefficiencies in the delivery of care in the United States will we be able to give our brothers and sisters the care to which they are entitled, by right, having been made in the image and likeness of God.

Only by eliminating the endemic social injustices and sinful social structures that cause the branches to wither on the vine can we ensure that they receive this care in a way that truly reflects Jesus, healing ministry in the world today. Like the vine and its branches, the rationalization of health care delivery and the right to health care share common roots. This shared root system is in fact God's natural law, revealed to humanity through both scripture and reason.

Just as our inherent human dignity has as its sole source the fact that we are made in the image and likeness of God, so too it is by virtue of this origin that we share in God's dominion – that we participate in God's ongoing act of creation – through the gift of reason. While reason itself is not the source of our inherent human dignity, we must use our reason in service of both the works of mercy and the works of justice. As Pope John Paul II has said, "The Church cannot remain insensitive to whatever serves humanity's true welfare, any more than she can remain indifferent to whatever threatens it" (*Redemptor Hominis,* 13). I believe that the failure to recognize and respond to the right to adequate health care for all persons is such a threat, and the rationalization of health care can serve humanity's true welfare. Thus, everyone who is engaged in the healing ministry of the Church shares a responsibility to involve themselves in the sustained struggle to rationalize the health care system and correct any unjust social, political and economic structures that interfere with our ability to heal the wounded world as Jesus taught us by his own example.

As John XXIII taught in his encyclical *Pacem in terris*, the fundamental human right to life implies a right to the basic goods necessary for the proper development of life and thus are essential elements of the common good. Included in these basic goods are a decent minimum of health care, and the means of livelihood in the event of ill health, the death of a loved one, and old age (*cf.* Pope John XXIII, *Pacem in terris,* 6). The corresponding vision of distributive justice requires that everyone has sufficient access to healthcare, not simply health insurance coverage. This vision is the basis for the social responsibility of Catholic health care services as articulated in Part One of the *Ethical and Religious Directives for Catholic Health Care Services*: "The first right of the human person, the right to life, entails a right to the means for the proper development of life, such as adequate health care" (see also, USCCB, *Health and Health Care* I, pp. 5, 17-18, and the *Catechism of the Catholic Church*, nn. 1928, 1936, 1937, 2211, 2239, 2446, 2820). The fulfillment of this vision requires us to recognize that, like the vine and the branches, the right to adequate health care and the imperative to rationalize healthcare share the same roots, the inherent dignity of all human life from conception until death due to our being made in the image and likeness of God. In this way, the rationalization of health care and the defense of the right to health care do not stand opposed to one another as opposite ends of a continuum; rather, the rationalization of health care is a necessary and appropriate means for responding to the right to health care and, thereby, contributing to the common good and promoting and defending human dignity.

The moral norms which flow from the fundamental belief that all human life is inherently valuable and deserving of protection and which guide the Catholic health ministry are truly universal. Since the beginning of the Hippocratic tradition of medicine, some 500 years before Christ, the universal fundamental norm of medicine has been *"Primum non nocere,"* "first, do no harm." Prior to the 1960s, the Code of Ethics of the American Medical Association would have been virtually the same as the *Ethical and Religious Directives for Catholic Health Care Services* of today. For thousands of years, then, the guiding norms of the practice of medicine and of the Catholic moral tradition were like two different branches of the same vine. Until the 1960s, no health care professional would ever seriously have considered performing abortions or helping patients to kill themselves much less performing an act of euthanasia. Today, the presence of the healing ministry of the Church is of ever greater importance than before, and the opportunity for evangelization ever more present.

As a public ministry that touches the lives of those it serves when they are at their most vulnerable, the Catholic health ministry can be a powerful instrument of the Church's prophetic voice for the good of all persons. More than simply the refusal to provide certain procedures that are contrary to human dignity, the strength and transforming vision of the Catholic health ministry lies in its opportunity, role and ability to act as a positive influence on the practice of medicine and the culture of health care. Most of all, the transforming power of this prophetic voice lies in the Catholic health ministry's abiding commitment to continue Jesus' healing presence in the world today. To truly rationalize the healthcare system we must remain in Christ. We must seek to live out our Catholic identity as we lead the transformation of health care in a rational way, so that we may respond to the most basic rights that all people share in common.

I would like to share with you what I see as the top five managerial priorities for leaders of Catholic health systems in the United States with respect to the rationalization of the health care delivery system. These five priorities are like branches on the vine that will ensure that our efforts to rationalize health care stem directly from our identity as a ministry in christ and bear fruit by leveraging the strength and transforming vision of our Catholic identity in responding more adequately to the right to health care. In no par-

ticular order, these five priorities are: 1) Theological and spiritual formation programs for lay leaders; 2) Solidarity with those who live in poverty and experience the injustices that accompany social marginalization; 3) The exercise of a robust concept of responsible stewardship that goes beyond merely doing more with less; 4) Developing a new model of health care that delivers truly *person*-centered care; and 5) Living a faithful commitment to the Church's vision of human life and the moral norms that flow from that vision.

Regarding the first priority, formation programs for lay leaders of the Catholic health ministry, I have personally chosen to make this a priority for our organization Ascension Health Alliance. In today's social morality of choice, consumerism and consequentialism, leading a health *ministry* requires more than just sophisticated business acumen. Our leaders must possess a spiritual-centeredness and an alignment with our tradition that informs an abiding commitment to the mission and identity of the organization. An essential component of ministry leadership is a virtuous character that predisposes us to do the right thing even when it is difficult, unpleasant or entails less than desirable consequences.

Within our tradition, our second priority solidarity can be understood both as a virtue and as a principle. As a principle it guides our distribution of material goods for the sake of a more just social order. As a virtue, it goes beyond a concern for the material goods of the created world and orders the sharing of spiritual goods. While a "preferential option" for the poor and vulnerable is often considered one of the primary, distinguishing characteristic of Catholic health care, something more than that will be required to meet the economic challenges of tomorrow's healthcare environment. We must also respond to those whose right to health care goes unseen and unmet in today's environment. Solidarity, understood as both a virtue and a principle, must guide our operational and strategic planning at ensuring a vital presence as needed in underserved, sometimes economically devastated areas, even when we know it will not be profitable.

The ability to make such difficult decisions requires that leaders and directors be confident in their ability to exercise our third priority, the responsible stewardship over the limited resources of their health systems. To be certain, such stewardship entails minimizing resource consumption, eliminating waste, and healing without harm while maximizing outcomes and providing the highest quality care. In this context, medical utility and operational efficiency are essential to remaining sustainable even when one willingly chooses to remain in a particular market for reasons other than economic benefit. Though such decisions must be made with the greatest amount of prudence and caution, an adequately robust notion of stewardship within our tradition includes an inherent element of justice. Justice that requires attention to equity, fairness and the basic human rights of all understood in light of the universal destination of goods.

In the context of rationalizing healthcare, stewardship which merely results in doing more of what we already do while using less resources falls short of meeting our obligations; stewardship must enable us to radically change *what* we are doing and *how* we are doing it in light of an appropriate understanding of *why* we are doing it in the first place.

Simply stated, the reason the Catholic health ministry exists at all is because of our fourth priority the human person, the image of God made manifest. As you are aware, anytime Jesus healed the sick or wounded persons, he healed them not only physically but spiritually and socially as well. As Pope John Paul II reminded us, we must not let the technical aspect of medicine overshadow the fact that the patient in the bed is a person in need of healing in many dimensions. Once we even refer to the person as a "patient," we have already reduced them in our minds to being an object of the healthcare system and consequently given priority to medical values over human values. While Pastoral Care Services are an essential component of the healing ministry, the current model isolates such care as separate and distinct, that is, as ancillary.

What is needed is a new way of thinking about the delivery of care that treats the whole person in an integrated way, that recognizes the multifaceted causes of illness, that meets the person where they are rather than requiring them to come to us, and that aligns the goals of the healing relationship in accord with human – not simply medical – values. Palliative Care is perhaps the best example we have today of such an approach. As His Holilness Benedict the XVI noted in his message for the fifteenth world day of the sick, "there is a need to promote policies which create conditions where human beings can bear even incurable illnesses and death in a dignified manner. here it is necessary to stress once again the need for more palliative care centers which provide integral care, offering the sick the human assistance and spiritual accompaniment they need. this is a right belonging to every human being, one which we must all be committed to defend."

Yet, palliative care is a model that is limited to those living with chronic and/or terminal illness and while it should remain a top priority, we need to continue to seek out new models of care delivery that place the person, with all their needs for healing, at the center of everything we do. Only then will we be able to deliver on our promise to continue Jesus' healing presence in the world today and bring about health, understood in the biblical sense as wholeness, and proclaim the kingdom of God on earth by healing our wounded humanity as Jesus did.

Finally, I would like to address the importance of our fifth priority, fidelity to the church's vision of human life and the moral norms that flow from that vision. For us in the United States, these norms are summarized in the ethical and religious directives for catholic health care serivices, currently in their 5th edition. I have saved these for last because they are the summation of the other priorities. I believe that, taken as a whole, the Ethical

and Religious Directives provide a roadmap for the rationalization of health care. While some in the U.S. see the Ethical and Religious Directives as a source of criticism against Catholic health care, and even some within the Catholic health ministry might be tempted to view them as an obstacle to new business ventures, the opposite actually holds true. By faithfully living out our mission in accord with the whole of the *Ethical and Religious Directives*, we can create a health care system based on rational principles, centered on the human person understood as made in the image and likeness of God.

A Health Care System that delivers high quality, safe, efficient care to all persons consistent with their most fundamental human rights. To be sure, however, the Catholic health ministry cannot do this on its own. If we are to rationalize the healthcare system in defense of the right to healthcare, we must form new partnerships with other providers and organizations who respect our fundamental beliefs. Those who respect our need to realign local delivery systems, provide a continuum of care to our communities, witness to a responsible stewardship, provide more equitable access to the poor and vulnerable, and implement the Church's social teaching. While the current model of health care in the U.S. is one of competition, the model of tomorrow, indeed of a raTionalized health care system, is one of collaboration.

So, in closing, I would like to thank you for your time and attention this afternoon. I hope I have been able to provide you with some information for your continued reflection regarding the rationalization of health care so that we, as a healing ministry of the Church, may respond to the right of all, and thereby proclaim the Good Word through our actions.

Biomedical Research in Hospitals

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Short Introduction

I will seek in this short introduction to outline a framework within which, in referring to my personal experience, the fundamental features of *research* activity emerge. I would then like to narrow my focus and concentrate on biomedical research and its specific aspects in order, lastly, to place the analysis in its context, within the hospital world, which is marked by strong special features: first of all the daily relationships with people who are ill and suffering, which research activity certainly shares, although perhaps in a not immediately perceivable way.

In reality, research activity is profoundly bound up with all those elements that characterise the normal living, thinking and acting of man and thus it takes part in every dimension of his existence, including the dimension of *Faith*.

Although, on the one hand, research appears to be the setting for approaching and organising the potentialities of human rationality, which is a gift of God, it is also offers to our eyes a virtuous circularity in which a researcher follows the inverse pathway and goes back, through a correct use of this gift that has been received, from the creation to the Creator, in the undertaking of exploring reality and in the taking of responsibility for all people.

1. Research and the Desire for Knowledge

The desire for knowledge forms a deep part of the nature of man; it has accompanied him since the dawn of history and in all latitudes and it is a constant from the early childhood of every individual. Faced with the real and provoked by the real, man feels the need to understand the world and himself. It is not sufficient for our reason to list the most shallow and evident aspects of reality. This desire, which is never fully satisfied, corresponds to our deep nature, a desire that Pope Paul VI, in his Message to Men of Thought and Science of 8 December 1965 referred to with the felicitous expression of St. Augustine: 'We search with the desire to find, and we find with the desire to search further'. Indeed, man, and the researcher *as man*, is marked by a yearning for the infinite which is placed in his heart by Mystery. This dynamic, like a void that asks to be filled, cannot completely emerge at the certain levels of the human pathway. It can, indeed, remain still confused about its ultimate End: unaware, therefore, although perceived and present. Theologians speak about 'self-transcendence', that is to say the capacity to go beyond ourselves, perceiving that we find our 'meaning' and our 'home' not in ourselves but in something that is greater, more fundamental and more original than ourselves. This experience is well portrayed by the notion of *amazement*: we are amazed, that is to say we are stunned, in the face of something that surprises us and goes beyond us, that we do not fully understand, something, rather, which we more *intuit* than *know about*.

It is precisely this openness that is the greatness of man, who, while he acquires increasingly complex truths, does not forget to keep the door open to Truth, thereby avoiding a reduction of the real to his

own limited scale. 'The supreme step of reason lies in recognising that an infinity of things rise above it' (Blaise Pascal, *Pensées*, fragment 466). Awareness and acceptance of their own finitude, and at the same time of a Greatness that goes beyond us, are the sign of that intelligence that is specific those who know how to enjoy and love things, and leads us to the emotion of knowing, to that experience of wonder in which, for that matter, the ancients recognised the origins of philosophical thought. However, it is not sufficient for the researcher to acquire knowledge. It would remain a small thing if wonder did not create the desire for *sharing*, an approach of openness and of gift. The ability to sound out reality at a deep level makes a researcher an authentic authoritative witness to the amazement provoked by the creation. In him the wish to know is at least on the level of the wish to make known, to contribute to the history of humanity in the knowledge that in his own work he makes productive the efforts that have preceded him as well. For this reason, an authentic researcher, while he reaps what others have sowed, is called to make himself available to placing seeds once again in shared land in a free way, without making any distinctions, so that others can benefit from them.

In the way that a researcher proceeds there is his own style which is constant during all the stages of his work, whose principal characteristic is a *capacity to be critical*. Here there is an authentic need for reason, a vocation to research with the exercise of doubt.

Avoiding the hard work of testing, of critical discussion, is an indicator of shallowness, of intellectual laziness, and of a rejection of one's own *responsibility* to justify what is proposed. A capacity to be critical has nothing in common with presumption or prevarication; indeed it is the exact opposite. Explaining oneself with a readiness to discuss one's advances and those of other people involves a rejection of anchoring oneself in concepts and knowledge that are taken as given and the *humility* always to allow oneself to be subject to discussion. A high idea of research asks us to walk along its pathways with audacity, with generous commitment, with an approach of freedom and confidence, adopting the recommendation that the Holy Father offered as a fundamental element for theology which knows how to relate to the contemporary world, that is to say 'the courage to engage the whole breadth of reason, and not the denial of its grandeur' (Address of Benedict XVI at the University of Regensburg, 12 September 2006).

In research that is guided by an upright use of reason that is not induced into a positivism that denies dignity to what cannot be measured empirically and is not absolutised into a dehumanising self-referential system, a scientist is a participant in the grandeur of the creation and is led in a safe way to truth: 'reason is by its nature oriented to truth and is equipped moreover with the means necessary to arrive at truth' (*Fides et Ratio*, n. 49).

In the modern acquisition of unmeasured power by science and technology we find implicit the risk that a healthy and reasonable autonomy as regards method, objectives and instruments is misunderstood and transformed into an illusion of omnipotence in which the limited scale of the human is lost from sight and there is the danger of being guided by the desire for dominion. This was a phenomenon that was already perceived by the Second Vatican Council. *Gaudium et Spes* observed that man 'especially with the help of science and technology…has extended his mastery over nearly the whole of nature and continues to do so…Hence many benefits once looked for, especially from heavenly powers, man has now enterprisingly procured for himself' (*GS,* n. 33). A researcher finds himself in this sense faced with a crossroads: to feel himself stronger by glorying in his conquests or to be aware of his own state of being a creature, recognising a greater hand that creates and regulates reality and calls him to serve Truth and humanity with the greater responsibility that derives from greater knowledge.

As Benedict XVI observed, quoting his predecessor John Paul II: 'Scientists, precisely because they 'know more', are called to 'serve more'. Since the freedom they enjoy in research gives them access to specialized knowledge, they have the responsibility of using that knowledge wisely for the benefit of the entire human family' (Address of His Holiness Benedict XVI to the Members of the Pontifical Academy of Sciences, 6 November 2006).

A researcher can, in addition, experience on his own journey that unexpected and surprising insight which, commonly defined as the 'madness of the researcher', I myself prefer to read as the enlightening gift of He who is Truth, of that *Wisdom* that guides small and large discoveries, at times reaching unexpected inspiration, at times stimulated by the circumstances: 'To assist reason in its effort to understand the mystery there are the signs which Revelation itself presents' (*Fides et Ratio*, n. 13).

2. Biomedical Research: a Concrete Expression of Scientific Research

Technically speaking, the term 'biomedical research' covers different branches of medical research: 'basic research', which seeks to understand the mechanisms that underlie various pathologies; 'applied research', which seeks to give answers to clinical research; and 'translational research', which is based upon constant circle between basic research and clinical research, 'from the bench to the bed of the patient'. All of these three kinds of approach are carried out with the goal of increasing knowledge in the sector of medical research with the aim of improving diagnosis and/or therapy.

2.1 An example of state-of-the-art biomedical research: research on stem cells

Basic research on stem cells is continuing to make great strides every day thanks to the important results that have been obtained. In the field of so-termed advanced cell therapies numerous clinical

trials have been conducted. It is by now well known that all post-birth adult tissues, from placenta tissues and foetal tissues to those that make up an adult organised, are mines from which it is possible to isolate stem cells. The possibility of isolating stem cells from blastocysts, the so-termed embryo stem cells, is equally well known and has been the subject of a lively debate. These are characterised, as can be imagined, by a high potentiality of differentiation into cells of different tissues. Recently, because of the attention given in the mass media to the award of the Nobel Prize to the researchers who first established the strategy by which these could be obtained, the so-termed Induced Pluripotent Stem cells (IPSC) have commanded attention, that is to say the pluripotent stem cells obtained from adult cells following their genetic reprogramming through the introduction of genes that can bring them to a state similar to that of an embryo, recovering both the interesting characteristics of differentiation towards all three embryo layers (ectoderm – for example the epitelium, the digestive and pulmonary cavity; the mesoderm – for example muscles, bone and blood; and ectoderm – skin tissues and tissues of the nervous system) and the characteristic, also common to embryo stem cells, of forming teratomas after inoculation into animals.

The methodology by which to obtain IPSC was greeted by many as an ethical victory because it allows the obtaining of cells 'similar to those of embryos' without the need to create or destroy human embryos. From a biological point of view, the IPSC are undeniably of great interest and this constitute a discovery of notable importance. However, I believe that the noise surrounding this discovery has been rather lacking in a critical sense and also risky in relation to the clinical potentiality of these cells, at least in the short term, inasmuch as some genes correlated with pluripotency are recognised as having a cancer-inducing capacity. It should be recognised that little or nothing is known about the biology and the real potential of these cells, in relation to which hitherto, both because of their characteristics of being similar to embryos and because of the genetic manipulation used to produce them, the possibility of causing tumours remains high.

2.2 The researcher as an individual and his responsibility

This short introductory framework as regards research on stem cells enables us to engage in some reflections about the researcher as an individual and his responsibility.

Linked to the reflection of point 1) about research as an expression of the thirst for knowledge implicit in man, it is clear that a researcher is not a mere and impersonal technician who has some skills and abilities. He is first of all a man, and this humanity of his enters legitimately into the pathway of research. In this sense, the neutrality of science does not exist. The *freedom* and the *responsibility* of the researcher, who does not only belong to an institution but also has a social dimension, must direct his action at every step of his pathway of research beginning with the choice of the lineage that he intends to follow and the criteria to which he should adhere in order to identify it. That of simple technical practicability? That of material reward? That of the prestige that may derive from it? That of the needs of those who suffer? That of justice in the allocation of resources?

A whole series of factors, together with an ethical assessment of the consistency between ends and means, comes into play. This was observed by the Holy Father on the occasion of the international conference organised by the Pontifical Council for Culture (12 November 2011): 'In addition to purely ethical considerations, then, there are issues of a social, economic and political nature that need to be addressed in order to ensure that advances in medical science go hand in hand with just and equitable provision of healthcare services'. The responsibility of the researcher also comes into play as regards the communication and dissemination of results that are achieved. In the case of stem cells, the greatest clarity is essential as regards the source from which they are isolated, the applicability of the discoveries in therapeutic approaches, and the fundamental difference that exists between *clinical experimentation* and *consolidated treatment* as was recently emphasised by Prof. Augusto Pessina ('Le cellule staminali adulte tra mito e realtà'; 'Adult Stem Cells Between Myth and Reality': *L'Osservatore Romano*, 27 November 2011). In the sector of the applicability of stem cells in therapeutic approaches, we have had, unfortunately, during recent years, an example of incomplete information, information that is not very clear or even manipulated. One can thus generate in patients and their families false hopes which provoke bitter disappointment, leading to the drawing of risky conclusions when one is still at the stage of clinical experimentation, if not indeed pre-clinical experimentation, and presenting as safe and effective therapies for which experimentation could in the end produce results that are very different from those expected. It is irresponsible not to take into account the impact that incautious announcements can have on people who suffer and who await, with trepidation, an answer from science to their illness. Patients have the right to correct information, to receive attention and care from medicine and research which with healthy realism and an awareness of limits do not promise what they cannot deliver.

Scientific seriousness and honesty require humility in drawing teachings from negative results as well and going back with realism on one's steps when the observations that have been made indicate that there are no well founded reasons for continuing on the pathway that was envisaged on the basis of a hypothesis. Just as it is not ethically acceptable to destroy embryos, and thus human lives, with a view to a possible future benefit, so it is not ethical to abandon a healthy prudence and underestimate the potential dangers of a therapeutic application that has not been sufficiently examined.

3. Biomedical Research in Hospitals: Respect for Life and Providing Care Starting with Research

I often use the following example to bring out the aspects which, on the one hand, liken, and, on the other, differentiate, the experience of a medical doctor with/from that of a researcher. The objective of both is to engage in the best diagnosis and then the best therapy. A medical doctor pursues this objective by entering into action in an immediate way, applying the knowledge and the instruments that he has available in order to solve, treat and alleviate the problems encountered in the patient. An inability to provide forms of treatment that solve the problem certainly does not indicate surrender by a medical doctor whose vocation involves the task not only of healing but also of *treating* and of *taking care of*. However, the unavailability of effective therapies leads him back in a strong way to a sense of his own limitations.

On the other hand, a researcher looks at an illness that can still not be cured as a challenge that provokes him to channel the efforts of experimentation in that direction. In a certain sense, where a medical doctor is faced with a closed route, a researcher sees outlined a route to follow. One could, however, think that the challenge becomes the illness in the abstract, without having the patient as an individual present. Although it is in reality medicine in general that is exposed to the risk of concentrating in an exclusive way on resolving the clinical expressions of illness, on parameters that are not normal, this risk is even stronger for a researcher, who does not come into direct contact with the patient but dedicates all of his energies to the search for the solution to a problem.

And yet never as much as during this historical period of biomedical research has the rediscovery of the centrality of the individual been of such fundamental importance, and this specifically to assure that technical knowledge and strategies are for the good of man, of each and every man, and not only for some men.

In a certain sense hospitals are the setting where the researcher as an individual enters into a relationship, albeit in a very special way, with the patient as an individual, and in a specific way that is his responsibility places himself at the service of that patient. The challenge certainly remains that of solving the problems of the illness but the context of hospitals provokes and educates the researcher in the goals of his activity, offering him the possibility of being an integral part not only of the treatment but also of taking care of, and also helping him to live his scientific dedication as an actuation of the great commandment of Christ to work hard to serve one's brethren, with whom, indeed, he identified: 'as you did it to one of the least of these my brethren, you did it to me' (Mt 25:40).

To keep one's eyes fixed at the level of ideals on the patient as the recipient of the results of one's own work sustains a researcher in his daily hard work and difficulties, and becomes a way of proclaiming the centrality and the irremovable dignity of every life. Indeed, the Pope when speaking about the sick person declared: 'His transcendental dignity gives him the right to remain the ultimate beneficiary of scientific research and never to be reduced to its instrument' (Address of the Holy Father Benedict XVI to the International Conference Organised by the Pontifical Council for Culture, 12 November 2011).

4. Scientific Research and Faith

'Experienced fully, the search is enlightened by *science and faith* and from these two "wings" draws dynamism and an impetus, without ever losing its proper humility, the sense of its own limitations. In this way the quest for God becomes fertile for the mind, a leaven of culture, a champion of true humanism, a search that does not stop at the surface. Dear friends, always let yourselves be guided by the knowledge that comes from on high, by knowledge illuminated by faith, recalling that wisdom demands the passion and effort of seeking' (Address of the Holy Father Benedict XVI to the Catholic University of the Sacred Heart in Rome on the Occasion of the Fiftieth Anniversary of the Faculty of Medicine and Surgery).

Starting with these words of Pope Benedict XVI, I will now seek to offer some reflections on a relationship that is often wrongly portrayed as being one of conflict.

In referring to my experience, I would like to share with you the perception that the domain of science and the domain of Faith, although they are distinct, are two different but not separate sides of my being which are to be found in my unity as a person, giving them breadth and depth.

In the field of the recognised autonomy of earthly realities it is certainly the task of the individual fields of human activity to construct their own pathways so that they are suited to the subject of inquiry. I believe that the point of departure for the construction of a fruitful dialogue is recognising that each of the two dimensions – science and Faith – has methods, instruments, domains, subjects of research and goals that are specific to each one of them. Each one, therefore, requires respect for its own specificity and the legitimate possibility of autonomous exercise according to its own principles.

This legitimate autonomy does not, however, imply the raising of scientific research to a final and absolute value which is without any limitation: 'One can therefore say that the autonomy of the sciences ends where the upright conscience of the scientists recognise evil – the evil of method, outcome or effect' (John Paul II, Address to the Rectors and the Lecturers of the Universities of Poland, 30 August 2001, n. 3).

All of the creation is ordered to the Good of man and every human activity must tend towards this same end. The *Catechism of the Catholic Church* observes: 'It is an illusion to claim moral neutrality in scientific research and its applications. On the other hand, guiding principles cannot be inferred from simple technical efficiency, or from the usefulness accruing to some at the expense of others or, even worse, from prevailing ide-

ologies. Science and technology by their very nature require unconditional respect for fundamental moral criteria. They must be at the service of the human person, of his inalienable rights, of his true and integral good, in conformity with the plan and the will of God' (*CCC*, n. 2294).

It is this reference to service to the human person, to his true and integral good, that ensures that science and Faith are not obstacles to each other but can, on the contrary, offer each other mutual support in pursing the same objective, to which, indeed, they draw near following different routes.

The Fathers of the Second Vatican Council observed: 'Therefore if methodical investigation within every branch of learning is carried out in a genuinely scientific manner and in accord with moral norms, it never truly conflicts with faith, for earthly matters and the concerns of faith derive from the same God. Indeed whoever labours to penetrate the secrets of reality with a humble and steady mind, even though he is unaware of the fact, is nevertheless being led by the hand of God, who holds all things in existence, and gives them their identity' (*GS*, n. 36).

It is evident at this point that between scientific knowledge, the other forms of (philosophical, ethical, theological) knowledge and Faith there is no reason for the existence of oppositions. When these arise they are a clear sign of some contradiction on the pathway of knowledge, of an error on the pathway that should be identified, explored in depth and healed by resorting to critical testing, to dialogue, and as far as I am concerned, as a believer, by bringing to bear divine illumination.

In interaction and dialogue between Science and Faith each in reality has a great deal to offer to the other. Taking up the words with which the Blessed John Paul II opened his encyclical letter *Fides et Ratio*, when describing the relationship between Faith and reason, of Faith and science as well we could say that they 'are like two wings on which the human spirit rises to the contemplation of truth'.

Faith, in leading man to pose questions to himself and to discover the full meaning of his existence, is a support for the researcher in acquiring knowledge about the meaning of his activity and helps him to understand it anew in the broader dimension of the integral vocation of man. In the recognition that he is a creature, the researcher who is a believer is in addition stimulated to keep alive awareness of his own finitude and his limits, which is also transmitted in his activity in the scientific field: scientific knowledge is not an ultimate end, nor is it able to meet all the needs and questions of men. It is faithful to its vocation when it places itself at the service of the Good of man and contributes to the creation of a more human world, thereby cooperating with the Kingdom of God. In this way the world of research can make its contribution, which is achieved in various ways, available to the Church. It teaches faithfulness to what is true, which is the fundamental element of scientific inquiry, and offers an opportunity for dialogue with the contemporary world. In addition, it allows participation in achievements inspired by international solidarity, thereby achieving a concrete and specific actuation of man's lordship over the creation, in the imitation of the example of the Divine Samaritan, who 'came not to be served but to serve'.

Amongst scientists there is a widespread awareness that technological-scientific knowledge and skills place great power in their hands. This calls on them to take upon themselves with greater awareness and a greater sense of responsibility the fate of the whole of humanity. Amazement in front of the infinitely small and the infinitely large that is revealed by the scientist also helps everyman to raise his eyes from the narrow space of his own immediate experiences, obtaining for him horizons of universal beauty and truth. Lastly, in unveiling the mechanisms that govern the world, scientific culture comes to the aid of Faith, purifying it and freeing it from encrustations and elements of superstition.

The Church is entrusted with the important task of fostering and creating conditions so that in dialogue and in mutual respect science and Faith can benefit from their mutual contributions. The Church also has a further responsibility in being a *mater et magistra*: that of looking at the scientific world with a caring gaze and special attention, offering her own message to these 'pilgrims marching towards the light' (Paul VI, Message to Men of Thought and Science, 8 December 1965).

In this sense, it seems to me that I can point to certain concrete needs. First of all, since an ability to intervene in the contemporary debate in an authoritative and effective way pre-supposes the capacity to act at high levels of competence, it is essential that attention is paid to the formation of consultants who have a solid training, above all in the field of the biosciences, and also to a commitment to the dissemination of scientific knowledge which is entrusted to qualified experts.

It is also important for the Church to work to promote the birth of networks of communication and activities involving cooperation between Catholic scholars. Lastly, specifically because research is a human activity, there is a great need for a pastoral care that nourishes the spirits of scientists, cultivating in them that intelligence and that wisdom that will make them able to be present as witnesses to the Truth and to Love in the challenges of modern science.

5. Conclusions

During the Year of the Faith all of us have the task of returning to embodying the Faith in the various contexts of life. I believe that scientific research must rediscover and continually discover its true origins, it true mission, so that in the life of a researcher a greater commitment to scientific research does not weaken Faith, but strengthens it, and the research laboratory can be not only a setting to be evangelised but also a setting in which evangelisation is actively worked for.

The Vocation of a University Hospital

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The relations between faculties of medicine and hospital institutions go back a long way in Italy and they were almost contemporaneous with the establishment and spread of the modern system of teaching medicine based on clinical observation.

The law of 17 July 1890, n. 6972, was the first legislation to address in an overall way the question of the relations between universities and health care. It clarified that cooperation between universities and hospital institutions in cities where there were faculties of medicines was necessary.

The reform of 1992 (d. lgs. 502/1992 art. 4, and 4-6) envisaged university clinics or polyclinics managed directly by universities for their own purposes, also acting as the providers of health-care services on the basis of agreements with agencies that owned services and hospital companies – public centres that provided health-care services – which had agreements with universities providing (wholly or by individual departments) a service of teaching and research.

The d. lgs. 517/1999 envisaged the transformation of polyclinics and hospital companies into integrated university hospital companies (AOUI) in which universities and regional governments together would create a new organisational model able to assure training and research while health care was being provided.

The pre-requisites for these AOUIs are: an ability to provide care designed to meet the need for health of citizens; the presence of care processes for those patients with more severe and complicated clinical profiles; attention paid to, the analysis of, and the solution of ethical problems connected with care provided in a clinical context; engagement in activity involving health-care research and basic research; the use of benchmarks to measure the qualitative levels reached by the care procedures and by the use of the resources of health-care technology; and the adoption of innovative technologies.

At a more detailed level, the characteristics of care in this field are: being qualified and adequate as regards periods of time, knowledge and needs in a way that is compatible with the resources available; being designed to respond to and meet the need for health in relation to hospital care; working in structures that have high volumes of services being provided and a high specialisation of the activities engaged in; using advanced technologies; privileging any initiative that improves continuity in care in services and the local areas from which patients come; and conceiving and implementing pathways for the admission and discharge of frail patients.

The characteristics of the teaching are: fostering the teaching/scientific supply specific to the mission of a university and having specific teaching areas; assuring access to the world of work for young people by offering them training experience directed towards their cultural, professional and human growth, as well as integrated structures for teaching, research and health care; assuring an exchange of experiences between the different generations; and valuing the cultural heritage of professionals of the regional health-care system

The research must be developed in a scientific-biomedical pole that is characterised by: educational areas organised within the hospital area; structures dedicated to applied research; the integration of research in the field into innovative organisational models, of a local-area kind as well; and contacts with institutions dedicated to basic research.

In the introduction to the document establishing the AOUI of Verona, some key words are indicated which are indispensable in achieving the goal of full integration between the university and the regional health-care service and between care, teaching and research: ‘innovation’ – grasping with intelligence and speed the points that come from the world of science in the biological, clinical, organisation and ICT field; ‘culture’ – basing oneself in every act of research on rational logic based upon scientific demonstration and the capacity to mediate between these and the facts of experience; ‘justice’ – responding to the requests for the protection of the weakest individuals inasmuch as illness is the gravest cause of the creation of differences between people and medicine is a privileged instrument for the recreation of a condition of clinical equality; and ‘clinic’ – using in a harmonious way the sets of technical and relational acts that characterise care for sick people.

Telemedicine: a Medical Reality that Calls on Ethics

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Introduction

The explosion of internet and the new communications technologies has helped to ensure that in many parts of the world, including Africa, telemedicine is seen with growing interest as a possible response to the very many problems that afflict health care, especially at a hospital level. Google has almost five million hits under the heading of 'telemedicine'. Many meetings follow one another on the various applications of this new branch of medicine while there are some thousands of research articles published on this subject in specialist scientific reviews, both medical reviews and ones on applied engineering.

In contrary fashion, little is known and even less is documented about the ethical implications connected with the use of telemedicine. And this applies in a particular way to developing countries where resources are limited and where needs are many and in competition with one another. Hitherto, indeed, only four countries in sub-Saharan Africa and one international association have developed ethical guidelines; only one article has been published in the prestigious review *Philosophy, Ethics, and Humanities in Medicine*, and there are very few publications that appear on the research engine *Pubmed* under the headings telemedicine, Africa and ethics.

The aim of this contribution by Doctors with Africa CUAMM is to provide some elements of discussion in this very complex subject starting with an empirical approach, looking that is to say at reality as it is in the field and allowing questions to arise from it.

This paper is divided into two parts. In the first I describe what telemedicine is and what its expected benefits are. After this there is a rapid look at the application of telemedicine in Africa and the obstacles that impede its widespread application. In the second part two practical ethical dilemmas are presented: the first concerns the relationship between telemedicine and the allocation of resources; the second raises the question of fairness in its use in favour of poor people. This is followed by an analysis of telemedicine and frugal technologies and, lastly, by conclusions.

Telemedicine: What is it?[1]

By telemedicine one means the exchange at a distance of medical information between points that are distant from one another. This exchange can take place in real time of after the information has been collected, stored and forwaded. Texts, audios, videos or fixed images can be transmitted. The technologies that are used are very varied in character, from cell phone to satellite systems, but in substance all of them share the use of internet. Given the rapid progress of information and communication technologies (ITC), there has also been a proliferation of names and acronyms such as telehealth, e-health, m-health, and with this, also, a loss of the terminological consistency of the very term 'telemedicine'.

The applications of telemedicine in the medical sector are many in number. The most frequent relate to the diagnosis and treatment of illness, in order to obtain a second opinion by specialists as well; the formation and updating of health-care personnel which is today indispensable in countering the obsolescence of knowledge; research which more than ever before takes advantage of the contribution of centres and expertise; and programmes for public health and administration.

The benefits expected from the applications of this technology refer to some of the most relevant dimensions of the working of the health-care system, such as the possibility of improving access to essential health-care services (increasing their quality and efficacy) and mitigating situations that involve a scarcity of personnel through cooperation, networking and formation.

These benefits are especially relevant in Africa where in many cases the population lives in rural and remote areas that are very far from health-care centres, and health-care workers, if they are present, work in a context of great isolation without opportunities for professional growth and exchange. If one considers that almost a half of the African population does not have access to essential services, and that there is a shortage of almost a million health-care workers in this sector, one can understand how telemedicine could make a fundamental contribution to filling this gap.

Telemedicine in Africa: What is it?[2]

Indeed, an in-depth look at how this technology is penetrating Africa highlights a rapid, albeit informal, spread of telemedicine in many sectors. There are very many examples of this.[3] The continent of Africa is the continent where there is the most intensive use of the HINARI programme which makes freely available 11,440 scientific reviews and over 8,000 books in

electronic form in 30 languages. Once again in the field of the formation of medical doctors and nurses, amongst the various global networks that use telemedicine for humanitarian purposes reference should be made to the SCART (short course on antiretroviral therapy) initiative of the Institute of Tropical Medicine University of Anversa which allows many people in the field, above all in Africa, to be updated on this subject through an interactive training course which is at done at a distance through internet. This is an example of a virtual community which gathers around a complex subject such as that of treatment for HIV. Another similar experience is UNFM/RAFT which involves a network of European centres and eighteen African countries, in large measure francophone ones, around the subject of diabetes. Specialist courses are offered online as well as debate forums, updating on the literature in the field, exchanges of clinical experience and epidemiological data.

In the field of diagnoses by images, the chronic shortage in Africa of specialists in radiology and pathological anatomy is, in part, overcome thanks to the projects respectively of teleradiology and telepathology. Amongst the various examples given in the literature in the field as well, mention should be made to the district hospital of Thyolo, in Malawi, which a year ago was able to receive radiology equipment for carrying out diagnoses from the United States of America, and this has benefited 158 patients with tuberculosis. Or the cooperation between the hospital of Mulago in Uganda and that of Fuerth in Germany thanks to which 92 biopsies have been analysed and referred at a distance. In the field of public health care, as well, ICT instruments such as SMS are beginning to be applied: in South Africa, for example, SMS are used in some programmes in the fight against HIV, against TB and sexually transmitted diseases, in order to support primary prevention, the regular taking of medical products, and the surveillance of epidemics. In other cases they have been applied to support the registration of life events such as births, deaths and the causes of death. Despite these positive developments, a large number of obstacles continue to exist to the spread and use of telemedicine in Africa. Amongst the most important one may list: an insufficient technological infrastructure; the inadequacy of national development policies and strategies; legislative uncertainty as regards the subjects of privacy and informed consent; and a shortage of studies on cost/efficiency and financial sustainability.[4]

The Ethical Dilemmas

Is telemedicine a priority?

The cost of a telemedicine system by satellite connection is around 15,000 euros. With the same sum of money one can employ two or three obstetricians in a Ugandan district hospital where the maternity wards are the most crowded, in need and short of qualified personnel. What are the criteria for choosing between these two options for a hospital management? The allocation of resources in medicine constitutes one of the ethical points that is most difficult to solve, even when they are of an organisational character, as in this case. The few resources that are available should be directed towards meeting primary needs, the financial sustainability of the hospital, and the organisational implications that all new technology involves.

One the other hand one should also consider the potential benefits that telemedicine involves at a clinical level and the level of diagnostic services and treatment, and as regards the subject of the updating and advance of professional skills and expertise, the recruitment of new health-care figures, and the attraction of new patients.

The assessment of benefits and costs, however, should not be limited exclusively to the institution of a hospital but should in addition include the perspectives of patients and of society more generally. This overall assessment of telemedicine in Africa is fully represented in what is today defined as 'frugal technology'.[5] This is an attempt to develop technological instruments in order to contribute to solving the health and health-care problems of the poorest populations in the world. There do not exist univocal answers to the question whether telemedicine is a priority but, rather, decisions connected, as the occasion requires, to the context and the finalities of its use and the benefits that it brings.

Is telemedicine for the poor?

It has been amply documented that those who use the new technologies in the health-care field are in large measure the highest social classes in terms of income and education. One is dealing here with the so-called 'inverse care law',[6] according to which the availability of high-quality health care tends to be inversely variable to need. To give a practical example connected with the African context: access to a caesarean operation, which constitutes a complex technological and life-saving service, is the prerogative of women who belong to the most well-off social groups.[7] The ethical problem that underlies the introduction of new health-care services, such as telemedicine, lies in the risk of creating explicit or implicit forms of inequality and thus of social injustice.

What are the implications for the management of a hospital? A first observation concerns the fee policy of a hospital. A fee policy as regards hospital services based exclusively upon the capacity of patients to pay would raise many questions about 'contributive justice'. With the same fee, the contribution of the most economically disadvantaged people would be greater and this would help to increase inequality amongst the patients.

In this case as well, this is not a problem confined to telemedicine: it concerns the ethical approach to the subject of the financing of hospitals. The ownership and the management of a hospital, especially if a Catholic hospital, should draw up, apply

and assess, constantly, a policy or guidelines for the social defence or protection of the poorest and most marginalised categories so that access to the hospital and to the services that it offers, as in the case of telemedicine, are not exclusively conditioned by the financial capacities of individuals.

Conclusions and Prospects

Telemedicine offers many and promising potentialities for the improvement of health-care services in developing countries. In sub-Saharan Africa it is already present and being used, even though in a very informal and not structured way. Side by side with the political, technical and organisational problems which have to be addressed in order to secure systematic and effective diffusion of telemedicine, two dilemmas of an ethical character should be pointed out as regards its correct use. These are the dilemmas connected with the allocation of resources and thus the assessment of telemedicine as a priority as regards other needs, and the dilemma concerning the fair use of this technology by the poorest parts of the population. These are dilemmas that are typical of the organisational ethics of such an important reality as hospitals.[8] The answers to these dilemmas require from management operational guidelines that are based upon clear criteria of moral philosophy and, at the same time, that are based upon a process that is participated in and open to discussion, dialogue and the concrete testing of the decisions that have been taken. It would be interesting here to foster the exchange of good practices so that one can learn from good experiences that are available in this field, remaining aware of the fact that single answers do not exist for all contexts and for all situations.

Notes

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Healing Spaces: The Science of Place, Spirituality and Wellbeing: Implications for the Hospital Environment and Health

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How do we make hospitals places of healing of the spirit in addition to the body and mind? This is the central question posed by this 27th Pontifical Council conference. It is also the central tenet of the emerging medical fields of integrative medicine and pain and palliative care, and the architectural and design field of evidence-based design.[1,2]

In our modern world, hospitals have too often been stressful places. The modern field of neuroimmunology provides ample scientific evidence that stress can make one sick and that belief can help heal, and the research to prove how this occurs. For that reason alone, it should be incumbent upon us to change the hospital setting from a stressful place to a healing one, which supports both emotional and physical health and helps the body to heal rather than worsening illness.

The knowledge of the many ways in which the brain and immune system communicate, have shed light on how stress makes one sick.[3] In order to understand this, one must define the concept of 'stress', first popularized in the way we understand the word by Hans Selye who borrowed the word from physics in the mid-20th century. Stress has many parts – the initiating event, the brain's physiological stress response, and the effects of the hormones and neurochemicals released during stress on the immune system and other organ systems in the body involved in the healing process. A key mediator that links the stressful event with the brain's stress response is perception. An individual must perceive an event as stressful in order to react to it. Once an event is perceived as stressful, the brain's

stress center, the hypothalamus releases the hormone corticotropin releasing hormone (CRH), which in turn causes adrenocorticotropic hormone (ACTH) to be released from the pituitary gland and cortisol to be released from the adrenal glands. Cortisol is an anti-inflammatory hormone, which when present in excess, as occurs in chronic stress, impairs immune cells' ability to fight infection, heal wounds and protect from cancer. Indeed numerous studies show that chronic stress is associated with more severe and frequent viral infections[4,5]; reduced take-rate of vaccines[4,5]; slowed wound healing[5]; speeding of cancer growth[6]; and speeding of chromosomal aging.[7]

More recent studies also show that salubrious activities such as meditation, exercise, yoga, tai chi and prayer reduce the brain's stress response and activate positive emotional brain pathways involved in anti-pain perception and desire – the brain's opioid and dopamine 'reward' regions.[8,9,10,11] In addition the vagus nerve is activated and releases acetylcholine and neuropeptides, which put a further damper on the stress response, slow the heart to a more healthy rhythm and enhance the immune system's healing properties.[12] Deep slow breathing is an important common mechanism in all these activities, which activates the vagus nerve.[13]

Many of these same brain processes are activated during the placebo response: the belief that a medicine or medical intervention will heal. Although often dismissed, the placebo effect is actually a very powerful effect: it is the brain and body's own healing mechanism. Thirty to fifty percent or more of the effect of any cure can be attributed to the placebo effect. It is so powerful that the benefits of placebo must be subtracted from the effect of any active drug in placebo-controlled trials in order to determine the magnitude of the active drug or intervention. Prayer, including Franciscan prayer, Carmelite nuns' mystical experiences, and Buddhist mantra repetition, similar to rosary prayer, have been shown to activate many of these same brain regions and brain outflow pathways.[14,15] Surveys of patients in intensive care units and those facing terminal illness show that large proportions seek religious observance and desire prayer, even if they previously had not practiced their religion. Such times in a person's life can become "teachable moments", when he or she may gain self-insight and find healing or wholeness through such practices. Health care providers should be trained and prepared to assist patients and their families achieve such healing experiences, and the physical hospital setting should be such that it can facilitate and support rather than hinder such moments.

The modern hospital has evolved over the centuries as sterile, stressful, noisy mazes – definitely not conducive to healing. These physical changes started out as positive advances in public health, in which all foments of infection were removed and soft homey surfaces and coverings were replaced with shiny, easy-to-clean tile and metal. This was very effective in controlling infections but resulted in the emotionally sterile and noisy atmosphere that we associate with hospitals today. Hospitals more and more became places to house expensive diagnostic machinery and attention to the emotions and spiritual life of the patients and their families was overlooked.[1]

Many recent studies have shown that thoughtful changes in the hospital environment can speed recovery, reduce pain, reduce medical errors, and improve the moods of patients, their families and the hospital staff. Roger Ullrich first showed in a landmark study published in *Science Magazine* in 1984 that patients recovering from gall bladder surgery whose beds were beside windows with a view of a grove of trees left hospital on average a day earlier, required less pain medication and had fewer negative nurses' notes that patients with a view of a brick wall.[16] This launched a field called evidence-based design. Subsequent studies in Italy in the summer and Canada in the winter have shown similar findings in patients with different forms of depression. Those on the sunny side of the ward had significantly shorter hospital stays (2-4 days shorter) compared to those on the shady side.[17, 18]

Part of the beneficial health effects of windows may come from light. Full spectrum sunlight is known to enhance mood and reduce symptoms of depression in persons with seasonal affective disorder and other forms of depression.[19] Color can also induce emotional responses, mostly through learned associations – blues and greens are generally calming and reds and yellows activating.[1]

Other beneficial effects may come from the view of nature itself. Certain scenes are universally preferred across cultures, ages and all segments of the population.[20] These tend to be views of nature, sweeping vistas in particular. Complex scenes are processed in the brain in a region called the parahippocampal cortex, which is rich in endorphins, those anti-pain, feel-good molecules. Irving Biederman at the University of Southern California has theorized that the reason we all like to look at beautiful views is that we are releasing endorphins when we look at them.[20] Nature is also rich in fractal patterns: geometries that are identical at every scale. It is not understood why people prefer to look at fractals,[21] but computer analysis of such patterns in a 15th Century Japanese Temple garden (the Ryonji Temple, Kyoto) indicate that the lines of fractal symmetry pass directly through the most peaceful viewing spot in the Temple.[22]

Similarly, other sensory experiences can have positive effects on emotions and healing. Lavender is calming and inhaling lavender scent can actually induce slow wave sleep in animal studies.[1] Frankincense, given by the Queen of Sheba to King Solomon and one of the gifts of the Magi, was so prized by the ancient Romans that they assigned sentries to guard the bushes that produced this resin. Frankincense resin was carried into battle by Roman Legion soldiers for its healing properties. Indeed modern stud-

ies show that this aromatic resin does have anti-bacterial and immunostimulatory properties that could help in wound healing.[1]

Sound can have a double-edged effect – with music reducing stress and inducing calm, and even reducing dose of pain medication required post-operatively. In contrast loud noise is a powerful trigger of the stress response. Noise levels in intensive care units can reach as high as 95 decibels – the same level as a motorcycle firing at close range. Swedish studies have shown that an intervention as simple as attenuating sound with absorptive ceiling tiles, reduces stress and results in better sleep quality in patients and nursing staff in intensive care units.[1]

Another important factor in the hospital environment, which contributes to healing is social support and positive human interactions, including love and compassion. This is one important element that is present at Lourdes, the Healing Sanctuary in Southwest France where the Blessed Virgin appeared to Bernadette, a poor peasant girl in 1864. There altruistic compassionate love is abundant between the 'malades' (the sick) who come there to be healed and their friends, families, strangers and pilgrims. The physical aspects of the place – the beauty of the mountains and the stream, together with the long history and fervent belief associated with the site, facilitate a sense of deep spirituality for all who visit, regardless of religion or culture. Those who visit cannot help but feel better once they have experienced this totality of spirit there.[1]

How do we capture these elements of healing in a modern hospital? Most hospital rooms today do not feature beautiful views, gardens, pleasant quiet sounds, diffuse light and have not been designed to accommodate families. Indeed in the previous century visiting hours were often kept to a minimum, exactly at a time in patients' lives when such social support is most needed. The vast majority of hospitals are not designed in a way that might help healing.

So why not include such features in the hospital setting – features to reduce stress and support emotions, social support and healing? We are entering an era when more and more is being done to the physical environment to reduce stress and support the emotions, and the benefits on health outcomes are supported by scientific evidence. The Pebbles Project coordinated by the Centers for Health Design in the United States has gathered evidence from renovations of dozens of hospitals across the United States and has shown that design measures such as including gardens, views of nature, diffuse and appropriate lighting, noise attenuation, warm and welcoming home-like décor, social spaces for families, and step-down units together result in shorter hospital stays, less infections, lower pain medication use, better patient and staff satisfaction, less nursing turnover, and fewer medical errors.[23] Cost calculations show that the additional money spent up front to design such hospitals can be recouped in the first year of operation because of these health benefits.[24]

Advances in non-invasive mobile health monitoring devices are allowing the sensitive detection of stress and relaxation responses in real-time as individuals move through their environment. In a study in office workers we have shown that improvements in office space, which take these features into account reduce physiological measures of stress in workers in the new compared to old office space lacking these features.[25] We have also developed a method to measure stress and immune biomarkers in sweat, to avoid the need for blood collection to detect immune status.[26,27] These new devices in combination can detect patterns of biomarkers that reflect the health and emotional status of individuals in naturalistic settings and can be used in future to help design healthier hospital environments.

Understanding the brain immune connection in scientific terms can thus explain how stress makes you sick, how belief can help heal and how place and space around can contribute to illness or health. Such data are providing the evidence needed for the health benefits of modifications in hospital design and also for the benefits of integrative interventions combining attention to the emotional and spiritual needs of individuals together with conventional medical care. In today's world we must use these scientific principles and evidence rigorously gathered through careful research, to design healing hospitals. With proper design, the hospital can become a spiritual place where individuals, even "in the Valley of the Shadow of Death" can find their place of peace and healing.

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ROUND TABLE
Hospital Workers: Evangelisers of Life

1. The Administrator

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Introduction

The Greek noun "*euangelion"* means "Good News" and is literally translated as "evangel" or gospel. Thus "evangelism" originates from the word *"euangelizomai"* which literally means "I bring Good News." The old Greek also used it to mean "bringing good news of victory". The good news is that God loves us so much that He gave His only begotten Son, Jesus, to die for our sins and to bring salvation to us. Jesus himself spread his Father's good news of love. One of the ways he used was the healing ministry. He combined the preaching of the Word with the practical healing of diseases and sicknesses (Mt 4:23). In other words, healing was one way of preaching the good news or showing God's love. He passed this on to his disciples "and gave them authority over unclean spirits with power to chase them out and to cure all kinds of diseases and sickness" (Mt 10:1). "And as you go make this proclamation 'the kingdom of heaven is at hand'. Cure the sick, raise the dead, cleanse the lepers, and drive out the demons" (Mt 10:7-8). Health-care workers are people called to continue and bear witness to that work of the first Apostles commissioned by Jesus before he ascended into heaven: "You will be my witnesses not only in Jerusalem but throughout Judaea and Samaria, and indeed to the ends of the earth" (Acts 1:8-9). How well health care is managed and provided indicates how well the good news of love is passed on.

In many counties Catholic health care still constitutes a sizable proportion of the national health care system at both institutional and non-institutional levels. This is definitely the case in many African counties including Uganda, as will be seen later. It is reported that even in the United States, away from Africa, Catholic health care forms the largest proportion of not-for-profit care. (1) But how do we or can we use the big numbers to influence health care so that it reflects the healing ministry of Christ? (2)

What was Characteristic of Christ's Healing Ministry?

What were some of the key features of Christ's healing practice? What opportunities are we missing to be evangelizers and inheritors of the ministry? How can we revive or strengthen our role as evangelizers? At least seven characteristics may be identified in Christ's healing ministry which we can examine against, or compare with, current health-care practices.

1. Jesus expressed the good news not only in words but also a great deal in deeds. Today's health-care workers are often absent from the sick both physically and spiritually, thus missing opportunities to emulate Jesus in the healing ministry. Various levels of physical absenteeism of health workers have been reported. A World Bank study in Uganda, for example, reported absenteeism of health-care workers in government facilities (after two visits) of up to 37%. (3) Another study in the Bushenyi district of Uganda (after seven unannounced weekly visits) recorded an average aggregate level of absenteeism of 47.9%. (4) Besides physical absenteeism, health-care workers are often also in great and unmet need of spiritual support, making it difficult for them to use the opportunity of clinical care to support spiritually patients and their relatives. In many instances spiritual care is thus sought separately from clinical care.

2. Restoration of the confidence and dignity of the sick was a feature of Jesus' healing ministry. He identified closely with them and touched them and allowed them to touch him (Lk 4:40; 5:13; Mk 1:40-42). Instead, today health-care workers are widely perceived to be detached from patients and often separated from them by attitude and technology, thus missing an opportunity to touch them physically and spiritually and to be touched by the patients. Emotional and spiritual detachment is also one of the factors leading to some health-care workers carrying out abortions or calling for the legalization of abortion as they do not feel for the life of the unborn.

3. Jesus did not segregate. The people he treated ranged from the poorest like lepers (Lk 5:12-14), a man with a withered hand (Lk 6:6-

9) and a blind man (Mk 8:22), to healing the servant of a centurion, a rich man (Lk 7:1-10). Today, most of our health-care systems are inequitable and segregating. Even "social health care" systems favor the rich more. Corruption has not spared the health sector in a number of countries. Poor patients suffer the final effects of corruption as they fail to receive the services they need when they need them or services of a required quality.

4. The faith of the person to be healed or of those taking care of the sick is as important as the physical touch of a doctor or the administration of medicines. This spiritual aspect is seen in many examples of Jesus' healing ministry as was the case with the healing the centurion's servant when he said: "I tell you, not even in Israel have I found faith like this" (Lk 7:9-10) or when he healed the paralytic (Lk 5:17-25).

5. Jesus allowed the quality of his work to speak for itself. He told his patients not to tell others what he had done (Lk 5:14-16; Mk 1:44) and yet his reputation continued to grow by the day through his good work without any advertising. Health care is today increasingly commercial. In many counties the rise in the cost of health care is disproportionately faster than the expected rise in quality of care. In poor communities this often leads to the marketing of poor products or poor quality health care to unsuspecting and desperate people. The poor, who are often uninsured, end up struggling to pay catastrophic costs out their pockets and thus get poorer.

6. Jesus preached and demonstrated compassion. Healing by touch demonstrated a high level of compassion because under Jewish law touching the sick was a sign of impurity. Unfortunately, today more and more health-care workers are seen to be "aggressive" with little or no love shown to the patients. The sick are often poor or made poor by their illnesses. Christ's compassion for them is also reflected in his directive that the presence or absence of money must not be the primary determinant of access to care. At their commissioning to heal and cure the sick Jesus told the disciples: "You received without charge, give without charge. Provide yourselves with no gold or silver, not even with a few coppers for your purse, with no haversack for the journey or spare tunic or footwear or staff, for the workman deserves his keep" (Mt 10:8-9).[1] This does not mean Jesus downplayed the fact that health care has a cost to be met, including the human-resource cost, and that health-care workers deserve fair pay, but he was stressing that money should not be the primary barrier.

7. But "touching" and healing also meant reaching out to the souls of the people he served. "Crowds were amazed when they saw the mute speaking, the deformed made whole, the lame walking and the blind able to see, and they glorified the God of Israel" (Mt 15:31). In this sense he did not only touch the sick: he also touched and healed the minds of the crowd who then believed in him.

Opportunities Available for Evangelization through the Physical Presence of Health Facilities and Health-Care Workers

First, the case of Uganda is here presented simply to exemplify such opportunities and to share some of the attempts being made by Catholic health care to evangelize.

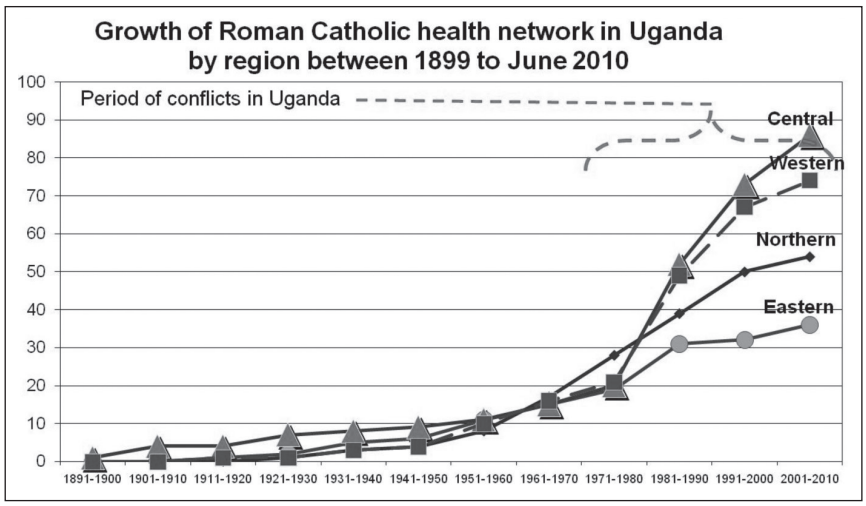
The first Catholic health facility, Rubaga Hospital, was opened in 1899. Since then the number has grown to 284 health facilities distributed across the country and accredited to the Uganda Catholic Medical Bureau which is the health department of the Ugandan Episcopal Conference. Thirty of these are designated as hospitals while others are health centers or clinics of varying levels with some soon to be formally recognized as hospitals. The growth pattern appears at some stage consistent with responding to the vacuum created by years of conflict and instability coupled with economic collapse and a poorly functioning government health-care system (Fig.1).

Together, Catholic health facilities had 8,043 health-care workers in June 2012, about one quarter of the combined government/Catholic health-care workforce.

The private-not-for-profit (PNFP) hospitals, almost all of which are religious-founded, make up 43% of total hospitals (with 43% of available hospital bed capacity). Catholic hospitals alone make up 23% of the total in the country and 28% of the hospital bed capacity (calculated from the MoH data of Dec. 2009). Catholic hospitals make up 53% of the PNFP hospitals. Out of 32 institutions training nurses and midwives, 20 are PNFP (over 60%). Of these, 13 are Catholic-founded training institutions and make up 40.6% of all institutions training nurses (and midwives) and 65% of all PNFP health training institutions in the country. So, the Catholic Church has a sizeable presence in Uganda. It has the largest non-state health care and training role in the country.

Most of the 8,043 employees in

Fig 1: Trend of growth in number of Catholic health facilities by region in Uganda



Catholic health facilities are Catholics. But besides those working in Catholic-founded facilities, there are several Catholic health-care workers in non-Church employment like government hospitals, various non-governmental organizations dealing in health or health-related work or in private practice.

This means that the opportunity for Catholic health-care workers to evangelize exists both in the large contribution the Church makes to the country's health-care system and outside Catholic health care.

Challenges

Jesus and his early disciples carried out evangelization amidst many challenges, including persecution. The healing ministry today also faces a number of challenges, but probably of a different nature. They are challenges that also affect the wider health-care system in the country and are mainly economic or economics-related and spiritual in character.

The widely acknowledged high level of corruption in the country has not spared the health-care sector. There is a policy of free health care in government facilities but in fact there is a lot of bribery in access even to basic care. Health-care workers are frequently accused of having lost their motivation to serve and are often seen as not caring enough for the sick. More and more health-care workers, especially in government institutions, are also seen as not manifesting their religious beliefs and ethics in their health-care practices. A shortage of medicines and medical supplies is common yet the government is reluctant to increase the health-care budget.

This means that even those who have the inner joy to serve may fail to translate that message of love and compassion into practice because of the broken health-care system.

Despite the fact that Catholics are the single majority religion in the country, Catholic health-care workers, particularly in non-Catholic institutions, are increasingly facing intimidation because of their faith. There is a great deal of talk about "evidence-based interventions or approaches", "human rights to health care including the call to legalize abortion," etc. The easiest force to blame for the stagnation and the rise in prevalence of HIV is the Catholic Church for being against these so-called "evidence-based interventions like promotion and distribution of condoms". The pressure is even increased by the donors. The US government, for example, has now severely cut off PEPFAR funds to programs promoting abstinence and faithful marriage for the control of HIV, despite these having been the hall-mark of successful HIV prevention in Uganda in the past. Catholics in positions of responsibility in government health care and other non-Catholic owned organizations find themselves between Catholic teaching, on the one hand, and having to comply with priorities of organizations employing them, on the other. Some of them feel some level of intimidation and an "identity crisis". These Catholic health-care workers need to be supported to maintain their confidence and become evangelizers of the system.

What is the Catholic Health-Care System Doing?

Amidst all these challenges, Catholic-founded health institutions and other faith-based health-care facilities have endeavored to bear witness to the presence of Christ among Ugandans. They have remained a beacon of hope for many people in regions affected by armed conflict for over three decades. At such moments they have lived Jesus' teaching: "The greatest love a person can have for his friends is to give his life for them" (Jn 15:13) and are largely still perceived as being more compassionate than government facilities.

However, Catholic health-care institutions and workers in Uganda and elsewhere would still do better if they emulated even more Christ's way by integrating medical care with spiritual care. Christ as a healer of the body was also a healer of the soul, thus using the occasion of healing to evangelize. The following are some of the things being done in Uganda.

Improving governance and management

Weak leadership and management have been blamed for many of the problems faced by the health-care sector. The Catholic Health Department, the UCMB, has for its part made strengthening of corporate governance in its network one of the top priorities in its system strengthening strategies, something for which it has gained respect within Uganda's health-care sector. The UCMB first ensures that its own governance structures function. It supports and strengthens the governance and management of the health institutions accredited to it through the training of individual managers, of Boards of Governors and collective workshops. It also carries out support supervision and provides scholarships. Catholic health-care facilities use the national Health Management Information System. The UCMB hitherto has made this HMIS very functional in its network, thus strengthening its capacity for planning and advocacy.

Deliberate efforts to increase accessibility for the less privileged of society

The problem of inequity is not unique to Uganda or to developing countries. Michael Sheedy gives an interesting description of a graphic representation of such inequity even in the United States. In Uganda (and other similar countries) the rising cost of health care at the same time as declining external donation to Church-founded institutions (which are often rurally placed among the poor) puts pressure on raising user fees which in turn threatens to reduce access to care for the poor. The Catholic health-care facilities under the UCMB have struggled amidst all these developments to keep fees as reasonably low as possible while advocating for more subsidies from government and donors. The UCMB monitors the trends of cost and user fees and the general economic trends in the country and offers advice to the network to ensure that economic accessibility for the poor remains the ba-

sis of all management decisions in responding to external challenges while remaining true to the realities of the economic environment. In this way we try to show concern and love towards the poor.

Building a spirit of compassion and service

The report of absenteeism of health workers in Uganda's public facilities as being between 37%-49% is disturbing. We do not have figures for faith-based facilities, including those of the Catholic Church. However, health-care workers in faith-based facilities are still perceived as being the most physically present despite their lower pay and they tend to shoulder both formal and self-referrals from the public facilities where high absenteeism is experienced. This physical presence, even amidst economic difficulty, is quite consoling to the community. People who qualified in Catholic health training schools are generally considered more kind and compassionate and hard working. In this way they show the love of Jesus to the patients. But the combination of a heavy workload and low salaries makes faith-based facilities have high annual staff turnovers, reaching 50% for some cadres, although these are quickly replaced.

Seeking and responding to patients' feedback

The UCMB, together with the respective hospitals, carries out annual patients' satisfaction surveys. This information is shared within the network so that Catholic health facilities try to remain relevant to the communities that use them by trying to address patients' concerns where possible.

Training in clinical pastoral care

The Catholic Medical Bureau (UCMB) is at the moment the only institution in Uganda that trains clinical pastoral care givers, many of whom are already health-care professionals, to strengthen hospital chaplaincy. Training a health professional in pastoral care offers a perfect opportunity to respond to the medical as well as spiritual needs of the patient and of caretakers in an integrated manner. The demand for them has grown so fast that the over seventy people trained so far are not enough for the thirty hospitals as they are often drawn into the health centers as well as into out-of-hospital care of the sick. The UCMB's strategy is to have a team in the chaplaincy and not only an ordained chaplain.

Increasing awareness of health-care workers about Catholic social teaching

To try and address the increasing pressure from pluralistic society, the UCMB is trying to create awareness in Catholic health-care workers about Catholic social teaching so that they understand the basis of certain positions taken by the Church. This is done during the annual general assemblies, during technical workshops and during the induction of new staff in some cases. For this purpose the UCMB spearheaded the formulation of a guideline for the induction of new staff both at the national headquarters (the Uganda Catholic Secretariat) and for hospitals and diocesan health offices.

Recommendations to Catholic health hospitals, clinics and health-care workers

The above are all examples of Christ sharing the good news with the sick and the crowds that brought them. Today these are patients and the communities among whom they live. Having been created in the image of God (Gen 1:26-27), we as health-care workers must let patients and communities see that image of Christ in us. Hospitals and clinics need to be seen not only as places of high medical professional practices but also and first of all as living testimonies to the healing Ministry of Jesus. Health-care workers can do this by emulating, among other things, the above characteristics of Christ's healing practice. The following thirteen recommendations are made:

1. The work of evangelization starts with us, the people entrusted with the leadership and management of Catholic health facilities. We need to evangelize ourselves, other leaders and the people we serve by demonstrating good leadership and stewardship of our institutions. Jesus already had authority but decided to earn respect instead of demanding; he demonstrated servant leadership and in fact emphasized that "The greatest among you must be your servant" (Mt 23:11). We are called to strive to serve as leaders but also to leave what was entrusted to us better than we found it (1 Pt 4:10). This means we must put good systems in place so that the institutions live beyond us.

2. To do the above we need to have leadership and management positions occupied by people appropriately trained in knowledge, skills and attitudes for the job. This applies to both hospitals and other health-related institutions like medical schools and other training institutions of the Church. We need to strengthen health leadership and management training by Catholic universities by making them special and able to impart the sort of attitude required of servant leaders.

3. We need to make a hospital not only a place for consultation and the practice of medicine but also a place of prayer and the strengthening of faith. Chaplaincy should be strengthened by training both priests and professional health-care workers as clinical pastoral care givers (thus forming a team: the chaplaincy), enabling pastoral care to be an integral part of the general care of the patients. In Uganda the Catholic Medical Bureau is at the moment the only organization training people for hospital chaplaincy. It is expensive and difficult to sustain single-handed, but it needs to be continued.

4. Catholic medical schools or training institutions need to strengthen and integrate ethical teaching and spiritual mentoring into routine training irrespective of the training specialization .

5. Leaders and managers need to put a special focus on improving both the physical and the functional presence of health-care workers amongst patients and their immediate communities in times of conflict or peace and in times of economic boom or difficulties. Again, this has a lot to do with attitudes and work ethics and appreciating that in serving there is the opportunity to give, as Jesus himself said "It is more blessed to give than to receive" (Mt 20:35).

6. In addition to the above we can further increase the participation of religious Congregations in health care. Religious Congregations need to be stimulated to once again become innovative and provide more health care especially outside the traditional systems (hospitals) and also move into home care and other community-based services that make them take the "face of Jesus" directly for the community.

7. A more human face can be given to patient care. Technology is fast reducing doctor-patient interaction. More and more the doctor knows the patient's illness better while knowing the patient less and less. Jesus touched and knew the people he healed. Patient-centered health care that also reflects the social teaching of the Catholic Church needs to be emphasized in training and in practice.

8. As health leaders, managers and health-care workers we must be or become defenders of human dignity and respect for life and without shame fight against all the crusades that dehumanize the sick and the unborn, for example the pro-abortion campaigns.

9. Catholic health-care workers should champion the fight for equitable or non-segregative health care that can be accessed by even the poorest in our societies, within the context of the realities of reducing resources and increasing costs in health-care facilities. The principle of "distributive justice", especially for basic care, should be central in our planning and provision of care, as well as advocacy actions. But with the economic challenges raging on, this calls for some health-care financing innovation even within the Church. Partnership with those who have the same objectives of serving the population, including governments, is one way to go. But we need to be firm on the rules of the partnership game. We also need to explore other probably more sustainable resource mobilization mechanisms within the different national contexts.

10. We should aim to provide quality health care that "markets" itself as exemplified by Jesus' own healing ministry.

11. Kindness and compassion should become the hallmark of our health-care practices. We need to show more love to the people who come to us for care. This requires attitudes and practice that should be built both during training and in service.

12. More attention should be paid to the spiritual and emotional needs of health-care workers themselves than is currently the case. A sick doctor or nurse cannot administer well to another sick person. We need support in training clinical pastoral care givers in "provider-oriented" pastoral care in order to support the health-care providers as well as patients and communities. However, the long-term solution lies in strengthening the foundation of one's faith. A new evangelization targeting families, creating stronger Catholic families where future health-care workers will grow might be the solution. Focus should not only be on health-care workers in the Catholic-founded hospitals, clinics and community-based programs. Catholic health-care workers wherever they may be in the country should be reminded of the duty to evangelize from where they are and helped to be proud of their identity and to take care of their own spiritual lives.

13. Health-care workers, especially those in leadership and management positions, need to move closer to and be present where policy is formulated in their respective countries or at least find ways of influencing policy. Traditionally doctors and other health-care workers have kept to their places in hospitals, fearing that they will be seen as becoming political. This needs to change. Catholics even outside the health system need to play a stronger role in influencing national health and economic policies. There are policy decisions that sometimes make the health-care system destructive of human dignity. Examples include the legalization and procurement of abortion, the promotion and distribution of artificial family planning pills, the under-funding of the health-care sector resulting in poor health-care systems, among others.

Conclusion

The Catholic Church has the mandate to provide health care as a fulfillment of Holy Scripture, thus a continuation of Christ's spreading the good news through the healing ministry. Health-care workers are people called to individually and collectively continue this evangelization. In many countries Catholic health care still forms a significant part of national health care. More needs to be done to evangelize both within Catholic health care and by Catholics working in government and non-Catholic health care. Challenges to Catholic health care seem to be worldwide, though to varying extents. More innovation will be needed to help mitigate the effects of the challenges faced by Catholic health care in emulating Christ and showing his presence among the sick and their communities. Health-care workers themselves need to be evangelized and spiritually supported so that they may evangelize better.

Note

[1] The African Bible has been used.

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2.The Medical Doctor

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First of all, I would like to express my sincere and keenly-felt gratitude to the President of the Pontifical Council for Health Care Workers, H.E. the Most Reverend Msgr. Zimovski, and its Secretary Rev. Msgr. Mupendawatu and all those who work with them for having bestowed upon me the honour and the privilege of being present at this important event for health-care workers and for having allowed me to take part in this initiative of an international character on the defence of health through carrying out the human and spiritual mission of evangelisation through hospitals.

A Religious Matrix has Always been Present in the Relationship of Man with Illness

The history of hospitals has its roots in antiquity and as a result thousands of years before Christ in India, in Ceylon and in Egypt the temples were seen as places of healing by the divinities of the time.

It was thanks to Hippocrates, the father of medicine (460 BC), that the art of healing began to be based on rational foundations. The Hippocratic physician was at first an itinerant professional.

The ethics that the father of modern Western medicine handed down reflected the ideal of the physician as a philanthropist at the service of the whole of humanity, and above any division between men.

Ever since its origins, the relationship between the physician and his patient, as it developed in the Western world with the Hippocratic tradition, adhered to a precise order: *the duty of the physician is to do good to the patient and the duty of the patient is to accept this*. This was a relationship of a paternalistic kind where the moral responsibility of the physician lay in the certainty that he worked for the absolute good of his patient.

The famous *Hippocratic Oath* entered history and still today has its validity, even though its contents with time have been enriched by Christian thought. Its most recent edition in Italy was on 23 March 2007 as edited by the National Federation of Doctors, Surgeons and Dentists.

The modern concept of the hospital goes back to 331 AD when the Roman Emperor Constantine, who had converted to Christianity, set in motion a new kind of hospital. Hitherto illness had isolated

The Hippocratic Oath

Aware of the importance and the solemnity of the act I perform and the commitment I undertake, I swear:

- To practise medicine in freedom and independence of judgement and conduct, rejecting all undue influences.
- To pursue the defence of life, the protection of the physical and mental health of man and the relief of suffering, on which I will base, with responsibility and constant scientific, cultural and social commitment, my every professional act.
- To treat every patient with equal scruple and commitment, without reference to ethnic grouping, religion, nationality, social condition or political ideology, promoting the elimination of every form of discrimination in the health-care field.
- To never engage in acts designed to deliberately bring about the death of a person.
- To abstain from all forms of diagnostic and therapeutic exaggerated treatment.
- **To promote the therapeutic alliance with the patient based upon trust and reciprocal information, with respect for and the sharing of the principles on which the art of medicine is based.**
- **To adhere in my activity to the ethical principles of human solidarity against which, respecting life and the person, I will never employ my knowledge.**
- To make my knowledge available to the advance of medicine.
- To entrust my professional reputation exclusively to my skills and my moral qualities.
- To avoid, outside professional practice as well, every act and all conduct that can damage the decorum and the dignity of the profession.
- To respect my colleagues even when there is an opposition of opinions.
- To respect and facilitate the right to free choice of a medical doctor.
- To provide emergency care to those who need it and to make myself, in the case of public disasters, available to the competent authorities.
- To observe professional secrecy and to defend privacy as regards everything that is confided to me, that I see or have seen, understood or intuited in the practice of my profession or because of my status.
- To work in learning and conscience with diligence, skill and prudence according to fairness, observing the deontological rules that govern the exercise of medicine and those legal rules that are not in opposition to the tasks of my profession.

sick people from the community to which they belonged. The Christian tradition, on the other hand, stressed the close relationship between the sick person and his or her neighbour, and found in that relationship the obligation to provide care and treatment. Illness thus became a question of priority importance for the Christian Church.

From a historical and experiential point of view, therefore, there is *a profound link between the reality of hospitals and the gospel message*: this relationship marked the various stages of the subsequent development of care for the sick. There were the so-termed '*hôtel-Dieu'*, 'God's hostels', centres attached to monasteries, where monks learned the art of medicine with a more rational approach. A lack of distinction between poverty and illness (*paupertas* and *infirmitas*) lasted for the whole of the Middle Ages and hospitals in the West remained for a long time charitable institutions.

During the eleventh century hospitals spread in Europe. They were placed along the principal routes, in cities as well as in the countryside, and were institutions with a religious matrix, organised in a structural sense like monasteries and in a legal sense like religious brotherhoods. Their head was usually a '*spedalingo*', who was nearly always an ecclesiastic.

The medical school in Salerno, Italy, was the first and the most important medical institution in Europe during the medieval period, and its first exponents and animators were Benedictine monks.

During the Renaissance great figures of saints stood out who created hospital Orders, that is to say communities of religious who in hospital service, carried out in a spirit of gospel charity, found their life task. This was the case with *St. John of God, the founder of the Hospital Order known as the 'Fatebenefratelli', and with St. Camillus de Lellis, the founder of the Order of the Regular Clerics Ministers of the Sick (Camillians).* From the Renaissance onwards the hospitals in Europe were usually built and maintained with public funds, even though there remained the link with religious bodies. During the nineteenth century there existed both in Europe and in the United States of America numerous hospitals that were publicly or privately administered.

During the nineteenth and the twentieth centuries the experiences of *St. Giuseppe Cottolengo, St. Giuseppe Moscati and Don Carlo Gnocchi*, who left behind them an unending legacy to the Church and the civil community, were unforgettable. They were luminous witnesses to *loving care for the 'least'* who could not find treatment in hospitals as they were then conceived: they had a function of public utility which is a great conquest but which cannot be sufficient to meet the emergencies and needs that emerge in every epoch from suffering humanity. *In the lives of these great figures the authentic spirit in which hospitals were born emerges with all its clarity*: to bend down before suffering man, placing him at the centre of attention, without forms of discrimination, and directing towards him every possible effort in order to meet the thousand situations in which human life should be protected. Their witness introduced into the Church the 'added' value of creative voluntary work to flank hospitals, which were by now codified in their canons, in order to keep alive care for the person and his or her needs and the freedom of free and not planned initiatives.

While the large and prestigious medical schools were created and the largest hospitals began to gravitate to the nascent universities, St. Giuseppe Moscati, a medical doctor and university lecturer, appealed through the force of his life witness to the great human and Christian value of the medical profession.

The rise of the great profit-making hospital chains was a phenomenon of the late-twentieth century. In Italy hospital institutions and local social and health-care units (ASL) became companies in 1992.

The Catholic University of the Sacred Heart

In 1920 the Catholic University of the Sacred Heart was founded in order to base on Christian ideas knowledge, university teaching and connected operational institutions. Article 1 of the statutes reads: 'The Catholic University, according to the spirit of its founders, adopts the goal of *assuring a presence in the university and cultural world of people committed to addressing and solving, in the light of the Christian message and moral principles, the problems of society and culture*'. And articles 9 and 10 read: 'The Catholic University promotes *the theological and moral education* of its students, including that relating to the problems of professional deontology, through other educational initiatives as well'; 'The Catholic University is a community of lecturers, students and administrative, technical and health-care staff marked by *respect for the fundamental rights of man* and personal and collective freedoms, as well as the *principles of solidarity*. The lecturers, the administrative, the technical and the health-care staff *work together to maintain and strengthen the Catholic unity and identity of the university*'.

For us, working as medical doctors and researchers inside this Catholic university community, the words of Giuseppe Moscati ring out with great contemporary relevance: '*Remember that in following medicine you have taken on the responsibility of a sublime mission*. Persevere, with God in your hearts, with the teachings of your father and your mother in your memories, with love and pity for the abandoned, with faith and with enthusiasm, deaf to praise and criticism, immune to envy, disposed only to good'.

'*The sick are the figures of Jesus Christ*. Many unfortunate people, delinquents and blasphemers end up in hospital by will of the mercy of God who wants them to be saved! In hospitals the mission of sisters, of medical doctors and of nurses, is to cooperate with this infinite mercy, helping, forgiving and sacrificing themselves'.

'*Let us remember that we have in front of us, in addition to a body, a soul, a creature of God*'.

'*Do not fail to cultivate and review every day your knowledge.*

Progress lies in a constant criticism of what we have learnt. One science is unshakeable and unshaken: that revealed by God, the science of the beyond!'

'*Not science but charity has transformed the world* in certain periods; and only a very few men have entered history through science; but everyone can be imperishable, a symbol of the eternity of life, where death is only a stage, a metamorphosis for a higher ascent, if we dedicate ourselves to good'.

We find the central thread of this witness which is so near to us, as with so many other things that have followed one another down the centuries, in the words of the Gospel which, lapidary and resistant to the wear of time, remains a fixed point on which to base the wishes, the will and the works of generations of believers involved in an authentic medicine that is impregnated with humanity.

In the third millennium, going back over the history of hospitals in general and our university institution in particular, we are led to ask ourselves how it is possible to achieve to the full the goals of such a noble but so difficult a profession as the medical profession, without hearing sound out in our hearts those words that call upon us as believers: 'Truly I say to you, as you did it to one of the least of these my brethren, you did it to me (Mt 25:40); 'a Samaritan, as he journeyed, came to where he was; and when he saw him, he had compassion' (Lk 10:33). These words have deeply touched men of every epoch and every ideology, inspiring initiative, behaviour, deontological and civil codes for the protection of the weakest, solidarity, universal brotherhood and free giving.

There are universal values inscribed in the heart of every man that cannot be disappointed without running the risk of betraying his humanity.

Today in a socio-cultural reality that is very much marked by ethical relativism, by materialism, by the logic of the market and by individualism, often these values can pass by unobserved or be forgotten, even where they should be defended and borne witness to.

In a recent communication of the Catholic University one reads: '*Faced with the growing complexity of a university institution and its daily life, the Catholic University has decided to reaffirm its fundamental principles and values, defining more functional rules in order to achieve the efficacy and the transparency of the whole institution. An important stage in this process is the introduction, starting on 1 November 2011, of the Ethical Code and Organisational Model of the Catholic University of the Sacred Heart*'.

One perceives in these words a moment of testing and self-examination that an institution of this kind must engage in so as to rediscover and reacquire motivations that should always be renewed and never taken for granted.

Evangelisation is the soul of medicine on the human scale. This is a value for the whole of humanity which yearns for good and it is an inescapable duty for those who work at the side of those who suffer in the name of the charity of Christ.

When thinking of the many occasion when I have found myself, as a specialist in senology, in front of a woman in a state of anxiety after learning that she has breast cancer, I realise how much Moscati's statement, the outcome of his experience as a medical doctor and a believer, is true: 'What can men do? What can they oppose the eternal laws of life with? Here there is the *need to take refuge in God*. But, however, *we medical doctors must strive to alleviate suffering*'. '*Pain* should be treated not as a dart or as a muscular contraction but *as a cry of the soul, to which another brother, a medical doctor, runs* with the ardour of love, charity'.

Self-presentation

I am a medical doctor who specialises in oncology and general surgery and a researcher at the Catholic University of the Sacred Heart of Rome. I am a breast surgeon and the head of the Unit for Integrated Therapies for Breast Cancer at the A. Gemelli Polyclinic, as well as being university lecturer in degree courses (medicine and surgery, nursing, obstetrics) and specialisation at the same university.

I am also engaged in the coordination of national work groups and scientific societies for the dissemination and standardisation of methods of diagnosis and treatment of breast cancer and the drawing up of documents for consent and guidelines to improve access to treatment throughout Italy as well.

At the level of voluntary work I am the Vice-President of Susan G. Komen Italy, a non-profit making organisation for the fight against breast cancer, being the head of its educational and missionary activities which principally involve: educational and training initiatives for students of high schools, general medical practitioners, nurses, obstetricians, pharmacists, the general population and women who have had breast operations, and initiatives offering health care through visits for the prevention of cancer in women for disadvantaged women, missionary sisters and women prisoners (health villages).

My Personal Experience

My first strong impact with suffering, solidarity and the need for relief and care of the sick took place at the age of thirteen during a visit to Lourdes that had been organised by the school of the '*Marcelline*' which I attended in Milan. On that occasion my wish to involve myself at a social, human and Christian level as a medical doctor was confirmed.

During my years of formation at the Catholic University there were other stimuli and encouragements as regards the pathway I had chosen. In attending the surgery department I remember the figure of the ward sister who was dedicated to her mission as an important reference point not only for the patients and their family relatives but also for the young medical doctors and students.

My subsequent decision in favour of specialisation in surgery in the cancer and breast cancer

field arose in an instinctive way in order to resolve in a radical way a disease that even today many years later is held to be fearsome and as aggressive as ever, and coincided with the personal impact of the contemporary diagnosis of the breast cancer of my mother. This family experience further allowed me to develop a sensitivity on the side of those who receive treatment.

I remember how many times my mother after tests or visits made me observe the lack of sensitivity towards, or respect for, the patient on the part of medical doctors who were in a hurry or distracted, and she exhorted me not to do the same in my profession.

The Scale of the Problem

Breast cancer is a social problem. Every year in the world 1,400,000 women are afflicted by it and in Italy 47,000, with about 11,000 deaths every year. The incidence of this pathology is on the increase and it is estimated that at the present time one woman in every eight during the course of her life will encounter this illness. In parallel with this increase in incidence it should be observed that over the last ten years the death rates have fallen because of a series of factors. On the one hand, we may point to increasing health-care education and sensitisation as regards prevention which has allowed an increasing number of prompt diagnoses and thus better prognoses, and, on the other, there has been the availability of increasingly effective forms of treatment and ones that respect the functional and aesthetic integrity of women, something that has led to a greater acceptability of such treatment.

At the present time the possibility is emerging of acting in terms of primary prevention through the adoption of correct lifestyles (correct diet and constant physical activity). Given that the age band that is most afflicted is that of 45-75, one can understand how this is an illness that affects people who are the fulcrum of society in their capacity as workers, wives, mothers and grandmothers and are actively involved in the multiple roles of contemporary society.

Breasts, the organ that is afflicted, constitute an important symbol at any age (motherhood, breastfeeding, beauty, femininity, the image of the body).

The possibility of mutilation, the important consequences of chemotherapy treatment, with the further loss of physical image, albeit temporarily, and the possible loss of a procreative capacity generate major difficulties in relationships with family relatives (husbands and children) and colleagues, with frequent phenomena of isolation, flight, rejection and excessive apprehension.

In contemporary society the increase in the age at which the first pregnancy takes place makes more probable a situation where the appearance of breast cancer takes place in a woman who wises for motherhood which has not yet taken place or with children of a pre-school age, with a consequent further grave malaise or suffering experienced by the woman involved.

For a medical doctor specialised in senology there is a need to act on various fronts: sensitisation and prevention for the healthy population (communities, places of work and schools) with a publicising of the importance of correct lifestyles; forms of early diagnosis such as breast scans etc; and the use of increasingly prompt and targeted diagnoses and integrated therapies.

In recent years at a national and international level there has developed the concept of the integrated diagnostic-therapeutic pathway which is based upon accompanying the woman along the whole of that pathway with a single centre of reference (the Breast Unit). This form of action allows the setting in motion of more suitable examinations with a clear reduction in the time that is needed, of bureaucratic procedures, and an optimisation of information with the patient being 'guided': for example at the moment of diagnosis it is important that information that does not involve divergences is provided by a single health-care worker. As regards treatment, at the present time in qualified centres in over 80% of cases there is the possibility of operations which are increasingly limited and conserve the female body and respect the physical integrity of the woman as well as the aesthetic dimension, albeit fully observing oncological criteria. When an operation which removes part of the breast is required, it is extremely important to have available the possibility of an immediate reconstruction using different techniques through close cooperation between the plastic surgery team so as to avoid the psychological injury of mutilation. The description of the subsequent stages should take place in a climate of empathy within a spatial and temporal context that is suitable to the importance and the critical character of the moment, with it being ascertained that the need for the treatment, and what the treatment consists of, has been understood.

The Breast Unit is characterised by the constant presence of a complete multidisciplinary group of medical doctors (radiologists, surgeons, anatomy pathologists, radiotherapists and oncologists), psychologists, nurses, physiotherapists and often voluntary workers who help to spread the burden of suffering caused by an illness that is so multifaceted as is the case with breast cancer.

In our country and in the member States of the European Community there is underway a collective effort by medical doctors, women's associations and government institutions to ensure that this model of diagnosis and treatment is implemented on a large scale in order to assure uniformity and fairness of treatment for women who have this pathology.

The Dimension of Listening

Down the centuries the relationship between the medical doctor and the patient has certainly changed from being paternalistic to having more informal and cooperative tones with the goal of achieving a therapeutic alliance. For a long time, however, communication in the therapeutic-care context was seen as a spontaneous process that was connected

with the features of the personality of the individual health-care worker or the individual patient. In other terms, *the problem was not posed of the meaning of communication and its value was ignored as regards the recovery of health or clinical improvement*. At the present time a large number of researchers have addressed the question of communication within the health-care relationship and have stressed the importance of this dimension in the wider context of health and illness. If every illness is an uprooting, a loss of belonging, then every patient can become a refugee who loses his or her certainties, the usual and safe spaces of his or her daily life.

When a patient turns to a medical doctor to ask for help, he or she intentionally looks for the possibility of a meaningful encounter in order to calm his or her anxieties, to find new answers to questions that are not only clinical in character. This is a search that takes place amongst unforeseen fears and new insecurities. It is precisely in this no-man's-land that the encounter between the medical doctor and the patient can take place.

It is striking that in the face of illness even men of success or culture, who are very self-confident and confident about their own decisions, display a disquiet that delegates to the medical doctor responsibility for complex and demanding decisions. To receive a patient being aware of this disquiet means for a medical doctor to cross a threshold, to forgo his or her language, and to construct with the patient who is his or her interlocutor a new language. Only this approach puts the medical doctor in a condition to listen to a history and not only a story of symptoms; not an anamnesis but a narrative.

However, knowing how to create a climate of *empathetic listening*, of trust and of security; knowing how to avoid excessive normative attitudes; being able to manage emotional dynamics and communicative processes; and, lastly, knowing how to be present for the other, are not innate and natural capacities, but, rather, the outcome of long personal and professional work, part of the necessary equipment of a complete medical doctor.

And to listen means *to direct oneself to welcoming the other*, in his or her irreducible otherness. The body and the mind are like prostheses on the threshold, ready to be reached by what will come: this is total listening to looks, to voices and to emotions.

Open listening requires a readiness to encounter the other where he or she finds himself or herself, in suffering, in fear and in loneliness. It assumes a natural inclination to freedom which is translated into an approach without temptations to engage in domination or judgement about the other. It assumes the courage to set out on a journey towards unknown lands through unexplored pathways, aware of one's own fears and frailties, with memories of one's own fallibility, aware of being alone and at the same time dependent on the other. Attention to the dynamics of communication coincides with attention to, and care for, the relationship in its multiple aspects: it involves not only a consideration of *verbal messages* but also attention to the *non-verbal communication of the patient*. Open listening is also, indeed, listening that is in parallel with a number of channels that have been opened up: from the channel of perception to that of the emotions and on to that of logic and reason. A medical doctor is thus engaged at different levels that belong to his or her interiority and to the relationship contemporaneously. The micro-elements and the macro-elements, *facial expressions* and *looks*, like *body posture and gestures*, allow an understanding of congruencies and discrepancies as regards the contents of verbal messages and at the same time are indicators of the quality of the relationship, indicating what is taking place here and now.

Having a cooperative and non-judgemental approach, a capacity to feel with another without becoming lost or confused (*empathetic understanding but not confusing identification*), means being able to respect the self-determination of the other, seeing him or her as free and able to choose. In this being present, with reason and the heart, in this openness, is achieved the cognitive experience and the relational experience.

In recent years people have come to acknowledge the advantages of effective communication in the relationship between the health-care worker and the patient, starting with very different approaches: from the strictly clinical approach to the ethical approach, and from the economic approach to the organisational and managerial approach. The *quality of communication* today constitutes an *ineluctable objective* which does not ask to be justified or illustrated but solely explained through forms and strategies, measured with increasingly sensitive indicators and translated into guidelines that mark the behaviour of all health-care workers at their respective levels. 'It is no chance, as the literature in the field has for some time stressed, that the variations in the processes of communication influence in a relevant way some outcomes in the behaviour and attitudes of patients, such as satisfaction as regards the medical examination, following the therapeutic indications (compliance) and a reduction in their worries'.

Once again the problem is not whether to do it but how to do it: *how to take responsibility for the need of the patient for communication*, which takes the form in practice of a need for information: knowing more, about oneself, about one's illness, about its management, and a need for education: *how to manage one's illness in a better way, but also how to manage oneself in relation to the illness, how to reorganise the complex network of social-familial ties which are troubled by the illness*. This is a relational sphere where the medical doctor, the nurse, are called to act above all on the educational front, acquiring an increasing awareness of the therapeutic value of non-pharmacological aspects. This is the moment to adopt the role of being a counsellor or to take advantage of the competence of a counselling service that is strictly integrated

into the medical area of reference.

In our reality, at the Gemelli Polyclinic, the Breast Unit avails itself of the support of a team of psychological/cancer women health-care workers who are especially dedicated to the problems of cancer in women and who are at the side from the very contacts onwards of the pathway of the patient both at the diagnosis stage and during the subsequent stages (admission and/or helping therapies).

In the case of breast cancer the feeling of a loss of fixed points and of exile is even more accentuated because of the innumerable symbolic and cultural meanings correlated with the part of the body that it afflicts.

Breasts in every culture are seen as a characterising element of the female identity, a symbol to the utmost of affectivity that nourishes and welcomes, of the capacity of women to give and to give of themselves. At a more unconscious and archaic level, breasts are the symbol of creativity and affectivity, indeed they are the basic symbol of creativity. The breasts and the heart are objects that are often seen as the same and interchangeable, not only because of their closeness but also because they share the characteristic of an analogous emotional meaning (indicated as symbols of affective life).

We can affirm that the breasts are the authentic system of values that are reflected both in intrapsychic terms (the relationship with one's existential identity and gender identity) and in relational ones.

A women with breast cancer is doubly wounded in her identity: wounded in her possibility of thinking in female terms and in portraying herself in relational and social terms; wounded in her possibility of thinking about herself in unconscious terms as the bearer of creativity: the breasts, that good and creative part that are so intimately linked to femininity and maternity, become, because they are struck by the illness, bearers of a message of death, of negativity and of destruction. New self-images and images of one's own body accompany the will to go on living and thus to receive treatment.

The change in the image of the body, indeed, passes not by way of the illness in itself but by way of the treatment: the operation, the chemotherapy and the reconstructive surgery. What is changed is not seen and does not deform, at least initially, the body. What treats is what modifies the body. A mastectomy operation: a devitalised body, a fragmented body: the patient thus finds that she has to face up to mourning, losing a part of herself, losing the self-object. That modified body represents the absence of the malady, the emptiness that was previously occupied by the tumour, the piece of a sick body that remains constantly in the memory. Losing oneself in the hope of surviving; the antithesis of what happens, at the level of imagination, to the cancer cells: so as not to kill, these kill; this (chemotherapy) kills so as to allow the person to live. Other corporeal changes are also caused by the therapies. Chemotherapy, in particular, is the other side of cancer, to the extent that it reveals what is hidden: the falling out of hair, the swelling of the face.

Illness as a School for Life

How often is it the case that a patient comes out of an illness transformed, not only because he or she is clinically cured but because *his or her outlook on things, in the facts that concern him or her, has been changed*. And this changes the person involved, it makes him or her different: he or she appreciates different things, attributes different levels of importance to them, tolerates some things better and does not in the least tolerate others. Essentially, the person involved has passed through a school for life, in which someone has taught him or her many things about his or her illness but above all about the person who has had that specific illness. But this assumes, as regards the medical doctor, a courage to go beyond his or her own boundaries, to go beyond his or her cultural and existential certainties. To cross the frontier means to venture into that harsh and unpredictable no man's land where anything can happen, where a different language is spoken. To listen without a memory and without wishes, as Bion says, means for the medical doctor to be able to listen to the other and to what is taking place in the relationship with the patient, rather than allowing himself or herself to be deafened by the noise of theories about the illness, by diagnostic concerns and by the urgency of therapeutic decisions. To cross one's own frontier means for the medical doctor to discover that dynamic towards what is concealed, towards what needs to find a voice and an interpretation. To interact with this reality means to forgo the cold and safe thinking of the technical in favour of affection-thinking that allows an understanding of the reality of the relationship with the other who is in front of one. It means understanding how one feels inside this illness, what it means for that patient to be what he or she is, what it means, for example, to suffer in a cardiac illness and have stomach cancer, what it means to have lost one's father at an early age perhaps because of the same illness or to have been abandoned by one's parents or to have a physical malformation or to have grown up without the possibility of hearing sounds or seeing colours. It means to interact with a sense of powerlessness, of anxiety and of loneliness: and this is not easy or painless. But only in this way can the patient be helped to tolerate in a better way his or her pain, the suffering that he or she is experiencing. In this sense can one educate the patient, giving him or her the possibility of acquiring experience. *One ought to be or become*, to use the words of Godamer, *a wounded healer*, a person, that is to say, who is able to provide care but also able to feel that he or she is a patient, able to feel wounded. *This does not mean to eliminate the asymmetry of roles, of knowledge or even less the existential Healthy-Sick asymmetry, but it does mean, rather, to be able to draw near and welcome diversity*.

A medical doctor is constantly in contact with sick people who

are reaching the end of their existences. Faced with a dying person, beyond the more strictly professional aspects connected with medical care and treatment, a series of questions are often posed which involve him or her at an emotional, ethical and spiritual level. Although the prognosis for many illnesses which until a short time ago were seen as incurable has changed, the prospect of death is always present in the evolution of some of them and anyway death remains a destiny that is inevitable for everyone. Removing the idea of death is not materially possible given that man is called to integrate the idea of death into his existence as a debt that sooner or later he will have to pay. Thus it is not ethically licit to remove the idea of death, given that every man must necessarily experience it. But *the dominant culture of contemporary society tends to mask the reality of death*, as though in avoiding thinking about it and understanding it on one's own personal horizon, in definitive terms ignoring it, it is also possible to defeat it.

It is not surprising, therefore, that when one cannot help speaking about it our culture chooses the most spectacular and dramatic forms and ways of doing this, as though whatever the case it wanted to distance it from daily experience. It is no accident today that people are much less prepared for addressing an event of such importance. Many of the human, moral and spiritual values with which in past years one prepared oneself for welcoming death on one's own existential horizon have been lost. In a culture of success, the value of life is measured by the categories of efficiency and productivity, as a result of which the drawing near of death is seen as a defeat, a failure that is personal but also scientific and professional in character. Despite the availability of very sophisticated technology, medicine retains its limitations which also becomes accentuated because the level of the expectations of man increases more rapidly than it is possible to satisfy them. *Faced with death*, even when it is only suggested as a hypothesis, *patients and their family relatives rarely believe that everything that is possible has been done and the doubt that the medical doctor has not been able to correctly manage the situation because of a lack of skill or negligence is always ready to spring out*. Thus is nourished a dispute well known to recent developments in legal medicine which has to face up to an increasing level of distrust towards the medical class which is very often guilty of not knowing how to transform the successes of technology and science into guarantees of immortality. *One consideration that one can draw from this fact is that nobody has adequately helped patients and their family relatives as regards the encounter with death*. For this reason, in some institutions, such as hospices, counselling in accompanying death has been created.

The encounter with death could become less complex if people were habituated to seeing death as a natural and inevitable event to which one should give a meaning according to one's personal beliefs and for which one should prepare oneself because one does not know where, where or how it will take place. A sick person should be helped to die, teaching him or her how to die as well, with full respect for his or her anxieties and fears, expectations and hopes. Beyond the undoubted professional competence with which a medical doctor must demonstrate in all of his or her conduct that everything possible has been done to ward off death, there is a relational aspect that has totally special configurations. Involving the patient so that he or she participates knowingly in the process of his or her death is an explicit recognition of his or her dignity and his or her right to be defined as a protagonist of the medical choices that concern him or her. In some cases, the levels of anxiety increase and can be controlled only by a dual pharmacological and psychological/educational intervention from which the medical doctor cannot withdraw, not even by placing to the fore the two arguments to which reference is most frequently made: lack of time and lack of specific training.

Learning to communicate with the patient at such delicate moments means *reviewing one's own way of informing, removing it both from a brutal schematic approach of data and from a general dilution of information in a conversation that is as cut back as it is fleeting*. Informing means bearing well in mind the emotional resonance that the data can generate in the patient right away and also after a period of time when, perhaps on his or her own, he or she will reason about things and their dramatic character will emerge. *The medical doctor and the patient can both try to flee* from this very onerous stage of knowing and making known about, but certainly an approach of this kind troubles all the other aspects of the relationship. The medical doctor in saying a truth of this nature fears that he or she will have to admit his or her powerlessness and his or her defeat, but the same situation can arise for the patient as well, and thus one can generate a circle of distrust where the patient seeks alternative solutions to the relationship with that medical doctor whose answer he or she does not see as satisfactory. This is a risk that the medical doctor has to run, but nonetheless assuring the patient his or her support and reassuring him or her about the fact that he or she will not be left alone to fight this very difficult battle. The patient, or his or her family relatives, may also acquire other information in order to check what has been said by the medical doctor but if they find a concordance they will know how to find in his or her intellectual honesty and his or her availability at the level of the relationship what they really need in order to face up to death and dying.

Honest and courageous information, with the admission of one's own limitations and the proposal of an alliance can allow pain and suffering to be faced up to in all their expressions, through a wise use of medical products for the treatment of pain. The patient should be helped to understand that *although the battle against the illness has in a certain sense*

been lost, that against quality of life during this very delicate stage is still *fully possible* and involves the greatest possible reduction in pain, the possibility of keeping alive the network of family affections, and an intense exchange of requests and answers between the patient and the medical doctor. Day by day, and at times moment by moment, the patient is called upon to talk about his or her pain and the efficacy of the drugs and medicines, about his or her wishes and the possibility of meeting them. There is a continuous monitoring that expresses a process of negotiation in which the medical doctor is an interface between the pain and the patient, in order to reduce the former to the complete advantage of the latter.

Counselling should also include the family relatives who most closely take responsibility for the patient and who add to the psychological stress which anyway involves them in the spiral of loneliness and abandonment: those who remain can feel terribly alone, almost betrayed by those who pass away, and they can also feel all of the physical stress of the relationship of care, above all when the patient is at home. Physical assistance, the organisational burden of caring for the sick person and the continuation of other family and professional responsibilities, create situations which often lead to authentic forms of burn out. Good counselling in this case can act beforehand, predicting reactions that are completely natural and strengthening individual defences, through calls on a broader family network of support as well. But it should certainly be set in motion as soon as the first signs of giving way are identified, which are that much more grave the more one is dealing with situations that tend to become chronic and where at times the family relative can also have feelings of guilt when the mental/physical hard work that he or she does not manage to deal with requires spaces of relief and a break for that person.

Counselling that prepares someone to die is counselling for that person's family relatives: with a clear and courageous discourse about death and life, about the meaning of both, which is open to recognising the meaning of the life that has been lived and the meaning of life that remains to be lived with that person or in those circumstances. Counselling that expresses confidence in the capacity to understand and to forgive, if this is necessary; in the capacity to be grateful and in simplicity to express what, however, has been an occasion for suffering and a lack of comprehension. Counselling where, of the patient so requests, one can speak serenely about God and heaven which awaits not only those who have lived an upright and generous life but also those who have not managed to live in this way because they were weighed down by negative experiences which they had not been able to work through and resolve. For them, as well, a moment of rest and abandon arrives in a divine justice that goes beyond human justice, in the love of God who will know how to amply compensate for a lack of love that has been lived through or wrongs that have been endured. Counselling at this stage is nourished by hope, a human and supernatural hope, which will grant to every man in practical terms what he needs, what he wishes for, in a perspective of life that endures beyond time, that heals injustices, fills gaps and places us in the condition of those will find lost affections and more simply will wait for affections that they are now leaving.

For many years a part of this counselling has been engaged in by the chaplain of the hospital, by the parish priest or by the priest. Today these figures have been notably reduced in number and in a certain sense the barriers have increased which separate the sick from a personal encounter with the Grace of God, whatever their faith may be, not least because fear of death and separation leads family relatives to delay – often to the point of making it impossible – the encounter of their sick relative with a priest. The explanation for this is that the patient could become frightened and thus the intention is to avoid anything that could render heavier his or her already difficult situation. Actual experience has been rather different and in general people who for many years have been distant from their faith and the practices of piety also receive with serenity and with peace this last catechesis. But in a completely surprising way one may observe that sick people appreciate even more the action of the medical doctor who when seated next to them does not withdraw from this dialogue about death, an authentic dialogue about the highest systems. It is in the face-to-face encounter with another person that fear gradually loses its dark tonality, closed to any possibility of a future development.

Conclusions

The drawing up of this paper proved a very important, unexpected and extremely useful moment of reflection on my work as a medical doctor inside a large Catholic university polyclinic. A moment of assessment and also of self-criticism as regards my initial ideals rich in enthusiasm, of a wish to contribute to alleviating human suffering until a maturing of an awareness of human and professional limitations and the need for a constant reference to faith.

My work has allowed me, and allows me, the opportunity and the privilege of helping to train young health-care workers, medical doctors and nurses. In this field, side by side with the possibility of providing technical notions directly in the surgical field, in a clinic or in a department, the fundamental effort has been to understand the importance of extreme attention paid to the sick woman and her context. For example, women patients with a tumour at an advanced stage who arrive still today in a large city to be placed under our observation are the result not so much of ignorance about the illness but often of a grave psychological malaise which at times they have preferred to go through in isolation in order to conceal their illness our of a fear of facing up not only to the treatment but also to

the judgement of the medical doctor. It is therefore fundamental to learn how to intervene helping but never frightening or judging.

My experience in hospitals has been enriched in recent years by new knowledge relating to technological advances and knowledge about man (anthropology, psychology), at times changing what I thought were rooted convictions. Suffering has been a great teacher with its reverberations in the lives of various patients whom I had an opportunity to meet and whose illnesses I have been able to follow. I am however still convinced that the evolution of technology, a fundamental instrument for the medical doctor and for the optimisation of care and treatment, cannot be separated from a careful dimension of 'listening' and of 'presence' in relation to the patient. From this point of view, Evangelisation is truly the soul of a medicine on the human scale.

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3.The Nurse

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At the outset I would like to thank His Excellency Monsignor Zygmund Zimowski for his kind invitation to me. It is a great honour for me to be here in front of the distinguished guests and participants of this international conference.

The evangelisation of the health-care world concerns all those of us who work in hospitals as medical doctors, nurses or health-care assistants. It does not concern only priests, consecrated men and women or volunteers who come to hospitals, but, rather, all of the lay faithful who by their baptisms became witnesses to the love of Christ.

An especially suitable context for evangelisation is, without doubt, a place of work where people live in suffering. Pope VI in his Apostolic Exhortation *Evangelii Nuntiandi* observed: 'The more Gospel-inspired lay people there are engaged in these realities, clearly involved in them, competent to promote them and conscious that they must exercise to the full their Christian powers which are often buried and suffocated, the more these realities will be at the service of the kingdom of God and therefore of salvation in Jesus Christ'.[1]

To be full of the spirit of the Gospel means to draw upon the words of the Lord, to know them, to make oneself shaped by them, and to spread them. This means inviting Jesus into every activity that we are engaged in for sick people, to be rooted in Christ so as to bear personal witness. Thanks to this fact we know the reason for our work because 'the love of Christ controls us' (2 Cor 5:14). From this personal relationship with God we draw the strength and the love to serve the sick. God touches the sick personally but also through health-care workers such as ourselves. We are instruments in the hands of God.

In order to be able to carry our work we need significant training or so-called ongoing apprenticeship in the health-care field. Side by side with the professional part of things, the human approach is the inseparable part which is required above all of we health-care workers. But what should a hospital assistant who is at the same time also an evangeliser be like? Is one dealing only with professional care or also with evangelisation? I was especially touched by the words of the Holy Father Benedict XVI to be found in his encyclical *Deus Caritas Est*: 'Individuals who care for those in need must first be professionally competent: they should be properly trained in what to do and how to do it, and committed to continuing care. Yet, while professional competence is a primary, fundamental requirement, it is not of itself sufficient. We are dealing with human beings, and human beings always need something more than technically proper care. They need humanity. They need heartfelt concern. Those who work for the Church's charitable organizations must be distinguished by the fact that they do not merely meet the needs of the moment, but they dedicate themselves to others with heartfelt concern, enabling them to experience the richness of their humanity. Consequently, in addition to their necessary professional training, these charity workers need a "formation of the heart": they need to be led to that encounter with God in Christ which awakens their love and opens their spirits to others. As a result, love of neighbour will no longer be for them a commandment imposed, so to speak, from without, but a consequence deriving from their

faith, a faith which becomes active through love (cf. *Gal* 5:6)'.[2] Love for neighbour as a consequence of our faith.

I live in the Congregation of the Sisters of St. Elisabeth, whose principal charism is assistance to the sick. Our patron saint is St. Elisabeth of Hungary whose feast day we will celebrate in the next few days. Elisabeth was a Princess and the daughter of Andrew II, King of Hungary, who forwent her inheritance, founded hospitals and personally served the sick. In this way, she carried out the great mission of love to which all of us are invited by the Gospel: 'as you did it to one of the least of these my brethren you did it to me' (Mt 25:40). This message during the seventeenth century touched our founder, Apollonia Radermecher. Following the example of St. Elisabeth, she completely dedicated herself to service to the sick. Mother Apollonia said: 'God gives to man the capacity and the necessary graces for the tasks He calls him to'.[3]

From the Gospel we know that Christ paid especial attention to the sick. God has called us to engage in a service that draws us near to Him. This is noble work which Christ has given to us through his words: 'As the Father has sent me, even so I send you' (Jn 20:21). In caring for the sick we carry out the message of God by which we health-care workers become 'merciful Samaritans' (Lk 10:30-37). Our work becomes a service to life by which by way of man we serve God and in this way become his co-operators'.[4]

Women nurses, who engage in complex care, spend most of their time with patients. Specifically for this reason they should be the first, if not the only, people with whom a patient can speak about his or her spiritual needs. I work as a woman nurse in the cancer clinic and I meet patients who live in fear and anxiety because of the uncertain prognosis about their illnesses. Patients often have to fight with the changes in their lifestyles and because of their admission to the clinic they live far from their families. For this reason, from us is expected empathy, respect and welcoming. If we dedicate time to them, listen to them with commitment and attention, they open their hearts and allow us to enter into their needs and help us to mobilise their strength.[5] A serious illness leads a person to reassess all of the values in which hitherto he or she has believed. If this moment is perceived correctly, it can become one of the most valuable and fruitful periods of his or her life.[6] It can be transformed into a period of personal prayer, research, and a closer link with God. Many people have found relief, help and liberation through prayer, and have been able to bear the burden of illness and to accept what they would otherwise not have had the strength to accept. [7] We must help sick people to discover the true meaning of suffering so that they accept it and unite their suffering to the suffering of Christ. [8] It is difficult to find comforting words in suffering but this can be compensated for through attention, personal interest and prayer for the patient or prayer directly with him or her. At first sight these are small things. However, they become for patients great expressions of love. Meeting the needs of the souls of people who are seriously ill has a rather important role. Here I would like to stress the importance not only of oral communication but also of non-oral communication by which we create a relationship with the patient which allows us to communicate at the level of feelings. The patients speak to us about their families, their wishes, their plans and their unanswered questions, often, however, they speak to us about their spiritual lives. To take care of a sick person means to bend down before him or her in order to make him or her feel better, to remain silent in order to share in his or her suffering. This is a personal approach which helps the patient to go beyond the feeling of loneliness produced by his or her uphill journey. [9]

A health-care worker/evangeliser is a worker full of the Spirit of the Gospel, he or she is rooted in Christ, attends to the formation of his or her heart, serves God through man, enters the world of the values and the needs of other people, and gives altruistically everything that he or she has received gratuitously.

I would like to end my paper by paraphrasing the words of our Founder: 'All great acts of love are nothing but a constant decrease and extinction in order to make Christ grow. This depends only on the spontaneous sacrifices and obedience of the servants of God, who in response to His call plant and water. However, the words of St. Paul always apply: "So neither he who plants nor he who waters is anything, but only God who gives the growth"' (1 Cor 3:7).[10]

Specifically for this reason, we must give gratuitously what has been given to us gratuitously!

Notes

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4. The Volunteer: Volunteers in Hospices, Hospitals and Home Care for the Elderly in Poland

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1. Volunteering as a Part of Caring Teams in Health-Care Institutions and Home Care

Volunteers play an important role in the caring process. Accompanying patients and their families and listening to their needs without a professional distancing are the values that are added by suitably trained volunteers. Patients usually feel a greater distance from a doctor, nurse or chaplain. A volunteer often becomes a friend of the patient and family and can help in responding to their needs.[1] Volunteers should not take the place of professionals and in their training they are informed that they are not allowed to enter the realm of responsibility of professional figures. However, there could be a valuable 'link' in various areas of care. This should be used in institutional and home care only when it is accepted by professionals and adequately coordinated by the volunteer coordinators. Such training has been prepared, conducted and published by the leaders of hospice-palliative care volunteering teams in Poland.[2] It can be adapted to all the institutions of health care and home care where the help of volunteers is accepted by the caring teams.

Holistic hospice-palliative care tries to respond to the different needs of the patients, offering medical, psychological, social and spiritual care which is implemented by various professionals of the caring team.[3] The time offered to patients and families by volunteers in hospice-palliative care is a valuable help for all these elements of interdisciplinary care. Helping the patients in their activities, leading discussions, helping solve everyday issues and responding to the various needs of patients and families are the tasks of volunteers. A reduction of anxiety, of uncertainty and a feeling of loneliness are important elements in non-medical care. The volunteer offers the patient his or her time, listens, and can respond (personally) or inform professionals of the caring team when this is needed. Offering time to listen to concerns, sharing prayers, favourite readings, and assisting the patients and their families could be the precious gift of a volunteer.[1] The importance of these aspects of care was stressed by the Founder of the Modern Hospice Movement, Cicely Saunders. She said: nothing else matters because you are who you are. Nothing else matters to the last moment of your life. We will do all we can, not only to help you die peacefully, but also to live until you die.[4]

2. Volunteering and its Development in Hospice Palliative Care in Poland

Volunteering for hospice-palliative care was crucial in the creation of the hospice movement in Poland. During the difficult period of political changes and 'Solidarity' the first home care hospices were created with the major support of the Catholic Church and they were based fully on the voluntary service of medical and non-medical staff. In Gdansk, the birthplace of Solidarity, health-care workers and students used to gather in churches. In 1983, during martial law in Poland, the first home-care hospice team was formed, giving help to the terminally ill and dying with great support from the Church. It became a model for creating more than a hundred home care programmes in Poland which were based on the voluntary work of physicians, nurses, chaplains and others[5] [p. 253]. The Church was, and still is, a very strong supporter of hospice programmes in Poland. In 1987 Pope John Paul II recognised the great amount of work done by hospice volunteers when he used these words during the meeting with the sick and disabled, health-care workers and volunteers: 'I admire the hospice, which has undertaken its service in Gdansk and is spreading into other cities. It was born out of the common concern of the chaplaincy and doctors standing by their patients' beds about the proper place and conditions for patients at the end of their lives. This concern is expressed in their shared attention and nursing of ill people in their homes, in heartfelt and disinterested *self-sacrifice*'[5] [p. 37].

In the twenty-first century, the professional and well-established hospice-palliative care system in Poland started to lack volunteers in caring teams. The involvement of society was promoted as a part of a nationwide campaign entitled 'hospice is life too'. One of the purposes of the annual national campaign is to educate the general public and to encourage people from different social groups and different age groups to volunteer in hospices. In 2007-2010 the National Chaplain for Hospices and the Hospice Foundation conducted a nationwide programme for hospice-palliative care volunteering which led to the development of voluntary involvement in home care and institutional care for people towards the end of their lives.[6] Promoting volunteer-

ing among different social and age groups, providing training and giving educational materials for volunteer coordinators meant that each of the hospice-palliative care centres that participated in the programming reported an increase in the number of volunteers and their lasting cooperation with the caring team. The quality of care for the patients and their families improved and more people towards the end of their lives received adequate care because of the support of volunteers in care teams. The social involvement of many people who directly supported hospice-palliative care as volunteers, or helped indirectly (organisational and financial support), showed that the programme was successful. More patients in hospice-palliative care institutions had assistance towards the end of their lives and that was the most important goal of this programme.[7]

What encouraged the volunteers to help hospice patients with the 'I like to help' project? 'My simple path to being a volunteer hospice was led by my terminally-ill friend Christine and my seriously ill mother, who along with my husband (a hospice volunteer as well) looked after them for two years...For over two years I have been a hospice volunteer in the group 'volunteers 50+'. I identify my service with the words of Mother Teresa of Calcutta: 'You can do what I cannot. I can do what you cannot. Together we can do something quite wonderful for the Lord' (Jola).

'My own illness, helplessness, complete dependence on others…and the enormity of human kindness and help, which allowed me to stand on my feet again, were the foundation of my decision to volunteer. So how could I not give back to others what had been given to me in the difficult days of sickness?...I do not know if I have enough energy to work in a hospice caring team. I have started with the child home-care team. Such suffering and yet a huge request for presence and love. I could not help them in sickness, but I could give them my time: stories, fun, hugging, listening. Their parents could have a little rest during my presence...Today I cannot imagine that I would not be here. Giving my heart and time I feel that I receive double. The joy of being with 'our' patients cannot be compared with anything. My life has such a meaning with voluntary service!' (Teresa).

The nationwide programme calling for volunteering in hospice-palliative care has been successful. It has promoted voluntary activities in schools and universities, trying to reach out to young people who are (always) willing to help and take up the challenge connected with hospice service. Hospice workers and volunteers have created promotional and educational programmes with teachers and tutors, educating them about end-of-life issues.[8] A special message was sent to the group of adults called the 'volunteers 50+' group. Hospice-palliative care centres have reached out to local parishes and to organisations for pensioners, showing people the possibilities of volunteering. The involvement of this group, often connected to parishes and prayer group, has been very successful, changing the stereotype of volunteering as an activity for the young and the students, and providing a solid and faithful group of reliable assistants for caring teams[2] [p. 35-38].

All the actions taken by the National Chaplain for Hospices and more than a hundred hospice-palliative care teams in Poland have been described, together with action at the level of research, and show how important a role volunteers can play in caring for those in need. We read: 'It is a unique record of efforts made by coordinators and voluntary workers in Poland, above all at a local level, to raise social awareness to responding to the needs of people towards the end of their lives. Life stories, written over the years by many people from across the country and published as a part of past projects, have been the source of inspiration for public education in end-of-life care, as well as for this paper which provides an account of social education activities in hospice-palliative care[7] [p. 170].

3. Volunteering in Pastoral Care Teams in St. John of God Helping Institutions

This initiative, which focused on transferring good practices and experiences in the provision of quality care to terminally ill patients to other health care institutions, was undertaken by the National Chaplain for Hospices in 2009. The Polish Province of Order of St. John of God, celebrating its 400 years of service in Poland,[9] decided to mark this anniversary by creating voluntary pastoral care teams in its health and social care institutions. It invited experts in order to train volunteers and their coordinators. At the same time there were moves to create a postgraduate school for team pastoral care for priests, religious or lay assistants and volunteers. International conferences helped people to learn from others how important a pastoral care team can be in various health and social care settings.[10] With the valuable help of Monsignor Zimowski and the Pontifical Council of Health Care Workers, a selection of articles from the Vatican journal *Dolentium Hominum* was published for the first time in Polish, giving scientific support for the promotion of team pastoral work and volunteering.[11]

Pastoral care teams, based on volunteers and cooperating with chaplains, have been created in ten of the John of God helping institutions. In 2011-2012 a series of training initiatives were taken, including lectures, workshops, study visits to every place where there were pastoral care team activities, and the international exchange of good practices. At the end of two years of preparation and training, study of the activities of pastoral care teams and assistance in their needs, all the volunteers and their coordinators went on a study visit to Granada, Spain. Meeting in the sacred place of the Order of John of God, prayers and practical knowledge exchanged with volunteer coordinators and caring teams confirmed actions taken by pastoral care teams in Poland.[12] The first of this kind of initiative in Poland was shown to be successful in clinical-pastoral prac-

tices as well where the students of the postgraduate school for pastoral team care worked as interns in cooperation with the Bonifratres Volunteers pastoral care teams. The results of these initiatives, which try to enrich pastoral care for patients, assisted mostly by busy chaplains, will be the subject of research and further studies (the author's PhD dissertation will study the involvement of volunteers in the pastoral care of health and social institutions in Poland).

4. The Development of Parish Volunteering for the Elderly and Patients at the End of Life

Since the initiative with hospice-palliative care volunteering has proved to be a success, these experiences may serve as a model for the development of end-of-life care for patients living in their own homes or in long-term residential care institutions. In 2010, the textbook for informal carers (families, volunteers) was published as a practical tool for those who need to care for their loved ones at home.[13] At the same time the 'I like to help' Foundation was established to transfer good practices in volunteering in hospice-palliative care to other kinds of institutional and home care. The demand for this educational tool encouraged the authors to invite the principal Christian charitable organisations in Poland (*Caritas, Diakonia, Eleos*) to endorse the new edition of this textbook and propose workshops for families and volunteers. Consequently, in 2011 the second, enlarged edition was published and widely distributed in Poland.[14] These endeavours constitute a good start but there is a need to implement further means of mobilising and recruiting people in Poland to be active partners in end-of-life care.

Since 2011 and this textbook and educational film, a series of workshops have been engaged in for the Catholic institutions of *Caritas* and the Protestant centres of *Diakonia*. In the Annual Pastoral Programme for the Catholic Church for 2011/2012, a report on the urgent need to create voluntary based teams in parishes and local communities to help the elderly and the chronically ill was published.[15] More steps need to be taken in order to develop these forms of charitable activities which are present in many local communities. Often their activities could be improved by the professional training of volunteers and volunteer coordinators. In this way the level of competence, and a motivation to serve those in need (from local communities), could increase.[16]

5. Conclusion

With the growing number of elderly, handicapped and terminally ill people in Poland and Europe, we are facing new challenges. The example of hospice-palliative care volunteering in Poland is a realistic example of the possibility of cooperation between the Church, the health care system and volunteers, who are of great help for those in need. The mission of the Good Samaritan continues and the assistance of voluntary pastoral teams in health/social care institutions is an answer to the spiritual and emotional needs of patients, their families and carers. The encouraging words of Cardinal Stanislaw Dziwisz give hope that pastoral care teams will help chaplains to meet the various needs of patients and help them to meet Jesus in the sacraments[17] [p. 7-11]. We are facing the reality of a growing number of chronically ill and elderly people amongst us. The Church should be present in discussions and actions addressed to the needs of the terminally ill and the handicapped. Cooperating with health-care structures, supporting volunteers in different services and giving religious and spiritual support is a part of our Christian and human mission. Apart from the chaplains and professionals in health and social care, inspired by Christian values, there is a great deal of space for volunteers[5] [p. 255-256].

Pope Benedict XVI encouraged all professionals and volunteers in his message for the World Day of the Sick: 'I would like to encourage the efforts of those who work daily to ensure that the incurably and terminally ill, together with their families, receive adequate and loving care. The Church, following the example of the Good Samaritan, has always shown particular concern for the infirm. Through the individual members and institutions, they continue to stand alongside the suffering and to attend the dying, striving to preserve their dignity at these significant moments of human existence. Many such individuals – health care professionals, pastoral agents and volunteers – and institutions throughout the world are tirelessly serving the sick, in hospitals and in palliative care units, on city streets, in housing projects and parishes'.[18] May these words help us build and support volunteering programs in neighbourhoods and parishes where the good practices and experiences of hospice-palliative care may be transferred to other institutions and care providers! More research is needed to understand the role of team pastoral work and the coordination of volunteers in order to provide better care in institutions and home-care settings. The Church and other faith groups, health/social care organisations and NGOs with volunteers, through a joint effort, could prove that elderly and terminally ill people in Poland might be able to enjoy higher quality end-of-life care[7] [p. 171].

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5. The Chaplain

DON WERNER DEMMEL
Chaplain,
Germany

Your Eminences, Your Excellencies, Reverend Sirs, venerable sisters, ladies and gentlemen!

1. Preliminary Observations

At the outset in my reflections I would like to formulate certain basic thoughts on the situation of pastoral care in Germany and not on the major part of Church realities.

1. The Reform of Martin Luther, secularisation and the reunification of Germany, as well, inflicted wounds on the German Church, weakening it, in part gravely as well.

Pastoral care in Germany, against this background, has to address major challenges, because of the contemporary process of an increased foreign presence in our society as well.

2. To this should be added the fact that the confusion and cancellation of boundaries and contents amongst the confessions makes many of our Christian brothers and sisters very insecure or even pushes them into the arms of various substitute religions. They do not find clarity and reliability in Christian doctrine and actual experienced realities.

3. Often a terrible indifference to religion is encountered.

4. Religious extremism increasingly prevails over a healthy central position.

2. Professional Beginnings

1. Ecclesial socialisation

When, thirty years ago, I began my priestly service in the hospital world I encountered a context that was still socialised in the main in a Christian-ecclesial sense, and this notably facilitated the entrance of a – and I use the phrase – 'fresh priest', that is to say one who had just been ordained, to carry out his task.

In the clinics that we worked in at that time directive and health-care work was often still carried out by sisters and monks and they determined the climate of the institution.

Secular people, naturally enough, shared the spirit of ecclesial support, carried out pastoral tasks, and in their health-care service had eyes and ears that were attentive to the spiritual needs of the gravely ill and the dying. They built humanitarian bridges, helped to overcome anxieties, and opened up the road to the administration of the sacraments.

It was equally natural to organise a religious choir in the clinic, regularly engage in Biblical conversations after the service, have co-workers, for example for the liturgical services, such as singers or readers, or for the adoration of the Eucharist during the Easter triduum.

2. The administration of the sacraments

My work was clearly and prevalently directed towards the service of the sacraments. Indeed, at that time there was a wish to receive the sacraments and pastoral accompanying was much more

natural and frequent that is the case today.

The administration of viaticum, extreme unction and the service of reconciliation were still to the forefront.

Short visits were fostered by the long stays in hospital because real accompanying was still allowed.

Thirty years ago I still lived in a context in which 80% of the people were Catholics, Today, Catholics make up only 40%. 30% of them are Protestants and the rest are Muslims or members of minority groups, as well as people who do not profess any religious confession.

3. The Contemporary Situation of Pastoral Care in Hospitals

1. The transformation of clinics

Against this background, comparing my situation of current work with that of that time, it is licit to speak about an authentic system and/or paradigm change.

Because of this change in general conditions, over the years my service has also been strongly changed and this has required a change of direction and a reorganisation.

Clinics have gradually been transformed, in the sense that they have become suppliers of services and economic enterprises.

Economics and technical competence have become priority elements to the detriment of a professional ethos.

The patient is seen as a customer to whom is sold a 'health package'.

2. Consequences for pastoral care in health in hospitals

All of this cannot fail to have consequences for pastoral care in health in hospitals.

The chapel of the clinic, for reasons of costs, is now available, something that would have been unthinkable previously in Catholic Bavaria.

In its place the supporters of the hospital prefer a 'space of silence', without Christian symbols, open to all faiths and thus a response to the 'multi-faith' society.

Considerations or visions of an ecclesial character or inherent in pastoral care are no longer taken into account; indeed, they are often extraneous to the management of what is a company.

The average stay in hospital at the present time has been reduced to 4.5 days. First a previously planned diagnosis takes place and the treatment follows immediately afterwards. Rehabilitation treatment is also planned beforehand.

Pastoral accompanying of a longer time period is by now almost impossible and short visits have been reduced to what are absurd lengths of time.

Hospital pastoral care, therefore, has shifted into the waiting rooms of the services (for example the x-ray rooms!).

4. The Regression of Ecclesial Socialisation

Christian-ecclesial socialisation ha strongly diminished at a personal level and at the level of patients as well. This should also be understood as a secondary effect of the reunification of Germany as a result of which we were invaded by a mass of fellow citizens who had not been baptised and who were indifferent to religion.

The ascertainment of a confession and/or membership of a creed is by now done only sporadically. On the one hand, this is because of the fact that one is dealing with information that is provided voluntarily by patients and, on the other, because such information has been practically obliterated by the defence of privacy and to such an extent that for the parish it is by now almost impossible to organise a service of hospital visits.

The administration of the sacraments has been strongly reduced and it is only rarely requested spontaneously. In the daily reality of the hospital only extreme unction is something of importance. Unfortunately, however, in general this is requested when things have gone too far and because of this fact this sacrament has by now been transformed into a kind of death ritual rather than a ritual of life.

5. Hospital Pastoral Care in a Team

1. At the present time, together with two lay workers who are pastoral assistants, I look after a general clinic with 490 beds and a specialised phthisiology clinic with 300 beds. The partners which support these are respectively two limited companies that have shareholders.

2. Our work is also supported by women who engage in pastoral care as volunteers. They were trained beforehand by myself and then accompanied and directed towards specialisation. They offer regular visits and report to me the wish of a patient to receive a sacrament. They are an important bridge between the patients and those of us who engage in full-time hospital pastoral care.

3. Because of the notable shortage or lack of priests, it is increasingly the case that lay theologians provide hospital pastoral care and they are often not flanked by a priest in the exercise of this responsibility. This was also the reason why I was entrusted with a second clinic as a priest.

4. As regards the administration of the sacraments, the lay theologians need a basic priestly service. However, when a priest is not available, a lay person can only do what he or she is allowed to do, namely accompany, pray and bless.

6. The Possibility of a New Evangelisation

1. Encounter as a way towards evangelisation

Whereas in the past it was more my ecclesial approach and my actions involving the sacraments that marked my being and my work, today I would be inclined to understand my service as that of being a builder of human and spiritual bridges, acting constantly between two worlds in a situ-

ation of condensing life within the context of the clinic and with reference to the decay of values within society, creating thereby a network of relationships between co-workers, patients and their family relatives, and between God and man.

In my frequent meetings, in the rooms of patients, in my office, in corridors or in the chapel, despite all the changes that have taken place in my situation, I see myself and my work as the guarantee of another reality, albeit always endowed with a great advantage in terms of trust.

The conversations, whether they are planned or take place naturally, are, as a rule, marked by mutual respect and are open to a deeper analysis, to a religious exchange or to the receiving of a sacrament.

Just by being there, but also specifically through my sacramental service as a priest, I allow people in the hospital, whether they are patients, their family relatives or co-workers, to open themselves to another dimension.

By no means rarely these meetings, which are often 'only' apparently human, are transformed into religious moments where people's outlook opens up once again to the presence of God.

The accompanying of gravely ill people or of the dying, of people in mourning or of people who are in a state of hopelessness, through a human encounter opens up access to life, to faith and to God.

2. Humanisation as a preparation for evangelisation

In my service as a hospital chaplain, the principal aspect is the service of answering calls, that is to say a readiness act day and night for emergencies of all kinds. Often hopelessness and anxiety dominate a room, a patient and very often family relatives as well.

Every day, above all during the night, I find that I intervene in situations where at the outset one does not understand whether the person concerned needs me as a priest or needs spiritual help, or whether he or she wants me as a human accompanier who has time, who can listen and help the situation to be borne, allowing reconciliation with God or with his or her family relatives, or as someone who can help in dealing with things that remain unsolved.

Given that I have always had the habit of going up to a patient whoever he or she may be, without first being informed about his or her religion or confession, naturally I never know beforehand whether the patient is a Catholic, if he or she had left the Church or whether he or she has another faith.

Simply, I accept the encounter. Hitherto I have never been rejected. Even Muslims are grateful for a visit, for an edifying conversation.

This openness allows many co-workers, even when they do not have a concrete point of reference in the Church, to ask me or to inform me in my capacity as a priest, thus allowing a number of prejudices towards the Church and some wounds inflicted by the Church to be forgotten.

On the agenda are in-depth conversations and/or exchanges of a religious nature with the co-workers, whether they are involved in health-care assistance, in the administration of the hospital, or even only employed at a technical level.

3. Offers of specialisation as aids for evangelisation

For a number of years now, in my hospital, I have offered my co-workers a specialisation in professional ethics and I have constantly encountered great interest in this project.

However, unfortunately I am also obliged to observe a troubling loss of identity as regards knowledge about Christian values and the contents of the Christian life, as well as a fall in the ecclesial dimension in general.

As a consequence, I see as even more important those offers that allow me to transmit messages and values in a manner that is not captious, bringing to people's memories attitudes that are typically Christian and reawakening a sensibility that has been lost as regards religious meetings and needs.

The immense changeover in personnel and the employment of temporary staff makes it extremely difficult to organise continual pastoral care because one almost cannot observe any longer a real identification with the clinic as an institution.

As regards hospital pastoral care, in general I can no longer rely upon personnel that are familiar to me and who can play an important role of mediation in pastoral care.

4. The person as an exponent of evangelisation

The transformations that have taken place in society and in the Church have made evident the role that the personality of the priest in general and/or in evangelisation should have, and how important are my faith and my spirituality in addressing all the difficulties that are to be found in pastoral care, taking into consideration the respective individuals that I meet: for example the image of God and of man that I carry within myself; my openness and transparency in relation to God; my readiness to relate to other people; and my reliability in meetings with people who entrust themselves to me.

A priest, in addition to the task that he performs in relation to pastoral care, is increasingly becoming a advocate of humanity and a person who warns about the need for respect for man who is made in the image and likeness of God.

To be present, to be ready to help, as a man and as/or a priest: this is what is becoming increasingly important in today's hospital world, where one increasingly feels that there are fundamental failings in a human but also in a religious sense, where often an institution loses its natural role of mediation, and where the relevance of individuals has increased.

5. Liturgical offers to support evangelisation

As regards the daily offer of liturgical celebrations, one should

not underestimate the importance of the way in which the liturgy is celebrated, of when the sacraments are prepared and administered, as well as the fact that spirituality that is experienced opens up pathways that allow people to accede once again to God, in extreme life situations as well.

The hospital chapel offers many people, in addition to the limits imposed by confessional membership, to enter the tranquillity of a holy area, to once again turn their faces to God, and to have a place where they can pray and give thanks, weep and ask.

I believe that the existence of a chapel is very important, above all in clinics for drug addicts or rehabilitation, and I regard it is as a great loss for sick people that this opportunity is precluded or removed for reasons of cost.

A 'space of silence' the size of a room can never take the place of a consecrated chapel.

Receiving a sacrament or taking part in the holy Eucharist in a hospital – during the course of a grave illness – can bring out many things that often have been concealed for years, allowing the return of relationships of faith that seemed for a long time to have been forgotten (for example, "Father, I have not confessed for more than thirty years. Can you help me?"!).

Often an illness can become an opportunity to once again rest one's life and one's faith on new bases.

As regards hospital pastoral care, in addition to visits to the patients, the liturgical services, the Masses, the rosaries, the meditations and good readings near the bookshelves with their publications are and remain important aids and instruments that manage to open many hardened hearts, often bringing back men to the open arms of the Father.

7. Final Remarks

Your Eminences, Your Excellencies, ladies and gentlemen!

1. For me a hospital constitutes from many points of view *a reflection of society* and a certain condensation of life's relationships which after a fashion are reduced and concentrated to the essential, until a person's breathes his or her final breath. Everything that does not matter here loses its value.

2. Pastoral care and evangelisation in a hospital have *another priority value* as regards what takes place, for example, in the varied reality of pastoral care in a parish.

3. However, and perhaps specifically because of these challenges, pastoral care in a hospital for me constitutes a special *opportunity for the Church and for evangelisation* because man in a hospital is made more sensitive than usual, more receptive to, and grateful for, messages of comfort and hope, and above all the love of the Son of God who was made man.

4. For these reasons, I believe that it is very necessary to have a *service of volunteers who are well-trained at an ecclesial and religious level* specifically in the field of pastoral care in a hospital, rather than having such pastoral care entrusted to lay theologians who are entrusted with it on the basis of an employment agreement.

A hospital chaplain on his own is without doubt overburdened with requests and responsibilities that arise from his situation. The chaplaincy requires qualified and engaged support, for example that provided by a post-catechumenal group.

Differently from what happens in pastoral care that is provided in a parish, where by now I only reach the active core of the faithful, in carrying out pastoral care in my hospital I encounter many people of different backgrounds and different characteristics: people who have been distanced from the Church or are interested in it, people who practice their religion or who are outside the Church, people who are Catholics or people who are Protestants.

5. For this reason, it has become indispensable to link *hospital pastoral care with local pastoral care*, that is to say with the pastoral care that is provided in a parish. And this not only to retrieve those contacts that have been lost but also, and specifically, to sensitise once again the members of a parish to be aware about its sick members and to transmit to these sick people the feeling that the parish community has not forgotten them but is thinking about them and praying for them because they are a part of the local church and are valuable members of the body of the risen Christ.

FRIDAY 16 NOVEMBER

II. Ethics and Humanisation

Health Care between Being and Acting: a Balance of Charity

FRA' MARIO BONORA, P.S.D.P.
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Your Eminences, Your Excellencies, reverend priests, dear brothers, Ladies and Gentlemen,

'He did not come to be served but to serve' (Mt. 20:27). I would like to begin with this phrase from the Gospel according to St. Matthew. It has been my companion during the longs years of my religious profession; it inspired my vocational choice; and it has comforted me during the many, the very many, hard moments of a life that has been spent in the wards of a hospital. In particular, however, this phrase of Matthew's seems to me to be able to capture the meaning of what we are reflecting upon: the Christian synthesis of being and acting *in* and *for* charity.

Christ Came not to be Served but to Serve

In the Acts of the Apostles there is without any shade of doubt a pointing out of the recipients of this service: the poor and the sick. Ever since its origins, the Church has privileged and raised to a sacred ministry specifically care for the poor and above all care for those sick people who, as Luke observes, Jesus commends to his disciples when he sent them out 'to preach the kingdom of God', connecting this supreme mission with the mission of caring for the sick: 'and heal the sick' (Lk 9:2). Since then, until our contemporary modern health-care complexes, there has been a flowering of care initiatives which drew inspiration and nourishment specifically from the values of the Gospel.

Today, in a society that is marked by fundamental technical and legislative developments that nonetheless encounter difficulties in identifying with that globalisation that is so much wished for but which is difficult to attain, the presence of social/health-care institutions that are managed by religious agencies and Congregations bears witness to the permanent ideal of the Church to offer to sick people, together with a generous and tiring service that is impeccable from the health-care and humanitarian point of view, above all else also a concrete sign of the extension of the love and solicitude of Christ for suffering people.

Memory of what has been achieved with hard work and sacrifice during these years of moving between the end of an epoch and the birth of the third millennium allows us to see future pathways and pathways for projects that confirm the vitality and dynamism of the presence of the Church is this break in our age. Namely, the opening of our beings to a panorama of programmes of very great value which, while being a confirmation of the traditional exercise of charity towards our brethren as a natural expression of Christian faith, would also raise such activity to the dimensions of the evangelising work itself of the Church and the defence of religious freedom, which are neither marginal nor secondary in the contemporary world, a world that is increasingly multi-confessional, more technological and more equipped both at the level of ideology and of behaviour.

I have deliberately used the conditional tense because in the practical health-care world, and the Italian health-care world in particular, there are by no means few obstacles to the implementation of a Christian synthesis between being and acting in the approach of charity. At the level of principle, there is nothing that can be criticised. But when one descends to a practical level one then has to take into account a reality in which increasingly a language is spoken which is held dear by the dominant logic of the market. In the field of health and health care, or to put it better in the field of human suffering, as well, this is not the language of the Gospel. So what is happening? One need only listen to the cry of alarm which by now has been raised from the world of health care of the Church – because these are the social/health-care institutions managed in Italy and the world by religious Congregations and agencies – to understand what is taking place. Cuts, a lack of appreciation, closures, and the transfer of management to non-Church

agencies, seem to drain this not marginal part of the mission of the Church – namely healing the sick – of meaning. This is a mission which if interpreted in a literal sense, that is to say treatment of the body, cannot be confined to the albeit indispensable forms of spiritual and moral assistance, sharing and accompanying, but which naturally requires the use of works with buildings, technological resources, agreements through contracts, and respect for the rights of workers. And it is this that in placing so many institutions in a state of difficulty.

But it is not specifically about this that I want to speak when invoking ethics in the management of the relationship between being and acting in health care. Nor do I want to demonstrate the disproportion between costs and income or the injustice that discriminates Catholic health care that is put on a level with state health care, where this latter, even though it has the same obligations as the former, benefits from state subventions and aid from which, indeed, the institutions of the Church are excluded. And I do not even want to speak about health-care ethics to defend Catholic institutions from accusations, which for the most part are of a rhetorical character, that they suffer from a lack of transparency as regards their budgets. We are the first to be responsibly convinced of the need for such transparency.

I would like to speak about the ethics of health care by referring to people who by the nature of things spend money in health care in order to act. I want, therefore, to ask myself in what human context the expenditure of material resources is carried out; with what style of behaviour and existence it takes place; and what the other resources are that contribute towards, support and justify financial expenditure.

The Human Person is the True Wealth

It should immediately be made clear here that the first resource of an institute of health care, whether it is a large hospital or the smallest health-care residence for elderly people, is the person. Therefore what is ethically positive is not one euro less or one euro more but the person, what he or she does, his or her organisation directed towards improving the use of the hours that he or she makes available in his or her service to the sick.

This is our great resource: if it is invested well it obtains unimaginable results. We are convinced, that is to say, that the ethical character of health care is to be found in minds and hearts; it passes by way of relationships between all those people who make up the thinking brain, the laboratory of projects, the generator of creativity, the mechanism that is constantly tested to assure that an institution has wealth at the level of human, moral and psychological resources, and to assure that patients receive readiness to help, a swift response, smiles, support, tenderness, welcome and accompanying. In a word: love.

It is clear that to obtain such results one has to act on our being. We need a real conversion of hearts – something which amongst other things should not be surprising in a Catholic hospital – but also humility which would be useful in the search for cooperation and a possible understanding, which are, indeed, indispensable for an endeavour which should involve the excellence of team work. These would be the first steps towards a renewal that would be capable of helping us to avoid that an exaggerated business climate ended up by being transformed into disinterest as regards the real problems of a hospital institutions, into a non-respectful use of the things of a hospital, and into a treatment of patients that was without humanity. This could also lead unknowingly to a passive approach, to a lazy creativity, and to a sense of irresponsibility or non-involvement in the face of a search for a future. And a future that was perhaps different.

The Crisis should not Frighten us

This crisis exists and it is certainly worse that what we imagine it to be. It is no use concealing the fact. They tell us that we can overcome this crisis. But it would be a terrible thing if solidarity entered into a state of crisis. With his innate prophetic sense, Benedict XVI, in *Caritas in Veritate*, at number 21, writes: 'The different aspects of the crisis, its solutions, and any new development that the future may bring, are increasingly interconnected, they imply one another, they require new efforts of holistic understanding and a *new humanistic synthesis*'. He shifts, that is to say, attention onto the anthropological question. Man is frightened in the face of the crisis. Instead, in face of a crisis, even the most burdensome crisis, we must learn (the Pope continues in his encyclical) to 'adopt a realistic attitude as we take up with confidence and hope the new responsibilities to which we are called by the prospect of a world in need of profound cultural renewal, a world that needs to rediscover fundamental values on which to build a better future'. And he goes on to add: 'The current crisis obliges us to replan our journey, to set ourselves new rules and to discover new forms of commitment, to build on positive experiences and to reject negative ones'. Benedict XVI urges us to revive the secret yearning for rebirth that is in each one of us so as to overcome all of our fears. We must stake all of our capacities for change in order to open up the road to a new journey.

This is a journey that begins with a rediscovery of the fact that man is made for giving, for self-giving. The Pope, however, also writes that: 'The logic of giving does not exclude justice and does not follow afterwards'. And he then defines solidarity, which is above all else 'feeling responsible for everyone'. And the Pope goes on to declare that 'Without gratuitousness not even justice can be achieved'. Perhaps it is worthwhile remembering that our holy men and women Founders placed stress specifically on gratuitousness and solidarity. Their only resource was charity. During ages when everything was uncertain or inexistent, it was specifically charity, the resolving force of love, the only certainty that could be counted upon. Fortunately, still today there are very

many testimonies to giving, to free personal engagement.

The Good Samaritan

This is the figure that emerges most often in the thinking of Pope Ratzinger. We should not see the unfortunate traveller on the road to Jericho as a symbolic figure of a dated parable, and the Samaritan, the person who gave of his own time and money to help the suffering man, as the only figure who still has true, authoritative and salvific words to proclaim to our society of consumption; the only figure, whether physical or moral, that gives hope to the world. We cannot allow his beast of burden, which carried him on the road to Jericho, to fall ill and stop carrying him to where the Lord calls him. We are that beast of burden, perhaps fatigued or perhaps disorientated by the noise that surrounds him, and this to the point of making him lose direction and no longer feel even the hand of the master who guides him. The Lord, and we should be certain of this, continues to guide our steps so that we continue to carry him where he is most needed, wherever a man is suffering. 'God's love', Benedict XVI tells us, '*calls us to move beyond the limited and the ephemeral, it gives us the courage to continue seeking and working for the benefit of all*, even if this cannot be achieved immediately and if what we are able to achieve, alongside political authorities and those working in the field of economics, is always less than we might wish. God gives us the strength to fight and to suffer for love of the common good' (*Caritas in Veritate*, n. 78).

Unity-Communion

And if this were not enough, we should look for strength amongst us, in unity. A unity that cannot be only proclaimed at the level of words but which must become a daily practice of solidarity between institutions. Hitherto, a self-referential approach has hindered us from constructing authentic and effective networks with each other and with others. The crisis is demonstrating all of the short-sightedness that has brought us to this point. We will thus rediscover that unity which, as a reflection of the unity which in Christ connects us to the Father and the Holy Spirit, is called to become visible communion and to have explicit missionary reflections. Then we will finally be able to achieve a state of charity that is a reflection of our being and of our acting.

The Humanisation and Fairness of Care and Treatment in Health-Care Institutions

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First of all I would like to thank H.E. Msgr. Zygmunt Zimoski for inviting me to take part as a speaker of the twenty-seventh international conference at this important meeting on 'hospitals as settings of evangelisation: their human and spiritual mission' which addresses a subject which is so relevant to the defence of the dignity of suffering patient.

An analysis of the humanisation and fairness of care and treatment in contemporary health-care institutions cannot be separated from the prevalent pathologies of this epoch and in this area of the world.

First of all, we should take into account a fact relating to age. The part of the population of Italy which is over 65, which at the present time is about 20% of the overall population, is destined to become 28% in 2030 and 34% in 2050 if the present level of increase in maintained. This involves an increased risk as regards illnesses that constitute the principal causes of death: cardiovascular diseases, tumours and cerebral haemorrhages. These are illnesses, therefore, which are different to those to be found in the South of the world, which are principally AIDS, malaria and tuberculosis.

Independently of the various approaches and various therapies, one should ask how medical doctors behave when faced with the various illnesses that exist. Is medicine directed solely towards the whole illness as a conceptually abstract nosological entity or is it directed towards the person as a whole?

In the Western world this question becomes more evident when we consider social developments and technical-scientific progress.

Indeed, the concept of welfare, understood as giving everything to everyone without limits, has been superseded and we have entered to the full the stage of post-welfarism. The patient is no longer a passive subject who receives medical products but an active ad exigent subject who wants to know, to be informed and to take part in the process of treatment.

In addition, we have lost the idea that although medicine only at times treats, it must, however, always provide relief and comfort. The concept has been lost that 'providing comfort' and 'taking care of' cannot be separated from the therapeutic and improvement process.

As regards these last purposes, medicine has failed and one should

therefore understand the reason for this failure.

The greatest cause that one can ascribe is the loss of a holistic vision, which is a direct consequence of scientific reductionism, in the face of a problem of increasing complexity as regards these pathologies.

The medical act cannot be depersonalised; it should always have at the centre of its activity the person and the relationships that he or she manages to establish. Specifically because the lack of integration of 'taking care of' with 'therapy' constitutes a not very effective model of clinical practice, one must promote a holistic model of treatment and care that takes into consideration not only the technical-scientific dimension but also the social dimension, the anthropological dimension.

Scientism in medicine impedes the adoption of a correct holistic vision. Scientism with its dogmatic position, which sees the methods of inquiry of the physical sciences superior to all the others, seeks to explain everything that happens in relation to the patient, the meaning of human life, of suffering and of death.

The patient, on the other hand, needs attention, benevolence and dignity and constitutes overall an inseparable psycho-physical unity. He or she has a social network of affections and friendships, relationships with his or her family and friends, and with institutions, which cannot be de-contextualised.

In order to achieve a journey of humanisation we need the direct commitment not only of medical doctors but also of all health-care workers in order to promote activity and conditions whose exclusive goal is the good of the patient. Patients must thus be treated with dignity and must be aware of the decisions that concern their health.

The definition that Pope John Paul II gave at a famous conference on 'The Humanisation of Medicine' which was held in Rome in 1987 is detailed and stimulating:

a) 'Within the context of the individual relationship where humanisation means openness to everything that can help to understand man, his interiority, his world and his culture. Humanising this relationship means both giving and receiving, creating that is to say communion which is total participation'.

b) 'At the social level the need for humanisation is translated into the direct commitment of all health-care workers to promoting, each in his or her own field and according to his or her competence, conditions that are suitable for health; to improving inadequate structures; to fostering the right distribution of health-care resources; and to ensuring that the health-care policies of the world have as their goal only the good of the human person'.

In Italy there have been important health-care policies directed towards fairness in health such as those outlined by the National Health Plan (NHP) of 1998-2000: combating inequalities in health as a principal objective to be achieved through the strengthening of the capacity of people and communities to adopt healthy behaviour and improvement in access to services.

The NHP of 2001-2003 and the NHP of 2003-2005: an approach confined to certain weak subjects (immigrants and drug addicts).

The NHP of 2006-2008: the reaffirmation of the universality of services and the promotion of fairness in the system to achieve the overcoming of social and local inequalities.

One must continue down this path by strengthening and promoting the processes of humanisation.

Religious hospitals, which are very much present in Italy and the whole world, could be the first forces and leaders in this process, with the experimentation of models of care that are closer to the needs of patients. ■

Hospitals: Bioethical and Biopolitical Problems

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1. In an editorial which rightly became famous in the review of which he was the editor, the *British Medical Journal,* Richard Smith placed at the top of the list, amongst the *ten truths of medicine*, the lapidary statement according to which *hospitals are dangerous places*. This aphorism was not explained further by Smith, not least because an explanation was superfluous: this observation, although elementary in character, makes us rapidly understand that hospitals are dangerous for the health of people who have been admitted to them; dangerous for the health of visitors; and dangerous for the environment. For my part, I would like to add that they are dangerous from a bioethical and biopolitical point of view as well because they activate questions to which the culture that is now dominant does not seem to be able to provide an answer.

2. It is well known that in the ancient world the institution of the hospital was completely absent. In vain do we look in the Greek-Roman lexicon for a term

that could be translated by the modern word 'hospital'. The *xenodochium,* as is well indicated by the etymology of the word, was simply a house to accommodate *foreigners*: a hostel, therefore, a hotel, which was perhaps also characterised by a special colour and warmth (if, for example, the foreigner was a 'pilgrim'). But I will speak of this subject no more. Medical practice was seen as a rigorously *dual* relationship between the physician and *his* patient and the place of treatment was arranged to be the same place, and with absolute naturalness, as the house of the physician: that house outside of which one engaged in *public* life and within which, for the ancients, one engaged in private life, the *naked life*, which was marked by its characteristic *rhythms*: births, procreation, illness, ageing and death. These rhythms, especially for the well-off classes, were penetrated with immense authoritativeness by the physician, who was animated not only by his knowledge but also by his *benevolence* towards the suffering of sick people and in general towards all those who looked for his help. This benevolence was alluded to by the Greeks when they used the term *philanthropia* or when they spoke about the warm bond that had to link the physician and his patient and thus used the phrase *philia iatriké.* Hippocrates taught, prefiguring Pascal, that only he who loves knows well: only when there was *philanthropia* could there be in the physician an authentic love for his profession, that is to say *philotechnia.* This linking of the physician to his home (in the broad sense of the Greek term *oikos* which referred more to the set of people who lived in a building than to its walls) produced the paternalistic *paradigm*: the physician related to the patient not only with the authority of a *father* but also with that of a *good* father (as all fathers should have been, even though they are not always such). In his turn the patient, perceiving that the physician gave him not only his professionalism but also after a certain fashion his friendship, returned it with that *trust* and *gratitude* that sons ought to have towards their fathers. In a famous passage from *De beneficiis* (VI.16), Seneca reminds us that it is not possible to extinguish a debt to our physician simply by paying him: this is because friendship does not have adequate payments. The physician should have our *gratitude*, and gratitude, as is known, is inextinguishable.

3. Hospitals began to come into existence in late-antiquity with the Christianisation of the Mediterranean world. But they did not arise as an institution that was primarily intended for the optimisation of therapies, but, rather, as a place to admit the poor, the elderly, the abandoned and thus *also* the *sick*. *Hospitalitas* was the response that Christianity gave at the level of practice, with slow but decided and aware progression, to the teaching channelled by the parable of the Good Samaritan. This parable evidently has a pre-eminent theological-doctrinal value by alluding to a fraternal love which – modelling itself on divine love – does not exclude anyone, does not know limits of rank, does not engage in any calculation of convenience, and expresses itself as pure gratuitousness. At the same time, however, the parable activates in the mind of the listener the image of a man who, finding himself in a state of the most absolute need and almost near to death, finds someone who takes care of him, pours oil on his wounds, and helps him on a journey of convalescence and recovery. To the innkeeper, to whom is entrusted the body of the victim of the robbers, the Samaritan gives precise orders of *care*. In this way in history an absolutely new horizon was opened up: the *xenodochium* ceased to be a place to receive the *xenos,* the foreigner, and became the *Hôtel-Dieu,* the place to receive a neighbour, following the impulse of those who, like the Samaritan, *make themselves neighbours*. *Hospitalitas* ceased to be a noble, but *subjective*, psychological attitude: it became the *objective* foundation of the care home and of the hospital, as an authentic spiritual force it activated confraternity, created rules and religious Orders, became intertwined in an almost indissoluble way with the practice of medicine and became an extraordinarily eloquent aspect of Christian piety, with its consequent practices of charity.

4. Albeit without taking from it the whole of the characteristic of being an *art* and of having a warm interpersonal relationship, the modern epoch worked to make medicine a rigorous science, in the context, which was ever broader, of the biological sciences and the natural sciences *tout court.* The modern *hospital* could not but feel the effects of this new direction, which was at one and the same time epistemological (because it was founded on the principle that only scientific knowledge was authentic knowledge) and ideal (because it was founded on the belief that only through scientific medicine was a physician able to assure a patient the greatest likelihood of defeating that illness that had attacked him or her). Through complex historical processes, but ones that are not difficult to reconstruct, hospitals became *machines à guérir,* being transformed into specialised systems of care which were indifferent to the *social* dimensions of illness and attentive exclusively to their *clinical* dimensions. The separation of hospitals from lunatic asylums, from places for the chronically poor and for elderly people, and from institutes providing care to children, became rigid and found its justification in the weakening of the philanthropic vocation and the spread of medical professionalism in the world. In parallel, the image was consolidated of hospitals as places not only of care but also of scientific research to which were entrusted the formation of the new generations of medical doctors: as a functional part of this task we witness the dynamic towards the most complete rationalisation of hospital structures (one may think, for example, of the birth of 'wards'), accompanied by an inevitable process of bureaucratisation. The separation of charity and assistance from treatment was consolidated in a definitive way when the definitive *systemic* structuring of hospitals

and the consequent creation of an authentic *governing class* within them brought out their *business* dimension. To this phenomenon was added another, which was also a consequence of the new systemic character, which irreversibly characterised the *modern* hospital: it became a place where, in a difficult balance between the *public* and the *private*, *dying* was managed. Eloquent statistics demonstrate the constant decline of *death at home* and the continual and steady increase in *deaths in hospitals*. The causes of this phenomenon are many and they are certainly not difficult to identify: on the one hand, the hope that high-technology treatment – which could be done only in hospital contexts – could, if not lead the individual to avoid death, then at least give him or her further chances of survival; on the other, the crisis of the family, which made terminal assistance by the family relatives of the dying person (an assistance, for that matter, and obviously, completely impossible for families that made up of a single individual, which was a spreading phenomenon in the great metropolitan centres throughout the world) almost impossible. We should not underestimate the paradoxical relationship with death that characterises contemporary man and which is based upon its *removal*, and this has become the more effective the more death in a home context has been excluded. Hospitals thus acquired the characteristic of being a setting in which one may perhaps die but in which *one should not die* and which thus has the duty to remove death from being visible in any form. Hence one of the most typical characteristics of hospital institutions today, which can be perceived to the full only in the most advanced hospitals, namely the extreme attention that the accommodation dimension receives, which was conceived from the outset as being directed towards a non-terminal admission, an admission that was always temporary and transitory.

5. It is here that a new series of bioethical problems of today's hospitals have their roots, problems that manifest themselves in a systematic way as *dilemmas*. If hospitals could be reduced to solely *functional* structures, these problems would not be perceivable. To think of them, however, exclusively in this way turns out to be impossible because this is unduly reductive. Hospitals have always inevitably had a multiple or at least a *dual* identity. They are at one and the same time places of scientific and technological innovation and places for the provision of social services: they receive salaried personnel and personnel moved by a spirit of voluntary service; they receive public funds and private funding; and they have the purposes of a company and humanitarian purposes. In their setting are expressed, in the most extreme forms, the most characteristic bioethical dilemmas. The impossibility, for hospital institutions, to address these dilemmas with their own internal resources and with their internal professional skills and expertise explains the presence within them of *independent* ethical committees. It is, however, specifically in hospitals that are expressed in the most extreme forms the problems of desisting with treatment acquired by the nature of exaggerated treatment, the problem of the allocation of (inevitably scarce) resources, the problem of the treatment of minors, and the problem of conscientious objection on the part of health-care personnel or anyway of the refusal by such personnel to engage in practices that are held to be scientifically not indicated or ethically contestable, etc. etc. The list could go on for a long time.

6. The problem of problems is that of hospitals 'under religious sponsorship', to employ a typically Anglo-Saxon phrase: hospitals which both because of their ownership and because of their management or anyway because of their image can have a religious label. In Italy, obviously enough, they refer back, with a few rare exceptions, to the Catholic Church, but in other countries, and most markedly in the United States of America, one much more frequently finds *Islamic, Lutheran, Adventist, Presbyterian or Methodist* hospitals, or ones connected with *Jehovah's Witnesses*.

7. Naturally enough, it is not the religious reference as such that creates the problem. Indeed, this is increasingly invoked as the optimal solution by which to direct the patient to identify that place of treatment which is most coherent with his or her vision of the world (this has been expressed, and with great vivacity, by Tristram Engelhardt Jr.). The problem lies in the tension that inevitably comes to be established between the identity of a *religious* hospital and its *vocation*, what is in general today expressed by the term 'mission'. Those who believe that illness, medicine and healing are fundamental anthropological experiences, undergone in a fundamentally homogenous way by all men and worthy of being addressed in an equally homogenous way whatever the religious identity of the patient, will see in *religious* hospitals the simple manifestation of the purest Hippocratic spirit, marked by a noble ideology and always, and whatever the case, directed towards the good of the sick person. Those, instead, who believe that the experience of illness, of medicine and of healing are culturally directed and anthropologically *differentiated*, starting with visions of the world that are held to be irreducibly multiple and mutually irreducible, will see in religious hospitals the definitive proof of the irreversible fragmentation of modern medicine, which has become by now definitively post-Hippocratic and structurally defined by a mere *functional* orientation. In this approach a physician, from being a healer, becomes a *technician of the body*, and his or her action acquires a justification that does not start from an incumbent attention to the *good of the patient* but from a *formal* request for a service based on a contract, a request which can come to him or her from the patient himself or herself or – when this is the case – from the health-care system by law, for reasons of a social character. In this second approach, there is no *qualitative* difference between medicine that

treats the body and medicine that strengthens it, between therapeutic surgery and aesthetic surgery, and between sterility treatment carried out to assure so-called 'reproductive rights' or even for mere eugenic purposes. The very category of 'medicine', comes in fact – always in this last approach – to lose its identity, coming to be identified (without any problems of an epistemological or ethical kind) with the category of 'manipulation'.

8. We can return at this point to the beginning of my analysis. Hospitals today are *dangerous* places, not only for medical reasons – because, that is to say, unexpected pathologies can be developed within them – but for *ethical* reasons: they are settings in which today a (probably) decisive battle is being fought for those who hold dear the Hippocratic paradigm, with everything that this paradigm brings with it, as regards principles that are not only bioethical but also, and above all else, anthropological in character. In the view of many people, indeed, the hour has now come to recognise that hospitals, because of the exaggerated functional characteristics that increasingly mark them out in modernity, are demonstrable proof of the superseding of Hippocratic medicine and the triumph of functional medicine. Those who generously seek to counter this dynamic with generous attempts *to make hospital institutions ethical* probably do not perceive that the core of the question is not that of giving to science and technology a varnish of being ethical but that of *bringing out within science and technology themselves the dimensions of being ethical*, and these are dimensions which continue to be systematically marginalised, if not rejected. From this point of view as well, therefore, it appears that one can observe that at the roots of hospital bioethics there are the same problems, which are widely unresolved, that torment general bioethics: these are unresolved problems because they are *meta-bioethical* in character, because in large measure they are anthropological. These are problems that concern our identity and which arose when the possibility was seen of proceeding to a total and extreme manipulation of the living, whether human or non-human.

Hospitals as Guardians of Life

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Hospitals Suited to the Defence of Life

When one speaks about hospitals and their function in caring for public health, reference is made to the criteria for assessment that are indicated: by the organisations at an international level, and connected with emerging countries, that constitute points of reference; by a comparison of experiences connected with health-care management in various countries; and by the evidence of medical-scientific literature.

In a publication of 2008 of the European Observatory on Health Systems and Policies and the World Health Organisation entitled 'Assuring the Quality of Health Care in the European Union', emphasis was laid on the various basic criteria which can be used for a suitable assessment of the quality of services that are offered in the health-care field according to the highest standards: the availability and allocation of resources; fairness and care in the choice of expenditure; the organisation and efficiency of the use of resources; the suitability of clinical conduct derived from interaction with the scientific evidence; the efficiency and safety of treatment; care for the patient: continuity in the gathering, reliability and transparency of information; the impact on public health; satisfaction of the expectations of the general public and workers in the sector, etc.

All of this is asked of a hospital such as ours which, as it belongs to a university community, is called to make a contribution of excellence in service to man and to scientific progress. To achieve these objectives, constant cultural enrichment is required in interacting with the social context in which it works and with the international scientific community, as well as a careful management of resources in order to value them but also to identify the priorities as regards their allocation. When one adopts the perspective of a hospital that works within a Catholic university, its commitment to the defence of life must be very precise because of the deep motivations that underlie its existence. One is dealing with making a contribution of excellence which, even before being expressed in terms of statistics of efficacy or surplus budgets, is expressed in practical terms in state-of-the-art health services directed towards the defence of human life from its origins to its natural end.

The defence of unborn life con-

stitutes a priority commitment for a Catholic university. For years our university has stood out for the attention it has paid to pregnancy at various stages and in the treatment of any pathologies that may interfere with its normal physiological processes.

Our School of Obstetrics and Obstetric Pathology has a consolidated tradition and a capacity for innovation which means that it is esteemed at a national and an international level.

Today, however, the international context has presented us with challenges which are increasingly difficult as regards our commitment to the defence of unborn life.

25 July 1978 is a date that entered history because of the birth in Great Britain of Louise Brown, the first child 'produced' in a test tube (the first 'test tube baby') using the technique of *in vitro* fertilisation, which was the work of the physiologist Robert G. Edwards in cooperation with the laparoscopist Patrick Steptoe.

By a fortuitous coincidence, on the same date the Catholic Church had promulgated ten years previously the encyclical *Humanae Vitae* on the transmission of human life, in which, starting from the very nature of man, the personal and relational nature of human sexuality and its intrinsic procreative finality were affirmed, as a result of which in the conjugal act of a man and a woman by nature there exists an indissoluble link between its unitive and its procreative meanings.

Humanae Vitae proclaimed that human nature, by nature, has its origins, according to the creative design of God, in the act of love that unites a man and a woman.

Today we can understand in a better way the prophetic value of this encyclical which proclaimed the dignity of procreation in an epoch when nobody would have imagined that one day human life could originate outside the warm nest of conjugal love and become a product of a manipulation in the hands of biologists and the technicians of reproduction.

The possibility of individuals outside a couple appropriating to themselves the mystery of life, becoming arbiters of its destiny and disposing of it without reservations, opened the field to one of the most controversial and disturbing debates that the history of man can remember and which can be captured in the following question: when does human life begin?

The Origin of Life: Fertilisation

Biology, development embryology and genetics have agreed for over forty years that an individual of the human species begins to exist at the moment of fertilisation, as was declared by the famous and never contradicted *Chamber's Encyclopaedia*: 'Pregnancy is a time when the foetus develops inside the womb of the mother, between fertilisation and birth' (Jeffcoate 1969) and by a famous work of medicine: 'For the new individual life, begins in the ampoule of the uterine tube with the act of fertilisation' (Scothorne, 1976).

What is a human embryo? The human embryo is an individual who belongs to the human species, as the geneticist Angelo Serra and the biologist Roberto Colombo write: 'the logical induction from the data provided by the experimental sciences leads to the only possible conclusion, and that is that – apart from chance events involving disturbance – at the fusion of the two gametes a new real human individual begins his or her existence, or life cycle, during which – given all the necessary and sufficient conditions – he or she will realise all of the potentialities with which he or she is endowed. The embryo, therefore, from the time of the fusion of the gametes is a real human individual and not a potential human individual'.

It is with the act of fertilisation, that is to say at the moment of the union between the male germinal cell and the female germinal cell at the level of the third distal of the fallopian tube, that a substantial mutation takes place and a new human being is constituted with an individual and unrepeatable genetic inheritance which allows him or her to be an active subject of his or her own construction and intrinsically autonomous in his or her continuous, gradual and coordinated growth. The embryo, therefore, is a human individual starting with fertilisation (Carrasco, 2010, Ventura Juncà, 2011).

In preparation for fertilisation, two highly specialised cells, one derived from the man (the spermatozoon) and the other derived from the woman (the egg soul), are subject to a series of modifications which have two specific objectives: to prepare the spermatozoa for fertilisation (capacitation) and to reduce in both germinal cells the number of chromosomes to a half of the number of the somatic cells, that is to say from 46 to 23 chromosomes (the process of meiosis). This reduction is necessary otherwise the fusion of the male cell with a female cell would have as its result an individual with a number of chromosomes that would be double the normal (Savada, 2010).

The broad variability assured in the gametes by meiosis is provided by two kinds of 'remixing' during the first meiotic division.

Firstly, the chance distribution of the paternal and maternal homologous chromosomes: during the first stage of the metaphase, the maternal and paternal chromosomes have the same likelihood of being aligned on one side or the other, with the possibility, therefore, of a 'remixing'.

Secondly, recombination with an exchange of portions of genetic material between couples of maternal and paternal chromatids (the sub-units of which the chromosomes are made up) through the phenomenon of meiosis called 'crossing-over' which further increases the potential genetic variability of the gametes and the children that come from this. The potential of the genetic variability generated by meiosis is astonishing. The possible number of different combinations for the independent segregation of 23 pairs of chromosomes in spermatozoa or oocytes is 2^{23}= 8,388,608 different germinal cells (Klug 2007, Cain, *Discover Biology,* third edition, W. W. Norton & Co., 2006).

Thanks to such a genetic variability between the gametes at the

moment of fertilisation, an enormous number of combinations of chromosomes is made available. Given that in a human individual (diploid), the genetic information is contained in the form of couples of homologous chromosomes, one coming from the mother and the other from the father, at the moment of fertilisation one can obtain 2^{23}= 8,388,608 x 2^{23}=8,388,608 = over 70,368 milliard possible genetic combinations, to which should be added the effect of crossing-over. This is a practically unlimited variability which constitutes the highly sophisticated biological mechanism on which is based the *uniqueness and never to be repeated character of each human individual*, as well as the variety and natural turnover of the population.

A recent sentence of the European Court of Justice (ECJ) of 18 October 2011 in Luxembourg defined the 'human embryo' as every 'human ovule from the stage of fertilisation' given that 'fertilisation is such as to set in motion the process of development of a human being'. For this reason, in the same sentence the directive was issued to the effect that one cannot patent a procedure which, in resorting to the removal of stem cells taken from a human embryo at the blastocyst stage, involves the destruction of the embryo itself.

The Advent of Artificial Fertilisation Techniques

Over the last thirty years we have witnessed a decisive acquisition of power by man over life and over man himself as regards his wide 'genetic-germinal' identity. This is a power that is as exalting as it is worrying and it is without precedent in human history: scientific research, and genetic research in particular, has no longer confined itself to knowledge about, control of, and responsible transformation of, nature, as it had always traditionally done. It has gone 'beyond' this.

In Italy, Law 40 of February 2004 tried to establish limits in order to introduce order into the so-called 'procreative far west' that had been created. Article 2 of that law reads: 'Resort to medically assisted procreation is allowed when there are no other effective therapeutic methods to remove the causes of sterility or infertility'. Sterility caused by pathologies of the peritoneal tube is the first of these conditions.

In reality, in daily practice, the tendency prevails to by-pass any sort of diagnostic examination of a sterile couple and to see so-termed 'medically assisted procreation' as a first option.

Article 13 of the same law provides the rules for the defence of the embryo: a prohibition on clinical and experimental research which is only allowed for the purposes of the health of the embryo, as well as a prohibition on the eugenic selection and manipulation of embryos and gametes.

In article 14 Law 40 prohibits the freezing and then conservation of embryos. However, following a change made by a sentence of the Constitutional Court to section 3 of the same article, it was indicated that the transfer of embryos must be carried out 'without prejudice to the health of the woman', a phrase which raises by means few problems at the level of interpretation and keeping open the possibility that at the discretion of the agent the freezing and conservation of embryos can take place as a foreseeable and planned act and not only as a consequence of a grave and documented cause involving greater force, as was indicated in the original version of the law.

The regulations of Law 40, however, could not avoid sterile couples from deciding to go to other nations where such practices are used without any obstacles, giving rise thereby to the practice of so-called 'reproductive tourism' (De Geyter 2012). In the most famous social networks, indeed, it is not rare to see advertisements that propose the donation of gametes or state-of-the-art techniques of artificial procreation. The complexity of the problems, the delicacy of the applications and the rapidity with which it is necessary to formulate questions and provide recommendations for ethical reference points, are thus clear manifestations of the emergency that is expressed by bioethics.

When we compare the procedure of FIVET ('Fertilisation in Vitro and Embryo Transfer') with the process of natural reproduction, substantial differences are highlighted: only 5-7% of oocytes obtained during the FIVET procedure produce a pregnancy and only 10-15% of the embryos lead on to the birth of a child. This means that for every 'babe in arms' obtained through FIVET, 80-85% of the embryos produced are lost (Kirkegaard, 2012). The transfer of more than one embryo has had the intention of improving the results but it has led at the same time to a marked increase, over the last ten years, of levels of multiple pregnancies, with consequent complications for the mother and also for the foetus.

The tendency over time has been to reduce the levels of twin pregnancies after FIVET, maintaining a good level of births after FIVET. To this end, increasing importance has been given to the selection of embryos, that is to say to that stage which seeks to identify the embryos of higher quality with the aim of assuring higher levels of success. The technique of selection that is widely used is based upon the microscopic observation of the morphological characteristics of the embryo and its level of cleavage. This technique has been shown to be sufficiently effective for the identification of embryos with a good implantation potential but it is not always able to identify genetically abnormal embryos. It is known that a relatively high proportion of embryos produced following the use of IVF are genetically abnormal (Kirkegaard, 2012). However, they can appear to have normal morphological characteristics when examined through the microscope. Pre-implantation genetic screening subsequently represented a more sophisticated technique directed towards identifying aneuploid embryos before their transfer. New methods are now being studied, although they are not yet available for clinical use, to achieve an increasingly effective selection of embryos in order to improve the implantation

rates. One of these techniques, namely 'Time-Lapse Monitoring', involves the constant observation of an embryo through a video camera applied to the incubator in order to register on film the dynamics of its development and thereby register signs of weakness or asynchronism in the sub-division (Kirkegaard, 2012). The improvement in levels of efficacy in techniques of *in vitro* fertilisation has witnessed a parallel increasingly fierce 'hunt' for embryos that are defective because of the procedure of manipulation itself. This is to say that more are produced to select more and to improve the standards of production.

The latest data of the European Register of the ESHRE (the European Society of Human Reproduction and Embryology) on the use of reproductive techniques in thirty-six European countries in the year 2008 in 1,051 clinics report a pregnancy rate through aspiration of the oocyte of 28.5% in the case of FIVET and of 28.7% in the case of ICSI. In the case of the re-implantation of frozen embryos ((97,120 out of a total of 532,260), the pregnancy rate with de-freezing was 19.3%. The cumulative percentage of births with FIVET and ICSI was 21.7%, almost the same as that reported over the last three years.

The Italian data, published in the report of the Ministry of Health of 28 June 2012, and relating to the activities of 357 centres for artificial reproduction in the year 2010, report, as regards direct techniques, that is to say where resort has not been made to the de-freezing of embryos or gametes, that out of a total of 44,350 patients and 52,676 cycles begun, the cumulative pregnancy rate for FIVET and ICSI was equal to 23.1% for cycles with oocyte removals. The use of ICSI was predominant and involves 84% of cycles with the removal of oocytes. The cumulative percentage (FIVET and ICSI) for live births from cycles with the removal of oocytes was 17.8%.

The same report of the Italian Ministry of Health informs us that from 103,587 transferred embryos, 11,964 pregnancies were obtained, of which 10,744 were monitored, with 8,161 births (1,772 multiple births) and 10,036 children born alive.

In the Italian data as well one finds an enormous discrepancy, which is described in the literature, between costs in terms of embryos, that is to say in terms of human lives, and assured results. The relationship between transferred embryos and births is 10/1. Such is the high price paid to assure the hoped-for result.

WHEN NEW LIFE DOES NOT BEGIN: ETHICAL SOLUTIONS IN THE FIELD OF STERILITY

The balance of thirty years in the use of IVF techniques with about four million children born in the world following IVF from 1978 until today (Finn H., 'The Baby Chase', July 23, 2011, *Wall Street Journal Online* URL), of whom 60% were born in Europe (Nygren & Lazdane, WHO, 2006), and the questions of the scientific community and of society, have increasingly brought out the need for solutions that are more congruous to, and safer for, the increasingly emergent problem of infertility.

Infertility is a condition that affects one in every seven couples (Templeton A., 'Infertility-Epidemiology, Aetiology, and Effective Management', *Health Bull.*, Edinburgh, 1995,53(5):294-298; Trolyce, 2011).

In the *World Report on Disability* of 9 June 2011 (WHO and The World Bank), infertility is defined as a 'disability from various points of view: the physical, the cognitive, the mental, the sensorial, the emotional and the developmental, in conjunction with each other as well'.

In developing countries secondary infertility is seen as one of the six conditions of maternal morbidity which remain ignored in the defence of maternal health (Hardee, Gay and Blanc, 2012, 'Maternal Morbidity: Neglected Dimension of Safe Motherhood in the Developing World', *Global Public Health* (2012), 1-15).

In the report of the World Health Organisation entitled 'Current Practices and Controversies in Assisted Reproduction, "Infertility and Social Suffering" 384-385' (Daar and Merali, 2001) it is emphasised that 'the media are often responsible for the creation of a very promising image of IVF and of what it can offer to an infertile couple. However, it is well known that in many countries the general public lacks basic knowledge about infertility, its causes and its prevention, as well as correct information about the realistic possibilities for the treatment of infertility'.

In the report of the Bertarelli Foundation's Second Global Conference, which was held in Prague on 16-17 November 2002, Lunenfeld (2004), a pioneer in the field of infertility, expressed himself in the following way: 'over recent years the advances in medical technology have offered hope to many sterile couples, above all in the developed world. However, the advances that have been made have raised new medical, ethical and social questions which require attention not only from health-care professionals but also from the whole of society… the use of these technologies of assisted reproduction should not take the place of a proven medical approach through individual examinations and diagnoses'.

It is this context that we should locate the function and originality of the Paul VI International Scientific Institute – ISI – for Research into Human Fertility and Infertility for Responsible Procreation. This is an institute that exists to defend life at its origins.

Eighty years after the foundation of the Catholic University, and at the time of the Great Jubilee of the year 2000, on 9 November 2000 the rector of the university, Sergio Zaninelli, gave His Holiness John Paul II, who was present at the inauguration of the academic year, the news of the creation by the university of a foundation dedicated specifically to the delicate and decisive sector of human procreation. This initiative was presented as the answer to the calls made by the Holy Father in his message for the Day for Catholic Universities of 5 May

2000 and for the Jubilee of Universities of 9 September 2000, when he expressed himself as follows: 'aim for a culture that assures the centrality of the person, his inalienable rights, the sacredness of life'; 'reaffirm the need for a culture that is truly humanist… become involved in the construction of a culture for the human person, do not give way to relativism, to pragmatism, to learning for its own sake'.

The Paul VI ISI Foundation for research into human fertility and infertility was created on 22 June 2001. In March 2003 clinical activity was begun with the opening of the ISI clinic for the treatment of sterility in couples, which was then flanked by research activity. The defence of life in the experience of the ISI coincides with the defence of life at its origins. This is a priority and delicate task because it is applied at the very moment that life comes forth.

Sectors in which the ISI is Involved

The operational sector connected with the Study Centre for the Natural Regulation of Fertility concerns the stage when the couple decides with a responsible choice to open itself or otherwise to welcoming a new life by taking advantage of the most modern instruments for knowledge about the rhythms of fertility (the most recent methods for the natural regulation of fertility). Knowledge about fertility opens up a pathway of self-awareness and the taking of responsibility of the couple which is a *distant preparation for welcoming life*. This takes place both through the professional contribution of workers in the sector in the field of consultation for the couple, through information and teaching, and through scientific studies in the field of the natural regulation of fertility.

The clinical sector connected with the ISI clinic. Specialist skills and knowledge are concentrated on the process which is at the origins of life in order to obtain a natural conception and foster the normal evolution of a pregnancy. Our work is directed towards defending life by following directly the stages that lead to its expression, intervening professionally upon what can alter the normal development of this process.

Clinical management involves:

The treatment of infertility in couples through an evidence-based diagnostic-therapeutic protocol which is innovative because of the fact that it involves in parallel both members of the couple, implementing a multi-specialist approach that envisages the contribution of a team of specialists (a gynaecologist, an andrologist, a gynaecologist who is an expert in reproduction surgery, an endocrinologist, etc.).

In our experience we have seen that in many cases it is possible to remove the causes of infertility and in particular to obtain successes even when there is a diagnosis of infertility rooted in the female tubes or a semen dysfunction (cases where the general tendency prevails of proposing only the artificial solution).

The recovery of the normal reproductive function places the couple in a condition of engaging in an experience that is completely different from that of artificial procreation: the couple can follow the coming forth of life as a natural event which involves them profoundly in the perception of a mystery.

The treatment of cases involving multiple miscarriage. Given that the causes of multiple miscarriage can be many in number and often interacting, a protocol is applied which envisages team work, with the involvement of a gynaecologist, an endocrinologist, a haematologist, a geneticist and other specialist figures.

The experience of repeated miscarriages profoundly marks the lives of the woman and of the couple. In these cases one observes the complexity of the events with which a new life comes into existence and the multiplicity of factors that can interfere with its normal evolution.

Every life that is lost is a defeat for a medical doctor who is called to utilise his or her knowledge to defend every life from the moment it comes into existence.

The efforts that are made are proportionate to the perception of the value of every unborn life that is entrusted to our care.

The Sector of Research into Fertility and Infertility

The role of the ISI in this field is fundamental in the advancement of knowledge about the physiology of production, the study of causes that are still unknown of infertility in men and in women, and progress in the diagnostic process and therapeutic solutions within the framework of natural procreation. On this sector depends the future developments of what the ISI wants to do for the scientific community.

The clinical activity of the ISI, ever since it was begun, has witnessed an increasing presence of couples and a constant increase in the services that are available and in correlated research activity.

With respect to the strong points of our protocol (reconstructive surgery and andrological research), it is useful to examine the salient aspects of the pathologies that are taken in hand, the forms of treatment that are undertaken, and the results that are obtained.

Sexually Transmitted Diseases as a Fallopian Tube-Peritoneal Factor in Sterility: Prompt Diagnosis and Pharmacological Treatment

The normal process of reception and fertilisation of the oocyte released by the ovarian follicle at the moment of ovulation requires a whole series of pre-requisites: an ovarian surface free from adherences, the fimbric-ampoule portion of the tube being free to receive the ovary and, in addition to the tube being pervious, a normal activity of the ciliary and secreting cells within the tube and a normal peristalsis of the muscles of the tube.

This condition of highly specialised normality (the presence of chemical tactical factors which, freed from the mature follicle, make the terminal part of the tube draw with its fimbrias near to the ovarian follicle in order to facilitate the reception of the mature

oocyte freed at the moment of ovulation, has been demonstrated), can be compromised as a result of infections that rise up from the lower genital tract.

Pelvic Inflammatory Disease

Over the last two decades the growing spread of sexually transmitted diseases has put at risk for many women the possibility of achieving pregnancy by natural pathways by altering the abovementioned normal relations between the tube and the ovary.

Pelvic inflammatory disease (PID), the most important of the sexually transmitted diseases (STD), is due to the ascent of pathogenic microorganisms from the vagina and the cervix to the upper genital pathways (endometrium, tubes and contiguous structures) (Centre of Disease Control, 1982).

Recent epidemiological data (Haggerty, 2010) indicate that pelvic inflammatory disease afflicts 1.7% of women between the ages of 16 and 46 in the United Kingdom every year, 8% of women of reproductive age in the United States of America, 15% of Swedish women during their lives, with more than a million women treated for this condition every year in the United States of America.

The rate of sterility of tubal origins is 12% after an episode of PID, 23% after two episodes, and 53% after three episodes.

The prevention or reduction of important negative consequences of acute PID for the female genital apparatus requires prompt diagnosis and the implementation of a swift and appropriate anti-microbe therapy.

Because of this, it is of fundamental importance that a medical doctor who works within a hospital institution knows about the most recent change in the guidelines of the Center of Disease Control of Atlanta (Georgia) on PID which were published in 2010.

According to the recent guidelines, all women who are sexually active and have pain at a pelvic level or in the lower abdominal quadrants should be treated for PID, if another cause for the morbose condition cannot be identified, in the presence of one or more of the following minimal criteria: pain on lateral movement of the uterine cervix with bimanual exploration, uterine pain, adnexal pain.

These guidelines suggest appropriate protocols of treatment with antibiotics by intravenous infusion, taken orally, and criteria for the hospitalisation of patients with PID in order to prevent the negative consequences of PID for female fertility.

The Tubal-Peritoneal Factor in Sterility: the Surgical Treatment of Female Sterility

Sterility of tubal origins is responsible for about 25-3% of cases of female sterility. The principal cause of the tubal-peritoneal factor in sterility is damage caused in previous episodes of pelvic inflammatory disease, resulting from the rising up of sexually transmitted infectious agents into the reproductive tract. These infectious episodes can give rise to a declared clinical picture or a sub-clinical form. The last three decades have witnesses a notable increase in this component of female sterility. Previous surgery and endometriosis are another two causes of pelvic adherences.

In assessing the results of reconstructive surgery we must bear in mind that whereas it is possible to re-establish normal anatomical relationships that have been distorted by the production of adherences because of the process of infection by surgical means, it is not possible to repair functional damage that is caused by the process of infection (for example the working of the endo-tubal epithelium, the capacity to contract of the tubal musculature). The success rates of surgical treatment are thus closely correlated with the kind of pre-existent damage and its location. Recent advances in laparoscopic equipment and the increased skills of surgeons in surgical laparoscopy now allow laparotomy to be avoided in the majority of cases.

The introduction of salpingoscopy which allows a direct assessment of the tubal mucus, has allowed a better selection of patients as candidates for reconstructive tubal surgery through the identification of those who have a good reproductive prognosis.

Lastly, as regards the results of surgical therapy, to summarise we can state that the proximal occlusion of the tube, a frequent cause of directing patients to FIVET, is a false positive in probably near to 96% of cases (Al Jaroudi, 2005). In the case of peri-tubal adherences the mucus inside the tube is conserved in 80% of patients and these last can expect a likelihood of a completed pregnancy of roundabout 70% . Patients with distal tubal occlusion have a normal mucus in about 40% of cases and these cases have a 40% chance of a completed pregnancy.

Sterility Associated with Endometriosis

Endometriosis, defined as the presence of tissue of the endometrium, of glands and of stroma in sites outside the uterine cavity, is present in about 7-10% of the female population of the reproductive age. In sterile women the presence of endometriosis rises to 25-30% whereas about 30-50% of women with endometriosis have sterility (ASRM, 2006).

Conservative laparoscopic surgery is seen as a front line treatment by recent guidelines and allow the obtaining of pregnancy in 50% to 60% of cases.

In the experience of the Paul VI International Scientific Institute, 143 patients with suspected or ascertained sterility of tubal-peritoneal origins had a diagnostic or operative laparoscopy, with peritoneal or endometrium salpingochromoscopy, salpingoscopy (when indicated), associated with diagnostic or operative hysteroscopy. Nine of them had minilaparotomy for intramural/sub-mucus myomas or voluminous/multiple intramural myomas subsequent to hysteroscopy and salpingochromoscopy.

The patients were subsequently contacted by telephone in order to obtain information on possible pregnancies and their outcome. The average follow-up was 49

months (the range was from 11 to 118 months).

Of the 152 patients, 61 women achieved pregnancy (40%). Of these, 27 patients achieved more than one pregnancy. In total, 94 pregnancies were obtained. 23 pregnancies were ended by a miscarriage (24%), 2 were extrauterine pregnancies and one patient decided for VIP after a diagnosis of Down syndrome. In total, 32% of patients received a 'babe in arms'.

Treatment of the Male Factor in Sterility

Aetiological therapies for male infertility, that is to say therapies designed to eliminate the cause of infertility and in this way obtain a conception, pre-suppose and follow an attentive diagnostic process that seeks to find the pathogenesis of the infertility.

Amongst the aetiological situations that are most frequently encountered in male infertility are endocrinal pathologies such as male hypogonadism; hypoprolactinaemia; tyroid pathology; infectious diseases affecting the genital apparatus; and varicocele, that is to say a dilation of the vessels of the testicular vein plexus

A correct diagnostic-therapeutic approach thus allows a search for such situations which give rise to infertility as well as intervention through medical or surgical therapy designed to overcome such situations.

In the presence of alterations in the semen parameters, of a severe character as well, a complete diagnostic-therapeutic process has to be followed which seeks to identify and where possible resolve the causes of such alterations. This approach in many cases allows an improvement in the quality and the parameters of the semen, although not reaching levels that are considered to be 'normal' (normospermia), such as to allow a spontaneous conception.

This is confirmed by the experience of the Paul VI International Scientific Institute which was described in a recent scientific work published in the *International Journal of Endocrinology*. Indeed, the analysis carried out by Milardi *et al.* demonstrated that only 35% of conceptions achieved from 2003 to 2011 came about in the presence of normal semen parameters and that in the majority of pregnancies (65%) the husband had alterations in at least one semen parameter. Of these, 9% had a reduction in combination that ranged from moderate to severe of the three principal semen parameters (oligoastenoteratospermia). This fact highlighted that a reduction in the semen parameters does not exclude the possibility of a spontaneous conception. Every patient should thus be able to have access to an in-depth diagnostic and therapeutic assessment, even when the prospects of obtaining 'normal' semen parameters appear low.

WHEN LIFE HAS BEGUN

Correct Consultations as Regards Fears about or the Risks of Pregnancy: the Red Telephone

This is a telephone line for future or recent mothers. It is called the 'Red Telephone' and it is a special free service of the Study Centre for the Defence of the Health of Mothers and the Unborn Child at the Catholic University of Rome. It offers information and clarifications 'at home' for the prevention of congenital defects of neonates and an assessment of teratogenic risks (factors that can cause malformations in the embryo), for example involving the taking of pharmaceuticals during pregnancy. The Red Telephone provides medical consultancy during the pre-conception stage, during pregnancy, or during breastfeeding to those who ask for it: for example couples, and in particular women who wish to have a child or who are during the first stages of pregnancy, but also general medical practitioners and other socio/health-care workers. The consultation is given by medical doctors who are specialists in obstetrics and gynaecology with a particular competence in the field of prenatal medicine, pregnancies at risk and clinical teratology. An assessment of the possible reproductive risk also takes advantage of specific data banks that are available at an international level. The Red Telephone is indeed integrated into a network of homologous services (the Teratogen Information Service) at a European (ENTIS) and extra-European (OTIS) level, with which there is a relationship involving a constant exchange of information connected above all else with the rarest or newest questions and issues.

Repeated Miscarriage

Reference is made to repeated miscarriage when in the obstetric history of a woman two consecutive episodes of miscarriage take place during the first twenty weeks of pregnancy. This condition is to be found in about 1% of couples of the fertile age. Recurrent miscarriage, is, instead defined as the presence of three or more consecutive episodes of miscarriage. At the present time, reference is made generically to multiple miscarriage and screening is done for this starting from the second consecutive episode of miscarriage. In the majority of cases of multiple miscarriage it is not possible to find a certain cause at the base of this problem. However, amongst the principal causes known as factors that involve a predisposition to recurrent miscarriage one may identify chromosome anomalies (5%), uterine malformations (15-27%), and pathologies in the mother (20-50%), such as infections of the genital tract, exposure to medical products and toxins, endocrinal alterations, and congenital and acquired thrombophilias.

The ISI has the basic task of investigating the principal causes of repeated miscarriage through clinical and basic research and of suggesting new therapeutic approaches in order to reduce the incidence of repeated miscarriage and to protect the initial development of the foetus.

Pregnancy

Pregnancy is a physiological condition accompanied inescap-

ably by a series of modifications relating to the whole of the female organism. As a consequence of these changes, during the pregnancy (and for a certain period after birth as well) some chronic pathologies can temporarily change their development (both for the worse and for the better) whereas other specific pathologies of pregnancy can arise. Albeit always within the inescapable unity of the foetus and the mother, some of these directly concern the foetus and what is connected to it, whereas in other cases the symptoms that arise are prevalently ones of the mother. We can thus encounter neuro-vegetative phenomena such as vomit and nausea, which are typical of the first three months, with an incidence of 60-80%. Amongst the commonest illnesses we find gestational diabetes (with an incidence of between 1% and 3%), for which a screening is required of all pregnant women between the twenty-fourth and twenty-eighth week of pregnancy through an analysis of the curve of the glycemic load. A second pathology that can be encountered quite frequently is hypertension induced by pregnancy which affects about 5-10% of pregnant women. One should also add that that this condition can complicate further and develop into preeclampsia/eclampsia (up to 3-7% of pregnant women, including light forms) or the more fearful HELLP syndrome (4-12% of patients with preeclampsia), which is characterised by a multi-organic involvement with a possible rapid compromising of the pregnancy. An alteration of the hepatic parameters can, in addition, be present within the framework of the so-termed 'intra-hepatic cholestasis of pregnancy' where there is an increase in the biliary acid levels and transaminase. Itching, however, remains a characteristic of this condition.

On the therapeutic front, in many cases the symptom is treated, and behaviour at the level of hygiene and diet are suggested which will help the patient to face up to the pathology. Whatever the case, reliance must be placed on the pharmacological sets of treatment allowed during pregnancy (as in the choice of anti-hypertension drugs and antibiotics) and the most effective therapies recognised by international guidelines. Taking all of this into consideration, it becomes evident that prevention and the education of patients is the first line of defence that should be used. Prevention means above all else 'pre-conception consultation', both in generic terms as regards pregnancy (and suggestions such as the simple but very effective folic acid supplements) and in specific terms for each patient. Those who receive chronic treatment need to reach pregnancy in optimal and stable physical conditions and with a suitable choice of medical products, in particular with the elimination of teratogens. Having to change chronic therapies during pregnancy without being able to foresee the effects in a precise way is not to be welcomed.

At a secondary level in pregnancy the woman should be educated in paying attention to her symptoms and to her behaviour, for example being attentive to diet, control of body weight, and the keeping of a blood pressure diary. All of this helps to decrease the risk factors for some of the most frequent pathologies mentioned above in order to avoid the development and the complications of the gravest. Amongst these, which may concern both the foetus and the mother, we may cite, for example, the hyper-development of the foetus, late miscarriage, neonatal prematurity, the inappropriate detachment of the placenta, renal insufficiency, CID, and in general post-partum mortality connected with the hypertension/preeclampsia/eclampsia complex. In the case of diabetes there is a risk of an increase in maternal infections, a pre-term birth, a worsening of the involvement of the micro-circle, malformations of the foetus (in particular of the heart, of the nervous system, of the gastro-urinary system and of the gastro-intestinal system), death of the foetus and even dysmetabolisms and their consequences during childhood.

It is evident, therefore, that the approach to pregnancy requires an attentive, targeted and continuous monitoring, as simple as this may appear in the absence of additional risk factors, and all of this to protect the foetus and the mother and thus to allow them to experience the pregnancy as a physiological, special and happy event in the life of a woman.

Malformations of the Foetus: the EXIT Procedure

The acronym EXIT refers to the so-termed '*Ex Utero Intraparthum* Therapy' procedure that literally refers to a treatment of the foetus outside the maternal uterus during the period of birth. This procedure is based upon the assumption that in a particular group of pathologies involving malformation to the foetus (voluminous neoplastic masses on the neck or the lung, anomalies of the larynx and the trachea, diaphragm hernias and congenital heart disease) there exists a high likelihood of obstruction of the upper breathing pathways such as to involve at the moment of birth the neonate being unable to breathe spontaneously with the risk of a severe reduction of cerebral oxygenation and as a consequence permanent damage if not also possible death.

Pathologies that cause malformations in the foetus and which may require an EXIT procedure at the moment of birth are, as has already been observed in this paper, voluminous neoplastic masses on the neck or the lung (such as lymphangiomas or teratomas of the neck, cystic adenomatoid malformations of the lung), anomalies of the larynx (atresia of the larynx) and of the trachea, diaphragmatic hernias and congenital heart disease. These are pathologies with a very low incidence, in some cases as low as 1:100,000-200,000 live births, and which are thus diagnosed before birth in a relatively 'sporadic' way in our country. However, the increasingly common use of policies of 'mass' screening in the obstetric-perinatological field, which has been made possible over the last twenty years by the 'systematic' use of screening methods during the first weeks of pregnancy, has meant that such diagnosis, and thus re-

quests for help in these highly complex cases, are constantly on the increase.

The EXIT method seeks to transform a 'critical' event involving high risk into a controlled and systematic procedure in order to reduce in a significant way the likelihood of grave neonatal complications. It can be summarised in the following phrases: 1. the planning of birth with a caesarean operation; 2. general anaesthetic for the mother in order to assure a relaxing of the maternal tissues; and 3. the partial extraction of the neonate from the uterus (in general only the head and shoulders) in order to allow the maintenance of a certain volume within the uterus itself (thanks as well to an infusion of a warm saline solution into the amniotic cavity) and to impede the separation of the placenta.

A caesarean operation using the EXIT procedure differs substantially from a traditional caesarean because of the fact that in a birth using EXIT the absolute priority is to impede the separation of the placenta (which must continue to provide oxygenated blood to the neonate during the manoeuvres indicated above). The second fundamental need is to obtain a sufficient level of anaesthesia in the neonate who can also be subjected to surgical manoeuvres in the case of an especially difficult intubation.

From these needs in July 2012 a joint initiative (in their respective fields of interest) was born of two internationally important medical institutions: the Catholic University of the Sacred Heart – A. Gemelli Polyclinic and the Baby Jesus Children's Hospital of Rome, two institutions that are strongly united by a shared Catholic approach and by a constant search for excellence both in the clinical/care field and in the field of scientific research. This initiative involved the establishment of a reference centre at a national level and the creation of a 'mixed' multidisciplinary team, one, that is to say, made up of specialists from both these institutions, to 'take responsibility for', and the prenatal and postnatal management of, pathologies involving those malformations to the foetus referred to above, and in particular for the use in selected cases of the EXIT procedure.

Preparation for Birth

Pregnancy and birth involve the woman, the couple and the environment that surround them in an experience that is not only physical and biological but which also relates to the mental, affective and intellective field. Today, obstetrics seeks not only to ensure women the medical care and treatment that are needed during pregnancy but also to provide hygiene and health-care elements, and ethical-social elements, that prepare them for pregnancy and monitor its harmonious development until the final moment of labour and birth. Pregnant women often say that have been given dramatic information about the pains of childbirth. It is the task of courses preparing women for childbirth to render 'non-dramatic' the problems connected with labour and childbirth and to reduce them to their proper level, describing them as a natural function of the maternal organism and creating conditions of serenity and self-control.

The course to prepare women and the couple for childbirth envisages seven meetings held on a weekly basis. During the course the meetings take place in the delivery room in order to foster encounter with all the professional figures who will accompany the couple within the framework of the experience of childbirth: obstetricians, anaesthetists, gynaecologists and neonatologists. The benefits of the course to prepare women and the couple for childbirth are also opportunities to pass time with other couples and for a greater involvement of the father in the pregnancy. The course also provides a weekly opportunity to ask questions between one obstetric examination and another and to develop confidence in a capacity to address labour and childbirth. All of this preparation leads to a reduction in the times of labour, a reduction in psycho-motoric agitation during labour and as a consequence less traumatism at the level of the pelvic floor.

The Role of the Obstetrics Team in the Delivery Room: the Obstetrician, the Gynaecologist and Neonatologist. Urgent Needs and Emergencies in the Delivery Room

The team, made up of an obstetrician and a medical doctor, of the delivery room has the task of receiving the pregnant woman in labour with empathy and of accompanying her throughout all the stages of childbirth, as well as assessing the state of wellbeing of the foetus during the stages of childbirth that involve dilation and expulsion. Although childbirth is a physiological event, there is no other setting in which emergency is experienced so often as in a delivery room

Real obstetric emergencies are those which take place in an unexpected and sudden way, that is to say they emerge from the 'normal'. In a few minutes the scenario can become complex and at times dramatic. It can be difficult to maintain the lucidity that is needed in order to remember everything that should be done or to make it happen; the team must be trained to deal with the prolapse of the funicle, an obstetric surgical birth, the dystocia of a shoulder, an emergency podalic birth, the separation of the placenta, an embolism in the amniotic liquid and post-partum haemorrhage. In order to deal with an emergency everything should be organised beforehand, everything should be planned beforehand, and communications should also be thought about and organised through the creation of local protocols that are practical and agreed upon.

Conclusions

The journey towards the birth of a new human life is a conquest achieved by stages that are not always easy and which require from those involved in service to unborn life competence, commitment, a spirit of cooperation and great passion for life.

But when one speaks about the origins of life, one requires, perhaps, greater sensitivity and care for a new life which, even before being visible only through a diagnostic examination, should be thought about and prepared for by fostering the natural process by which it can come forth in a way that is consonant with its dignity.

We believe that service to life at its origins, to which the ISI is called, is very important and of contemporary relevance not only for our university but also for the Church and civil society.

At a historical time when the logic of the global economy predominates, in the health-care field as well, it is difficult to assess the quality of service to life in economic terms or in terms of results that can be quantified.

The document of the WHO that has already been mentioned in this paper (World Health Organization 2008, on behalf of the European Observatory on Health Systems and Policies, 'Assuring the Quality of Health Care in the European Union'), like other publications on health-care policies, warns about the widespread error of basing judgement on the quality of services solely on results obtained in quantitative terms, inasmuch as they do not constitute the best measure of quality in the health-care field. In addition, some results of a health-care action can be identified often only after a period of time following that service (WHO 2008, Wareham, 2001, Brook, McGlynn and Melzer, 2001).

This is very true as regards all the services that a hospital like ours can activate in defence of frailest life: unborn life, beginning with its origins.

A preferential commitment to economic support for these services is today absolutely necessary and will in the future be a demonstration of the quality of a commitment that will never be running at a loss because life can never be a question of 'the market'.

Ethical Committees in Hospitals Today

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Georges Clemenceau, the Prime Minister of France before and after the First World War, declared: "War is too important to be left to the generals". There is a way in which the same thing can be said about health care. "Health care is too important to be left to the physicians." The existence and the function of ethics committees is one expression of this fact. The provision of health care is truly a communal affair.

It is striking that the Hippocratic Oath, the enduring physician's pledge to practice moral medicine, takes place in a communal setting, both celestial and earthly. The physician swears by Apollo and Asclepius, and all the gods and goddesses in front of the community. Only in the keeping of his sacred oath can he hope to enjoy respect from others. "While I continue to keep this Oath unviolated, may it be granted to me to enjoy life and the practice of the art, respected by all men, in all times." The gods and the family and the community are called to bear witness to the taking of this sacred oath.

The communal dimension of health care can be seen in this pagan oath as true to human nature. We are communal creatures. The communal character of the provision of health ought to be even more clearly seen when it is provided by the Church, by the Mystical Body of Christ. We are saved in community, in and through the Body of Christ. The moral strength of any one member of the Church strengthens the entire Body; the moral turpitude of any member of the Church weakens the entire Body. Ethics committees help to keep the healing ministry of the Church true to itself, true to Christ. One reason physicians take an oath is so that they will be provided divine and human support when they might be tempted to do something wrong for good reasons. One is tempted to euthanasia, for example, not out of hatred of humanity, but usually out of a sense of compassion and love for humanity, particularly this patient suffering here before me now. But as the physician might be tempted to do something wrong for a good reason, the community is there to strengthen him, to reorient him, to hold him to his Oath. "I will give no one a deadly medicine even if asked, nor counsel any such thing," as stated in the Hippocratic Oath. This helps keep the physician true to his calling even when a false sense of compassion might tempt him to do otherwise. And an ethics committee might be called upon to help the physician decide whether or not the removal of the feeding tube from this comatose patient in this particular circumstance might constitute euthanasia.

There is a way in which ethics committees in hospitals bear witness to the communal character of health care and to the uncompromising commitment of health care to the good of the patient. Ethics committees help health care professionals and institutions guard against ever violating the dignity of the human person. Ethics committees can help the health care

provider by developing institutional policies or protocols which clarify the demands of the moral law when they might not appear so obvious, for example, in an emergency situation.

In the United States the largest provider of health care after the government is the Catholic Church. And the Church, more than any other institution today, is committed to the principles of the pre-Christian Hippocratic Oath and the spirit of the Divine Physician, Jesus Christ. The Hippocratic Oath was always embraced by Christians as articulating in health care the demands of the natural moral law. In The Gospel of Life, Pope John Paul II referred to "...the still relevant Hippocratic Oath which requires every doctor to commit himself to absolute respect for human life and its sacredness".[1]

The Catholic Church is invariably forward looking as it addresses the ethical issues of any given age. This is particularly true with respect to the provision of health care, and in this case even with the use of ethics committees. Since 1973 the bishops of the Church in the United States have insisted that Catholic hospitals have ethics committees to assist in the provision of health care. On the other hand, ten years later, in 1983, the United States President's Commission for the Study of Ethical Problems in Medicine found that only about 1 percent of all hospitals even had ethics committees.[2] The Catholic Health Association, on the other hand, did a survey of its member hospitals and found that 92% had formal ethics committees.[3] It is only now that the accrediting agency for hospitals in the United States requires that hospitals give evidence of a functioning ethics committee before giving them accreditation.[4] Here we can see that the Catholic Church led the way in making use of ethics committees in its hospitals, a practice that has finally become virtually universal in the United States.

Ethics committees can serve a very useful role within a hospital helping it to provide the most humane health care possible. They do this primarily in an educational and an advisory capacity. These educational and advisory tasks take on their own unique character in *Catholic* institutions since they are aided by a highly sophisticated and developed moral tradition which the Church has refined over centuries. Even as the Catholic Church provides health care to ailing bodies and minds, she ought never forget that her ultimate task is assisting all people attain their ultimate goal, which is eternal life with God in the next.

In the United States, the bishops exercise their pastoral oversight of the vast health care ministry of the Church in part through a document known as the *Ethical and Religious Directives for Health Care Services*[5] which they issue themselves. In that document the bishops speak of the source of their ethical guidance for health care being the natural moral law clarified through divine revelation. "The moral teachings that we profess here flow principally from the natural law, understood in the light of the revelation Christ has entrusted to his Church."[6] The bishops go on to point out that these moral teaching are ultimately ordered beyond this life. "The dignity of human life flows from creation in the image of God, from redemption by Jesus Christ, and from our common destiny to share a life with God beyond all corruption. Catholic health care has the responsibility to treat those in need in a way that respects the human dignity and eternal destiny of all."[7]

The only thing that can place in jeopardy that common destiny of all, i.e., a life with God beyond all corruption, is sin, is acting against the dignity of the human person, either one's own dignity or that of one's neighbor. The moral tradition of the Church is an essential guide to assist everyone in the journey of life toward that ultimate goal. Ethics committees within hospitals ought to serve this role as well. They are not concerned about some abstract set of moral principles or in a code of ethics issued by some large bureaucracy. Rather ethics committees are concerned about safeguarding the dignity of the human person who has been entrusted to Catholic health care. As the American bishops state: "First, the Catholic health care ministry is rooted in a commitment to promote and defend human dignity; this is the foundation of its concern to respect the sacredness of every human life from the moment of conception until death."[8] This should be the ultimate concern of any ethics committee, secular or Catholic, i.e., respecting the dignity of the human person. It is just that the Catholic institutions understand the eternal significance of this and have received invaluable assistance in the task from divine revelation and the trustworthy moral guidance of the magisterium in *its* interpretation of the natural law.

The Task of Ethics Committees

Except in the most rare cases, ethics committees do not assume responsibility for actions taken in a health care setting; such responsibility rests with the health care professionals in their practice of their healing art or with the administrators who manage health care institutions. However, ethics committees can help establish protocols, institutional policies, and guidelines to assist those professionals. Physicians, nurses and other health care professionals often have to act quickly in difficult and complex circumstances. Protocols usually reflect the careful and reasoned deliberations of a health care institution, usually with the assistance of the ethics committee, to assist their professionals carry out their tasks in a way that is consistent with the mission of the hospital in its service to those who are weak and vulnerable.

The Composition of Ethics Committees

Perhaps it would be good to mention briefly the ideal composition of ethics committees before addressing their fundamental tasks. It is obvious that there ought to be representatives of the medical and nursing staffs on the committee. Since the administration of the hospital usually appoints

the members of the committee and since the ethics committee answers to the administration of the hospital, there should be a representative of the administration on the committee serving at least as a liaison if not an active participant. However, the composition of ethics committees should also reflect the communal character of the delivery of health care.

There are many more individuals than medical professionals who are needed to provide holistic health care to patients, and the ethics committee should reflect this. There should be representation from the chaplaincy program, for example, and social work. There should be someone trained in ethics. In areas where there is a diverse ethnic population, it could be important to see that there is representation from these groups since cultural differences are often very significant in the provision of health care. Some populations tend to be more passive in a hospital setting, perhaps unwilling to engage those providing medical services and reluctant to share information that might be vital for their care. Ethics committees would be aware of and sensitive to such matters.

Sometimes there is even the attempt to expand membership on an ethics committee to those outside the hospital setting itself but who are often essential in saving lives and providing care, such as paramedics, or even police or fire fighters who often have to respond in emergency situations. Such breadth in representation will assist the committee in carrying out its work.

The educational task

Perhaps the most fundament task of ethics committees is educational. The committee cannot provide advice if the members themselves are not well grounded in the art of medicine and in the moral tradition. And the community of health care providers in the hospital likewise cannot hear or receive the advice of an ethics committee if its members themselves are not educated and formed as well.

The educational task of an ethics committee can be undertaken in a number of ways. It is usually sufficient that these committees meet once a month, but someone on the committee should assume responsibility for the education of the committee members and the broader hospital community and establish an educational program covering a year or two. There have been many authoritative documents issued by the Church that can of great assistance in this task.

For example, an ethics committee could undertake a systematic study of the *Charter for Health Care Workers* issued by the Pontifical Council for Health Care Workers in 1995. There are very helpful magisterial documents. There are the teachings of the Popes themselves. Pius XII, Paul VI, John Paul II, and now Benedict XVI have provided encyclicals and allocutions addressing a wide range of medical moral issues. One the is the great encyclical The Gospel of Life, or the allocution by Pope John Paul II to the Transplant Society in August 2000 or his allocution on the provision of hydration and nutrition to patients in a persistent vegetative state which he delivered in April 2004. There are also formal documents issued by the Congregation for the Doctrine of the Faith such as its Declaration on Euthanasia in 1980, or *Donum Vitae* on the means of overcoming infertility issued in 1987 or *Dignitas Personae* in 2008. The Pontifical Academy for Life has also released a number of studies and analyses which can be of tremendous help in the educational task undertaken by ethics committees.

And of course there are the publications of approved authors, such as Cardinal Elio Sgreccia and his monumental work, *Manuale di Bioetica*[9] which has now been translated into English by The National Catholic Bioethics Center under the title *Personalist Bioethics*. There are certainly ample authoritative ecclesiastical publications which can be of tremendous help in the educational tasks of an ethics committee. There are also educational programs developed by various institutions such as Ascension Health in the United States. The National Catholic Bioethics Center has developed a year-long certification program which is principally offered on the internet and which can be utilized by anyone virtually anywhere in the world. It is targeted specifically at members of ethics committees. But whatever materials are utilized, a systematic educational program should be developed for the sake of the committee itself as well as those health care professionals serving within the hospital.

The consultative role

When one hears of ethics committees one often thinks first of its consultative role to physicians faced with difficult moral decisions. Even though this is not the most common task of the ethics committee, it can be of great assistance to individual health care providers and well as the larger community of the hospital. The consultation can be anticipatory, immediate or retrospective. The anticipatory consultation is perhaps the most helpful since the committee is able to study and reflect on ethical issues that might arise and to assist in the formulation of protocols and guidelines to be adopted by the hospital.

Unfortunately the consultative role of the ethics committee is sometimes falsely perceived as a disciplinary one. Physicians will sometimes not want their best medical judgment called into question by others who were not party to his or her care of a particular patient in a difficult situation. However, ethics committees have no policing powers and ought not to be seen as if they did. They are there to assist their peers and colleagues in the humane delivery of health care. Some professional societies or governmental bodies, such as legislatures, have ethics committees which do act in a disciplinary manner which is probably one reason why it is sometimes falsely understood to be the task of hospital ethics committees.

As an ethics committee provides counsel, it must be remembered that at the heart of the heal-

ing process of the care provided to the sick is the intimate and confidential relationship established between the physician and the patient. The ethics committee may be drawn into this relationship in order to facilitate it or enhance it but it ought to be *invited* into it. In the directives of the United States bishops, one reads of this sacred bond between physician and patient. "The person in need of health care depends on the skill of the health care provider to assist in preserving life and promoting health of body, mind, and spirit. The patient, in turn, has a responsibility to use these physical and mental resources in the service of moral and spiritual goals to the best of his or her ability."[10] The ethics committee merely assists in this intimate and sacred bond between physician and patient in the healing process; it ought never undermine it.

The Declaration on Euthanasia also speaks to mutual decision-making roles of the patient and the physician which must be respected. The physician brings expertise and competence in the medical arts and the patient determines what kind of intervention he or she is willing to accept. It is necessary to look to the competencies of the physician in assessing appropriate therapies. As the Declaration points out: "It will be possible to make a correct judgment as to the means [of treatment] by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources."[11] These complex questions clearly fall within the purview of those who have the professional competence to address them. However, the Declaration also speaks of the "reasonable wishes of the patient" assisted by "the advice of doctors who are specially competent in the matter."

The ethics committee, then, has a very circumscribed role assisting the physician and the patient and perhaps family members in making health care decisions. There are a number of tasks of the ethics committee in carrying out its consultative function. The committee can clarify institutional policy for the physician and patient, it can raise questions and issues which may not have been considered by those seeking its advice, it can explain what legal or regulatory constraints might be involved in the particular case under consideration, it can clarify the proper role of a surrogate decision maker for an incompetent patient, and it can apply the ethical norms of the Church which are in place for the sake of both the patient and the physician.[12]

It must be made abundantly clear that the ethics committee has no authority to make medical decisions. Its role is to educate and provide counsel to the decision makers. It ought not to be stepping in to assume the decision making responsibilities of the health care professionals or of the patients or their surrogates. One author writes: "…regularly assigning to ethics committee the task of making decisions on life-sustaining treatment could undermine recognizing the obligations of those who should be principally responsible."[13] And those who should be primarily responsible are the health care professionals and the patients. They cannot shift responsibility to an ethics committee. There are some jurisdictions in the United States which will designate an ethics committee as the final arbiter on disputed questions which might arise in a hospital. By and large, however, members of ethics committees assume no legal responsibility and are not at risk of legal liability for the advice they offer.[14]

There are those emergency situations, however, that can arise any time of the day or night and the chair person of the ethics committee might be called in the middle of the night and forced to convene a meeting of key members of the committee by phone or in person. Membership on an ethics committee is a task of service to others and should be acknowledged as such.

A brief word should be said about "Institutional Review Boards" or "Independent Ethics Committees". These committees are designated to approve and monitor bio-medical and behavioral research on human subjects. They might also be involved in the ethical oversight of drug trials. Most hospitals would have clinical ethics committees; Institutional Review Boards would be important for teaching hospitals which certainly can include Catholic institutions. Again, their fundamental concern would be in protecting and safeguarding of human dignity in research and so would have the same motivation as the clinical ethics committees.

As human beings, we are born and nurtured in community. As Catholics we are born again through baptism and nurtured in community. The provision of health care, whether Catholic or secular, is inescapably a communal task. Ethics committees provide an invaluable service to this communal task by assisting health care professionals and institutions remain true to their sacred calling through education and counsel.

Notes

[1] *Evangelium vitae*, March 25, 1995, 89.

[2] *Deciding to Forego Life-sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions*, President's Commission, 1983, 443-449.

[3] "Today's Ethics Committees Face Varied Issues", Lappetito, J. and Thompson, P., *Health Progress*, 1993 November; 74 (9): 34 – 9, 52.

[4] Joint Commission for Accreditation of Healthcare Organizations (JCAHO). Comprehensive Accreditation Manual for Hospitals. Oakbrook Terrace, IL: JCAHO, 1996.

[5] *Ethical and Religious Directives for Catholic Health Care Services*, Washington, D.C.: United States Conference of Catholic Bishops, Fifth Edition, 2009.

[6] Ibid., Preamble.

[7] Ibid., Introduction to Part Two.

[8] Ibid., Introduction to Part One.

[9] Elio Sgreccia, *Manuale di Bioetica Vol. 1: Fondamenti ed etica biomedica*. 2007.

[10] Op. cit., Introduction, Part Three.

[11] Congregation for the Doctrine of the Faith, *Bona et Jura*, May 1980, Part IV.

[12] See Daniel O'Brien, "HealthCare Ethics Committees: Purpose, Functions, and Structure", *Catholic Health Care Ethics: A Manual for Practitioners* (Second Edition), Philadelphia: The National Catholic Bioethics Center.

[13] Paul W. Armstrong, "Legal and Judicial Issues of Ethics Committees." In *Ethics Committees: A Challenge for Catholic Health Care*, 44 – 54. St. Louis: The Pope John Center and Catholic Health Association, 1984.

[14] Legal Aspects of Clinical Ethics Committees, J. Hendrick, Journal of Medical Ethics, 2001 April; 27 (Suppl 1): 50 – 53.

ROUND TABLE
Catholic Hospitals in a Changing World

1. Catholic Hospitals in Africa in a World Undergoing Transformation: 'Wells' of Encounter with Christ

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Introduction

1. I was happy to answer the request made to me to make my contribution to this round table and I will try to engage in a modest analysis of the questions and issues relating to the need to adapt our Catholic hospitals in Africa to their vocation as settings for evangelisation in this world which is undergoing transformation. I will do this in the awareness that the subject of this conference was chosen specifically to have us share in the concern of the Church to engage in a new evangelisation, we who are engaged at varying levels of proximity in pastoral care in health. The *Instrumentum Laboris* of the XIII Ordinary Assembly of the Synod of Bishops invites us to see in 'every activity of the Church an essential evangelising note' and to never separate it 'from the commitment to help everyone to encounter Christ in faith' (*IL*, n. 34). The final message of that assembly calls upon us to draw inspiration from the approach of Jesus at the well of Sicar in order to make our places of ministry or of apostolate – including hospitals – settings where we sit 'at the side of the men and women of this time to make the Lord present in their lives so that they can encounter him, because only his Spirit is the water that gives true and eternal life'.[1]

2. This is why I believe that it is important to reflect on the way in which our Catholic hospitals in Africa try to respond to this recommendation. And, taking into account the request to link my paper to the mutations that are underway in our world, it is advisable to try, subsequently, to engage in an identification of the challenges that are connected with the impact of these mutations, in relation to the vocation of these hospitals. In addition, it will be necessary to see whether there are not other challenges to be faced up to that are inherent in the situations that are typical of our continent because of its cultural traditions and its recent past. And we cannot but ask ourselves, lastly, what we should do to meet these challenges and to place, in an effective way, our pastoral ministry under the banner of the new evangelisation that has been urged by the Church.

Our Catholic Hospitals and their Vocation Today

3. We may observe first of all what we all know or can easily imagine: in Africa the number of hospitals in general, and Catholic hospitals in particular, is far from being sufficient when we take into consideration the rapid growth in the population and the multiplicity of illnesses that have to be addressed. Benedict XVI in his *Africae Munus* recognises this fact when he addresses the health-care personnel of the continent of Africa: 'Difficulties of every kind rise up along the way: the growing numbers of the sick, inadequate material and financial resources, the withdrawal of support by organizations which had helped you for years and are now abandoning you; at times all this can give you the impression that your work produces no tangible results'.[2]

4. It is in these very conditions that the pastoral action carried out in Catholic hospitals seeks to help those hospitals to answer their evangelising vocation by expressing witness to charity, by listening and sharing, by the explicit proclaiming of the Gospel and by the celebration of the sacraments.[3] There undoubtedly exist differences from one country to another or even from one area to another, both from the point of view of quantity and from the point of view of quality. Not being able to examine them all in order to identify their characteristics, I will confine myself to commenting on testimony received from the chaplain of the Hospital of Bukavu which is in the Democratic Republic of Congo.

5. In reading his testimony, I

note with joy that, although he concentrates principally on the activities of ordinary pastoral care, that is to say the expounding of the catechesis, the celebration of the sacraments, the animation of various devotions and the exercise of charity, the efforts involving evangelisation engaged in at his hospital include the formation of managers and the medical/health-care personnel and the use of the means of social communication. These are two encouraging advances when we consider the needs of evangelisation in an Africa that is not in the least immune to the effects of globalisation and the Western secularist revolution. What have these consequences been?

The Challenges that Still have to be Addressed

6. While there has still not been a recovery from the anthropological crisis[4] caused by the cultural shock of the 'irruption of the colonising West into its historical trajectory',[5] Africa today has to deal with the assault of the 'transnational agents of transformation' who are trying to 'change mentalities' in order to make it capable of being permeated by secularism.[6] This led Benedict XVI to say that 'Like the rest of the world, Africa is experiencing a culture shock which strikes at the age-old foundations of social life, and sometimes makes it hard to come to terms with modernity'.[7]

7. Amongst the challenges linked to the historical element that has already been cited, the most important are in practice those that the first Special Assembly for Africa of the Synod of Bishops deplored in its final message. It regretted, in particular, 'a frightening poverty, bad administration of scarce available resources, political instability and social disorientation'.[8] One thus understands how the difficult conditions indicated at the beginning of this paper as the context for the work of our Catholic hospitals did not begin yesterday.

8. But at the basis of these challenges which stare us in the face there are another three which I cannot but emphasise because of the potential they have to bear upon the lives and the management of our hospitals. One is dealing above all else with the survival of a mythical conception of reality, together with a mentality of resignation.[9] I mean by this a conception which holds that behind what happens as perceived through our senses there are invisible mysterious forces that have to be conciliated, according to the indications of people who are held to be experts in such matters, whether one wants to or not. This can also be described as a conception that involved magic and witchcraft. This mentality of resignation, in its turn, is characterised by a conscience that adapts itself to submission and to a concern to save both the fox and the chickens.

9. The second challenge of the series is that this conception and this mentality, which are deplorable, unfortunately coexist in by now means few Africans, with a consciousness that is dominated by an 'assistance complex'. Rather than relying upon their own personal efforts and upon pride in flying with their own wings, they base themselves on cliental systems, where a favour from an intermediary prevails over capacity and professionalism. As a consequence, this unhappy attitude bestows upon our countries a burden of clientalism and corruption, to the detriment of the common good and the development of the community.

10. Lastly, the third basic challenge that I cannot ignore is that of the very deep psychological wounds and violated memories which demand, respectively, to be treated and also healed. I believe that for all of this there is no need in the least for explanations. The wars and other forms of violence that our continent has experienced provide sufficient testimony of this. These are challenges which in my opinion underlie the others. They, too, are linked both to the cultural past of our countries and to the social (that is to say also ethical) disorientation mentioned above which was generated by the shock of colonisation.

11. Dealing now with the challenges connected with globalisation, they emerge easily from those that we find in the second chapter of the *Instrumentum Laboris* of the recent Synod of Bishops or in the fourth chapter of the encyclical *Redemptoris Missio* of the Blessed John Paul II. Taking into account the question of hospitals which is here the subject of attention, I believe that I should first and foremost cite secularism with its dual corollary made up of hedonism and relativism. Then there is the danger of falling into the trap of what the *Instrumentum Laboris* of the recent Assembly of the Synod of Bishops calls 'the culture of the ephemeral, of the immediate and of appearance' which is channelled by the information and communications technologies.[10] The third challenge connected with the phenomenon of globalisation, and which is of importance for pastoral care in a hospital context, has advanced with the proliferation of sects and consists of the risk of a utilitarian conception of religion which measures its authenticity according to immediate success or prosperity. Given that these are the challenges posed to evangelisation in our hospitals, what should we do to address them and thereby win the wager of conforming our hospitals to their vocation?

Future Prospects

12. Without having to dwell upon each of the challenges that have just been pointed out, I will immediately give you some suggestions for action which came to my mind, by intuition, while I was reflecting about the contents of this paper of mine. They are principally of a strategic and methodological character. The first is connected with the need to conjoin our efforts in order to engage in discernment and act in synergy. The second, on the other hand, concerns the need for formation and the spiritual and moral accompanying of medical/health-care personnel.

13. At the beginning of my paper I referred to the difficult conditions in which our hospitals work. In directing my attention to the common denominators of

our African countries, I did not ignore the great diversity of situations and I am well aware of the complexity of the challenges to be found that are contained within them. I thus believe that in order to address these challenges with a greater chance of success, our bishops' conferences and our pastoral workers should organise their work in synergy and in solidarity. As Benedict XVI reminds us in *Africae Munus*, confirming what was stated by the Fathers of the Second Special Assembly for Africa of the Synod of Bishops, 'the Church is a communion that gives rise to an organic pastoral solidarity'.[11] In the field of pastoral care in health, it is required that 'this communion appears in particular in the effective and affective collegiality of bishops in their ecclesiastical provinces and at a national, regional, continental and international level'.[12]

14. On this point I congratulate and thank the Pontifical Council for Health Care Workers because every year, through this international conference, it deepens in those bishops who are responsible for pastoral care in health a sense of the importance of this solidarity and calls on us to implement it in our respective countries. In doing this, I take the liberty of asking the Pontifical Council to do something more: *to think about organising for the continent of Africa and the islands off it, in cooperation with the SCEAM, an integrated meeting on the model of the meeting that was organised by the Pontifical Council for the Pastoral Care of Migrants and Itinerant People in the month of September last in Dar es Salaam*. A meeting of this kind would enable us not only to become aware of the importance of the synergy and solidarity that are called for – it would also help us to bring things to completion through an analysis of the shared challenges which have to be addressed and of how to discern more effectively the ways and means by which to do this.

15. In relation to the second suggestion as well, I think that this meeting would be for us an opportunity for a fruitful exchange of experiences on what we already manage to do in the field of the hoped-for ongoing formation. It would at the same time offer us a possibility to help each other to discern what still remains to be done. I have no doubt that such an event would also have the effect of engendering emulation and also encouragement for the diocesan and national systems of coordination of our health-care services.

16. A need for the ongoing formation of our managers and the personnel of our hospitals does not relate solely to the doctrinal, spiritual and moral aspects – it also refers to the managerial dimension. It is certainly the case, as the bishops of the recent Special Assembly for Africa of their synod emphasised, that 'we should continue to work hard in forming consciences and changing hearts, through an effective catechesis at all levels'.[13] But our dioceses and their works, as well, 'must be models of good governance, of transparency and of good financial management'.

17. Belonging to the same category of ideas, we cannot forget that our countries and our local Churches still suffer an evident need for medical and managerial skills and expertise. We should, therefore, invest a great deal in initial academic formation in order to achieve a better future for the performance of our hospitals. I was happy to learn that our Pontifical Council has invited representatives of our Faculties of Medicine to this international conference and to a meeting at which their colleagues will participate for an exchange on the situation of their institutions and their future prospects as well.

Conclusion

18. I will end my paper by expressing the wish and the hope that this initiative will help to promote a strengthening of the academic formation in question and the scientific research which our Catholic hospitals in Africa, indeed, greatly need. In the face of the transformations that are underway in our world, our hospitals cannot allow themselves to function as if Africa were immune to these transformations. Our continent is called to take advantage, to the extent that this is possible, of the scientific advances of our world, albeit conserving jealously the values which made Benedict XVI see Africa as 'the spiritual lung of humanity'. The Church, through her pastoral action, should help Africa to place these values at the service of mankind, as a sign of gratitude for the goods that it receives. If God wanted Africa to be the 'cradle of humanity' as we have known it to be hitherto, this is because Africa helps humanity to conserve the meaning of all these values today, values which are being undermined by the secularist culture transmitted by globalisation. The Church has the task of applying this idea and of drawing from it all its pastoral consequences. And it seems to me, on this point, that Catholic hospitals constitute a pastoral channel that should be privileged. ■

Notes

[1] XIII Ordinary Assembly of the Synod of Bishops, *Message to the People of God*, n. 1.

[2] Benedict XVI, post-synodal exhortation *Africae Munus*, n. 140.

[3] Cf. Ordinary Assembly of the Synod of Bishops, *Instrumentum Laboris*, n. 92.

[4] Cf. F. Eboussi Boulaga, *La crise du Muntu : Athenticité africaine et philosophie, Présence africaine* (Paris, 1977 and 1997).

[5] The phrase is taken from Kä Mana, *Théologie Africaine pour temps de crise* (1993).

[6] Cf. the paper already cited of M. Peeters given at the colloquium of Abdjan.

[7] Benedict XVI, post-synodal exhortation *Africae Munus*, n. 11.

[8] John Paul II, post-synodal exhortation *Ecclesia in Africa*, n. 40

[9] Cf. Michel Kayoya, 'Développement et mentalité rundi', paper given in March 1971 in Bujumbura.

[10] Cf. XIII Ordinary Assembly of the Synod of Bishops, *Instrumentum Laboris*, n.62

[11] Benedict XVI, post-synodal exhortation *Africae Munus* n. 105.

[12] Second Special Assembly for Africa of the Synod of Bishops, final list of propositions, n. 3.

[13] Second Special Assembly for Africa of the Synod of Bishops, *Final Message*, n. 19.

2. Asia: Catholic Hospitals in a Challenging World

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1. Introduction

'To be healthy' and 'to be fully alive' is everybody's dream. It is a basic human drive. Jesus' mission was to respond to this fundamental human yearning. As he said, 'I have come to give life, life in its fullness' (Jn 10:10). Christ gave the same mandate to his disciples, saying: 'Go and heal!' (cf. Mt 10:1; Lk 9:1). This is a mission entrusted by the Master. This major mission of the Church is so challenging and at the same time its exigencies are so demanding. The Holy Father, Pope Benedict XVI, when addressing the international conference organized by the Pontifical Council for Health Care Workers, on 15 November 2010 said: 'It is necessary to work with greater commitment at all levels so that the right to health is rendered effective, favouring access to primary health care'. The Holy Father further also said: 'Justice requires guaranteed universal access to health care, the provision of minimal levels of medical attention to all is commonly accepted as a fundamental human right'.

In this paper, I will first try to have a general understanding of the health scenario of India today, particularly the emerging challenges. The second part will be an attempt to understand better the healing mission of Jesus. In the third section, I will seek to outline a better understanding of the mission of the Church in India in the field of health in today's context, and in the last section I will analyse the challenges faced by Catholic health-care facilities in India.

2. An Update on the Health Scenario in India

In India, there has been a remarkable improvement in the health situation of people. There has been a gradual and steady growth in personnel, health-care facilities and the availability of some of the best treatment and care. This has contributed positively to the health situation of the people in our country.

2.1 New trends, new achievements

Through the initiatives of successive governments, and their attempts down the years to implement various national health programmes, the country has achieved great progress as regards the health situation of its population. There are some indicators which helps us to understand this advance.

The crude *birth rate* (CBR) declined from 29.5 in 1991 to 26.1 in 1999, while the crude death rate (CDR) declined from 9.8 to 8.7 per 1,000 people over the same period. The annual *population growth* rate declined from 1.97 in 1991 to 1.74 in 1999. The increase in *life expectancy* at birth rose from 58.7 in 1990 to over 62 in 2001. *Infant mortality* decreased significantly from 146 in 1951 to 64 per 1,000 people in 2001 (R. Misra, 2003, p. 12).

This substantial improvement in key health indicators is the result of many factors, including improved public health services, the prevention and control of infectious diseases, access to modern medical practices in diagnosis and treatment, as well as an overall improvement in the socio-economic situation (CBCI Health Policy, 2005, p. 3). According to government statistics, in 1951 the number of hospitals in the country was 2,685 but by 1997 it had grown to 13,692. During the same period, 23,015 new dispensaries came into being.

The new economic liberalisation policy of the government of India has involved a notable change in all sectors of Indian life, especially in industrial development, export growth, food and agriculture production, the utilisation of natural resources, etc. Globalisation has created many new highly specialised hospitals in our country. These 'state-of-the-art' facilities have brought new trends in health care, including 'medical tourism'.

2.2. A reality that is shocking

The aforementioned achievement is only one side of the coin! For the vast majority of people, especially the poor in the underserved areas, basic survival itself is still a daily struggle. Today, in our globalised and highly commercial world, despite the many advances in preventive medicine and therapeutic skills, for a vast section of the people health is a distant dream, both as individuals and as communities. Many people do not have access to affordable medical care. Basic necessities such as safe drinking water, sanitation etc. are still not available.

While preventable diseases are still major concerns in many parts of the country, chronic illnesses often related to lifestyle, behaviour etc. are on the rise, causing much suffering in most parts of the country.

India has more tuberculosis patients than any other country in the world. 'About 14 million people are estimated to be suffering from active TB, of whom

3 to 3.5 million are highly infectious. India accounts for nearly one third of the global T.B. burden and every year has more than 2 million new cases of tuberculosis. Approximately 2.9 million people die from tuberculosis each year worldwide; about one fifth of them in India alone. Nearly 500,000 die from the disease – more than 1,000 per day: nearly one every minute. The spread of HIV/AIDS would increase the number of TB cases, as well as deaths' (Ministry of Health, Report, 2000-01, p. 53).

Malaria has taken many lives over the past two or three years, especially in the northern States. According to the official statistics, malaria deaths were below 500 annually until 1993, but they more than doubled by the year 1995, and are now on the increase.

In India it is estimated that there are 2 to 2.5 million *cancer patients* at any given point in time, with about 0.7 million new cases every year and nearly half die every year (J. Kishore, 2001, p. 98).

Since the identification of HIV in 1986 in India, the rate of infection has been increasing at an alarming rate and reached 5.1 million people by May 2004 with an adult prevalence rate of 0.9 percent. Although India is still considered a low prevalence country, the absolute number of its current HIV cases makes India the second highest country next to South Africa. In addition, with the size of India's population, even a one decimal point of increase in the nation's HIV prevalence rate would result in an addition of about half a million new individuals to the total of HIV cases.

Every region in India is experiencing a snowballing increase in the spread of HIV. The infection has spread from people who practise high risk behaviour (sex workers, drug-users through injection, and people having same-sex relationships) to the general population (housewives and children) and from urban to rural areas. If the spread continues at its present pace, it is going to have devastating effects on the entire fabric of our society. If the spread is not checked and the trend reversed, it will probably also wipe out decades of development in our country (CBCI HIV/AIDS Policy, 2005, p. 3).

India has 61% of the world's recorded *leprosy* patients. About 14-20 percent of the patients are children. India also has 60 million diabetics, 40 million arthritis and 40 million hepatitis B patients. (Hameed, 2002, p. 10).

The *costs of medical care* have risen to prohibitive levels, making facilities unavailable to many and leading to medical systems becoming unsustainable. High technology has an inhuman face and this leads people to feel isolated and fragmented. Death in modern medicine is seen as failure and is aggressively fought, indeed to such an extent that people are not able to die with dignity.

2.3. An analysis of reality

When we attempt a closer analysis of this appalling scenario, we realise that there are some strong undercurrents prevalent in Indian society.

2.3.1 Inequality in access to health care

Research reveals that the richest 20 percent enjoy three times the share of public subsidies for health compared with the poorest quintile. The poorest 20 percent of the population has more than double the mortality rates, fertility rates and levels of under-nutrition compared with the richest 20 percent. On average, the poor spend 12 percent of their income on health care, as opposed to the only 2 percent spent by the rich (R. Misra, p. 12). In short, there exists extensive inequality in access to health-care facilities and the availability of care, support and opportunities.

2.3.2 Progress that ignores the poor

Globalisation has certainly brought about encouraging economic growth. As a result, many new hospitals have been created, mainly in major metropolitan areas, with very modern equipment, advanced technology and sophisticated treatment facilities. This welcome progress has not only kept the poor far away from accessing any medical care, but worse still, the tough competition has led to the closure of many of the ordinary hospitals, including some of the mission hospitals.

2.3.3 Widespread poverty and uncontrollable migration

The large uncontrolled influx of rural migrants to urban areas in search of better earnings and job opportunities leaves them very vulnerable and this is particularly true of the children of the migrant families. Our metropolitan areas and cities are becoming overcrowded whereas villages are becoming less populated.

2.3.4 Lack of monitoring and assessment

There is a substantial difference between States as regards their health indices. The inefficiency of systems, the lack of true commitment on the part of the implementers, and above all widespread corruption have led to the deplorable situation in which millions of the poor are deprived of basic health needs. There is a huge shortage in human resources in institutions, especially in the remote rural and tribal areas where health-care needs are the greatest.

3. Jesus and his Healing Ministry

Given the background described above, the health mission of the Catholic Church has to play a vital role in attending to the sick and alleviating their suffering, especially those who are poor and cannot afford adequate treatment. Let us first try to understand the healing mission of Jesus to obtain a vision with a view to a better response.

3.1. The entire Biblical tradition, as it describes the salvific intervention of God in human history, systematically gears itself to the redemptive mission of Christ. The Prophet Isaiah, for example, foretold: 'He endured our suffering. He bore our pain. We are healed by the punishment he suffered' (Is. 53:3-6). In the New Testament each Evangelist

testifies to the healing ministry of Jesus.

As regards the four gospels, we find most healing episodes in the gospel of Luke, the author who is traditionally called a medical doctor. Jesus in the gospel of Luke is portrayed as a healer *par excellence* (4:40; 7:11-17; 5:15; 6:18-19; 9:11; 13:10-13; 14:1-6; 17:11-19; 22:50-51). Whoever approached the Lord with firm faith and trust received a new life of peace and serenity.

The Acts of the Apostles summarises the entire life and ministry of Christ by saying 'He went about doing good'.

3.2. Personal contact

'It has been observed, personal contact is the element which is most prominent in the healings. Christ places himself in physical contact with the sick. He touches the eyes of the blind, he touches the ears of the deaf, he touches the hands of the infirm, and so forth. We can see in this activity a kind of compassion on the part of Christ himself, and compassion in the strictest sense of the term. It is a compassion which is effective that cures the illness' (Barragán, 2002, p. 47)

3.3. The request for faith

Another element which is often evident in the healing interventions of Jesus is the request for true faith in God of those who approach Jesus for healing. Christ praises the faith of those who go to be healed and also at times of those who are near to the sick. Therefore, faith is often required as a prerequisite for his healing activity. 'All the miracles have only one aim: to proclaim the kingdom of God has arrived; and this kingdom has its centre in the resurrection of Christ (Barragán, 2002, p. 49).

3.4 The restoration of human dignity

The respect, protection and care proper to human life derives from its singular dignity. Most of the narratives on healing by Jesus are examples of the restoration of the lost dignity of the individual and thus the liberation of the total person.

3.5. Healing activity led to a liberating experience of God

Christ's healing activity helped people to a unique experience of God, in particular intense divine intervention during a time of pain and suffering. The cured paralytic and the crowd give witness to this: 'He went to his home, glorifying God and were filled with awe, saying, 'We have seen strange things today'' (Lk. 5:25-26).

3.6 The redemptive meaning of human suffering

'From a simply human point of view, pain and illness might appear as an absurd reality. However, when we allow ourselves to be enlightened by the light of the Gospel, we succeed in appreciating its profound salvific meaning' (Pope John Paul II, 2004, p. 10).

The cross and resurrection of Christ affirms that God's healing power is not staying apart and above the reality of pain, brokenness and dying but is reaching down to the very depths of human and creational suffering, bringing light and hope in the uttermost depths of darkness and despair. The image of the resurrected Christ may be encountered among people who suffer (Mt 25:31-46) as well as among vulnerable and wounded healers (Mt 28: 20 and 10:16; 2 Cor. 12: 9; Jn 15:20).

4. The Health Care Mission of the Church

4.1. The health mission

'The mystery of Christ casts light on every facet of Catholic healthcare: to see Christian love as the animating principle of healthcare; to see healing and compassion as a continuation of Christ's mission; to see suffering as a participation in the redemptive power of Christ's passion, death, and resurrection. For a Christian, the involvement in healthcare and to serve those suffering is not just a social profession, but is also a 'mission'. It is a mission for evangelization. One is called to discern the very image of Christ in the image of the sick, always recalling what the Lord said, 'I was sick, and you visited me' (Mt 25:36). The twofold dimension of this mission, the care of the sick and the announcement of the Good News, continues through the work of all Christians. To care for the sick is not just a health or economic issue. It is above all a sign of God's love, which Christ wants to manifest to each one through the Church' (Gauer, 1994, p. 38).

Christ, the 'first evangelizer', above all proclaimed the Gospel to the sick and the poor in spirit and in body. 'Evangelizing culture to a great extent means having to deal with experiences of suffering, illness and death' (Angelini, 1994, p. 9).

Following in the footsteps of the Divine Healer, Jesus, the Catholic Church has provided yeoman service in the field of health from time immemorial. Health care is one of the most crucial and essential services required by every citizen regardless of caste, creed or status. Appropriate and high quality care can save and change innumerable lives.

Catholic health-care institutions are based upon the message and example of the merciful Jesus Christ and adhere to his missionary mandate: to go all over the world and preach the Good News of salvation. His disciples set out, preached the Good News, cast out demons and anointed the sick and healed them.

4.2 The holistic approach in health care

The definition of health given by the WHO envisages three specific dimensions: the physical, the mental and the social. The servant of God, Pope John Paul II, took our understanding even deeper by explaining health as 'far from being identified with the mere absence of illness, [it] strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level'. In the age of hyper-spe-

cialisation the care of the whole person is often forgotten about whereas in the true Christian understanding a holistic approach, which includes emotional and spiritual care, is followed.

Therefore, a true Christian approach would be to see integrally the needs of the whole person and to get him or her involved in his or her restoration to health. 'Health is the core of all human development. It is to be understood in a broader sense to include all aspects of human life: physical, social, mental, and spiritual. Therefore, health would mean adequate food, housing, clean water, clean air, good social milieu, and good social and interpersonal relationships. In short it means the satisfaction of ones basic needs: harmonious relationships with one another, nature and God. Together with the physical and psychological aspects, the spiritual and pastoral areas are to be properly attended to' (CBCI Health Policy, 2005, p. 3).

4.3. Catholic health facilities

The Catholic Health Association of India (CHAI) is one of the world's largest non-governmental organizations. It has an expansive base of 3,300 member institutions, including large, medium and small hospitals, health centres, and diocesan social service societies. Its network comprises 11 regional units, 600 sister-doctors, 25,000 sister-nurses and 10,000-plus religious paraprofessionals. Every year approximately 21 million people access CHAI health-care facilities.

The Catholic Church has 746 hospitals, 2,574 health centres, 70 rehabilitation centres, 107 centres for mental health care, 61 centres for alternative systems of medicine, 162 non-formal health facilities, and 115 nursing training centres which include 6 medical colleges.

Along with these there are 165 leprosy centres, 416 health care centres for the aged, 62 centres for tuberculosis or the terminally ill, 67 community care centres for people living with HIV/AIDS and 60 counselling centres. It is interesting to note that as a result of this vast network of ours, in spite of the fact that Catholics constitute around 2% of the population of India, our Catholic health facilities account for around 20% of the health care provided in India.

Looking at this from a global perspective, India has around 4% of Catholic health-care facilities available in the world.

While Catholic health facilities globally continue to perform the mandate of Christ, the changes in the world around us call for some serious introspection. There are various challenges that face Catholic hospitals anywhere. Some basic questions remain: what should be the identity of a Catholic hospital? What should be the level of Christian witness in a Catholic health-care structure? How can we make it a privileged place for evangelization? How can we continue to remain more relevant in a world where the commercialization of health care has become so rampant?

There are numerous challenges faced by Catholic health-care facilities across the globe. Management of health care has become more and more complex. The administration of hospitals and health-care institutions has become a highly technical and specialized function. Religious communities are not able to provide all these highly trained professionals as well as keep pace with the technological advances and requirements they impose in terms of manpower and finance. Medical litigation is also on the rise which makes it difficult to provide low-priced care based on trust and there are fewer diagnostic tests.

4.4. Pastoral care for the sick

An essential element of a Catholic hospital is the pastoral care given to patients. Even though a vast majority of the beneficiaries in our health-care facilities are people of various other faiths, they all treasure the spiritual solace offered to them, of course respecting their individual religious affiliations and sentiments. 'Pastoral care is compassionate, spiritual care given to people who are going through difficult times. Pastoral care helps people to draw on the resources of faith to see them through. Through pastoral care, faith communities can endeavour to meet the spiritual and emotional needs of people affected' (HIV/AIDS Policy, 2005, p. 44). 'When life is challenged by conditions of sickness and inexplicable pain, it is the constant and intimate communion with the Absolute that springs forth in a person an incessant hope and serenity' (Barragán, 2005, p. ix).

4.5. The option for the poor

'Jesus Christ decidedly sided with the poor. Health institutions administered by personnel who are his disciples must do the same. Today equipment costs much, some specialized medicines are expensive, doctors' fees are high and the poor are sometimes unable to afford the care that they need. It is here that the Catholic hospital's role is seen, where through a system of sound management, the rich subsidize the medical care of the poor. No poor person should turn away from a Catholic hospital because of lack of money, as no one turned away from the Lord because he or she was poor' (Oswald Gracias, 2003, p. 88).

In order to make the health care more affordable, available and sustainable, the Church needs to think seriously about introducing some sort of health insurance scheme that caters especially to the lower income groups of society. The existing experiences in health insurance schemes could be studied and an adaptable programme could be prepared which could be implemented either at a diocesan or a regional level.

4.6 Creating a culture of humanizing care

The words of Pope John Paul II, in his message for the World Day of the Sick of 2003, are very significant in this context: 'Catholic hospitals should be centres of life and of hope, where, together with the chaplaincies, ethical committees, the training of lay healthcare staff, the humanisation of care and treatment for the sick, care for their families and a spe-

cial sensitivity towards the poor and the marginalised should also grow. Their professional work should be expressed in a concrete way in an authentic witness of charity, bearing in mind that life if a gift of God, of which man is only the administrator and guarantor' (John Paul II, 2003, p. 4).

The culture of care implies respect for, and the value of, the life of every human being. The Health Policy explains in clear terms that 'from the moment of conception, the life of every human being is to be respected in an absolute way...Human life is sacred because from its beginning it involves the creative action of God and it remains forever in a special relationship with the Creator, who is its sole end... Therefore, respect for the sacredness of life marks an important element of a Catholic healthcare institution. Every medical procedure, care and treatment has to be oriented to the betterment of the quality of life of the patient' (Health Policy, 2005, p. 7).

5. Challenges Faced by Catholic Health-Care Facilities

5.1 A culture of death

The sanctity of human life is under attack in the world today. This is manifested in various forms. Whether it be threats to the life of the unborn by abortions, taking decisions on whether a person should live or die through the movement to legalize euthanasia, or the modern tendency to reduce human worth to its so-called productive or relational capacity, the sacred dignity of human life made in the image and likeness of its Creator is threatened by a culture of death.

5.2 The technological/ scientific imperative

The discovery of penicillin and antibiotics, the introduction of vaccinations, advances in radiology and imaging, the development of non-invasive surgery and pharmacological treatment – these have transformed health care by enabling people to live healthier and longer lives. The challenge faced is the uneven distribution of the fruits of these technological advances because of global inequalities.

5.3. Health care as a commercial commodity

Health care being seen as an economic commodity is a real challenge. This stands in stark contrast to the teaching of the Blessed John XXIII who in *Pacem in Terris* wrote: 'Man has the right to live. He has the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, medical care, rest and finally, the social services…'.

Both the government and the private sectors have increasingly come to view health care as a commodity to be managed like any other product intended to generate profits on a sustained basis.

5.4. Funding

The continuing attempt at the state and federal levels to contain government expenditure on health care as well as the fiscal constraints emerging from the realignment of private insurance through managed care have challenged the financial stability of the ministry. This has become even more acute due to the financial recession sweeping different parts of the world today resulting in governments further decreasing resources allocated for health care. Similarly, many donor agencies involved in funding health-related initiatives in developing world settings have also significantly decreased their funding which in turn is impacting the provision of health care.

5.5. Labour

The combination of significant pressure from labour unions and other forces to significantly increase salaries as well as the emergence of a critically short supply of trained nurses and other health-care professionals have put an incredible strain on the health-care delivery system.

5.6. Genetics

Similarly to the previous revolutions in health-care delivery brought about by the discovery of anaesthesia and penicillin as well as the current revolution in practice patterns associated with the remarkable achievements in pharmacology (i.e. designer drugs), we are at the cusp of a new revolution brought about by the mapping of the human genome. Genetics and cell research are finding an entirely new way of practising medicine and delivering health care.

The result of these challenges and those of technology is that the very face of Catholic health care has changed. The traditional hospital which in recent times has been the centre of health-care delivery today is often described as a dinosaur, a relic of the past that stands in the way of a vibrant future. Patient health care increasingly is provided along a 'continuum of care' that includes ambulatory care centres, free-standing diagnostic services, rehabilitation centres, out-patient surgery programmes, home-care services, assisted-living, long-term care and hospices. Social services often are needed to help – especially in a hospital setting – the patient and the family plan for and access the services they will need once the patient has been discharged from hospital.

6. Conclusion: Witness in the World of the Sick is True Evangelization

'Charity is the heart of the Church; without charity the Church is not the Church of Jesus Christ', said Pope John Paul II. We also recall the famous dictum of St. Augustine who said: 'If you see charity, you see the Trinity'. Charity is the privileged way to make the Gospel credible. The mandate given by the Lord, 'Go then, preach the Gospel and heal the sick' (Lk 10:9), compels us, as true followers, to be credible witnesses in the world of the sick and the suffering. This witness is true evangelization.

The healing ministry has a

greater role to play in the existing health-care situation of the country which is marked by challenges posed by communicable and non-communicable diseases, women and children's problems, as well as environmental issues. Lethargic government and profit-minded private health care cannot alone succeed in providing accessible, available and affordable care to people. It is in this context that it becomes even more important that the sustainability of Catholic health-care facilities is ensured.

The Church in India is a tiny minority community: just 2.3% of the total population in this vast sub-continent. The mandate to witness the mission, death and resurrection of Jesus in the world of the sick can have a transforming impact in the lives of the sick themselves, their families and in society as a whole since the moments of the cross and suffering are the closest to the Absolute. St. Leo the Great wrote; 'O admirable power of the cross! O ineffable glory of the passion! Through you believers find strength in weakness, glory in opprobrium, life in death itself'.

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3. North America

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1. Introduction

1.1. The topic of our discussion is "The Catholic Hospital in a Changing World". It is an indisputable fact that rapid and often dramatic change is characteristic of our contemporary society and culture. One of the driving forces behind such change in the world is the advent of modern technology, particularly the technology of modern communication. One far-reaching result of this explosion of highly innovative and sophisticated communications media is the phenomenon of globalization.

1.2. The arrival of modern technology has also had a dramatic effect on Catholic hospitals. In the last century, there has been a radical transformation in how Catholic hospitals operate and organize themselves, in large measure because of significant advances in medical technology. But what has not changed in the culture and daily operations of Catholic hospitals and what is responsible for the continuity of health care in these Catholic medical institutions in their distinctively Catholic mission. This mission finds in foundation in the healing ministry of Jesus which he exercised during his public ministry two thousand years ago.

2. The Mission of Jesus and the Mission of the Catholic Hospital

2.1. All four canonical Gospels attest to the fact that healing the sick was an integral and awe-inspiring part of the public ministry of Jesus of Nazareth. He cleansed the ten lepers (Lk. 17:11-19); he restored sight to the blind (Mt. 20:29-34; Mk. 10:46-

52); he made the lame walk (Mt. 15: 29-31) and he even raised the son of the window of Naim from the dead (Lk. 7:11-17). Indeed, the words of the prophet Isaiah "Yet it was our pain that he bore, our sufferings he endured... by his wounds we were healed" (Is. 53: 4-5) were fulfilled in the healing ministry of Christ.

2.2. The healing ministry of Jesus was also confided to the Twelve: "He summoned the Twelve and gave them power and authority and to cure diseases and he sent them to proclaim the Kingdom of God and heal the sick" (Lk. 9:1-2). The Acts of the Apostles which narrates the life of the early Christian community speaks of the healing ministry of the apostles. St. Luke even notes that people would place the sick in the streets on their mats so that 'when Peter came by, at least his shadow might fall on them" (Acts 5:15) and they might be healed.

2.3. Over the centuries the charismatic healing performed by individual Christians was formally institutionalized in Catholic hospitals, often sponsored by religious communities, which understood themselves as perpetuating the healing mission of the Lord Jesus. Since the Church is the body of Christ in the world, to which Christ's saving mission has been confided, it was only appropriate that such a central activity in Jesus' proclamation of the dawning Kingdom of God should remain throughout history in the life of the Church's pastoral ministry.

3. Modern and Post-Modern Anthropologies

3.1. The psalmist writes: "What is man that you are mindful of him and a son of man that you care for him? Yet you have made him little less than a god, crowned him with glory and honor" (Ps. 8: 5-6). Biblical revelation teaches that God is the creator of all that is, and that the pinnacle of his creative activity is the human person. White the human person is made in the image and likeness of God, he or she still remains a creature. The human faculties of intellect and free will do indeed make the human person "God-like," but they do not make the human person divine. The human person's share in divinity is a result of grace.

3.2. In anthropological terminology, the creaturely status of the human person may be described as a person's enjoying a "theonomous autonomy". To be who he or she is called to be, to achieve that fullness of humanity that is God's will for all his human creature is to live one's life in relation to the God who is the Author of all life itself. This dependent, metaphysical relationship between Creator and creature does not detract from the fundamental dignity of the human person but is in fact the very condition of possibility for the existence of such a lofty human dignity.

3.3. The recognition of the Creator/creature relationship was an integral part of the theological and philosophical patrimony of Western culture until the modern period when there appeared the philosophy of Immanuel Kant which introduced the notion of "the turn to the subject". In some ways, the Kantian turn to the subject precipitated an anthropological shift in the understanding of the human person. The dependent relationship between God and the human person was no longer viewed as a reason for the dignity of the human person but rather as establishing a type of rivalry between the divine and human. If the human person were dependent on God, that is, if the human person were not autonomous, then men and women could not be truly free and fully human.

3.4. The anthropological shift from theonomous autonomy to the absolute autonomy of the human person became a unquestioned presupposition in the philosophy and politics of the Age of Enlightenment. Reason, unencumbered by the shackles of an outdated faith, would be free to create a world where men and women were capable of constituting themselves. In the post-modern period, with the rise of such philosophies as deconstructionalism, the very ability of human reason to construct a society where the human person could flourish was soon called into question. Moreover, with the demise of a traditional metaphysics, the notions of a common human nature and of the natural moral law that is derived from the fundamental inclinations of such a nature were called into question. The very meaning of human existence was subject to various speculations, and the ability to know objective truth and morality was widely doubted or even rejected.

A disturbing example of the rejection of the objective meaning of human existence that derives from both faith and reason can be found in a decision of the United States Supreme Court of 1992. In that decision, a Supreme Court justice wrote, "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe and of the mystery of human life..."[1]

4. The Dictatorship of Relativism

4.1. The anthropological shift that happened during the Enlightenment and post- Enlightenment periods laid the philosophical basis for what Pope Benedict XVI has repeatedly referred to during his pontificate as "the dictatorship of relativism". This intellectual and moral phenomenon has influenced every dimension of life our contemporary Western culture, including the field of medicine and in particular, the doctor-patient relationship. Within the last forty years, the principle of patient autonomy[2] in the moral decision-making process concerning the use or non-use of medical technology has become predominant. In a perhaps overly simplified way of speaking, the presumption that "the doctor knows best" has given way to the presumption that "the patient knows best".

4.2. The principle of patient autonomy is intellectually and morally defensible if its exercise involves a well-formed conscience in making decisions relative to one's health care. In a culture and society influenced deeply by moral relativism where there are

no moral absolutes because, in great measure, there is no commonly accepted understanding of the nature of the human person, or an acceptance of the natural moral law, the presumption that patients have well-formed consciences can readily be called into question. In secular hospitals, it can be reasonably argued that the physicians in such hospitals share the prevailing cultural bias in favor of moral relativism. Moreover, even if such secular hospitals have in place ethic committees that can be appealed to in helping to resolve morally contentious medical decisions, it might certainly be the case that at least a majority of the members of a hospital's ethics committee work out of a framework of moral decision-making that is relativistic. This is not the case with a Catholic hospital that is true to its mission to provide compassionate care that respects and promotes the inviolable dignity of the human person.

5. The Catholic Hospital in the United States of America

5.1. Catholic hospitals in the United States of America are governed by a document that the United States Conference of Catholic Bishops (USCCB) has crafted and that is now in its fifth edition. This document is entitled *Ethical and Religious Directives for Catholic Health Care Services (ERD)*. It has been adopted as particular law in many of the archdioceses and dioceses in the United States and reflects a body of moral principles that has developed throughout the centuries. In the Preamble of the ERDs, the purpose of these directives is articulated as follows: "The purpose of the *Ethical and Religious Directives* is two-fold: first, to reaffirm the ethical standards of behavior in health care that flow from the Church's teaching about the dignity of the human person; second, to provide authoritative guidance on certain moral issued that face Catholic health care today."[3]

5.2. The ERDs touch upon a number of current realities that are integral to the mission of an authentically Catholic hospital: 1) the social responsibility of Catholic health care services; 2) the pastoral and spiritual dimensions of Catholic health care; 3) the doctor-patient relationship; 4) medical-ethical issues concerning the beginning and end of life; and 5) Catholic hospital partnering or merging with secular medical facilities.

5.3. The moral principles that are presented in the ERDs as part of the patrimony of the centuries-old Catholic moral tradition seek to provide an objective moral framework within which health care providers and patients can make moral judgments and decisions. The document states, "The moral teachings that are presented here [the ERDs] flow principally from the natural law, understood in the light of the revelation Christ has entrusted to his Church. From his source the Church has derived its understanding of the nature of the human person, of human acts, and of the goals that shape human activity."[4]

5.4. The ERDs are an invaluable instrument in assuring that the moral decisions concerning the practice of medicine in a Catholic hospital are not subject to a calculus of decision-making that is morally relativistic. This moral assurance is not readily available in secular hospitals in the United States of America in our rapidly changing world.

6. The Role of the Diocesan Bishop in a U.S. Catholic Hospital

6.1. A final point that is pertinent to our discussion of "The Catholic Hospital in a Changing World" is the role of the local diocesan bishop in safeguarding the Catholic identity and mission of a Catholic hospital under his jurisdiction.

The pastoral responsibilities of a diocesan bishop flow from the episcopal "triplex munus" of teaching, governing and sanctifying. The ERDs concisely express how these episcopal responsibilities are exercised in relation to a Catholic hospital in his local Church. "The diocesan bishop exercises responsibilities that are rooted in his office as pastor, teacher and priest. As the center of unity in the diocese..., the diocesan bishop fosters the mission of Catholic health care in a way that promotes collaboration among health care providers, medical professionals, theologians and other specialists. As pastor, the diocesan bishop... encourages the faithful to greater responsibility in the healing mission of the Church. As teacher, the diocesan bishop ensures the moral and religious identity of the health care ministry... As priest, the diocesan bishop oversees the sacramental care of the sick..."[5]

6.2. The role of the diocesan bishop is not to be the Chief Executive Officer (CEO) of a Catholic hospital. His responsibility is to assure that the Catholic hospital is authentically Catholic in all dimensions of its operation by adhering to the fundamental and objective moral principles of the Catholic moral tradition. The diocesan bishop in a very practical manner exercises his teaching and governing roles in relation to Catholic hospitals within his local church by being the authoritative and ultimate interpreter of the *Ethical and Moral Directives* and their proper implementation in his diocese.

6.3. A related matter to the exercise of the diocesan bishop's teaching and governing roles is the matter of Catholic hospitals' merging and affiliating with secular hospitals. These mergers and affiliations can present serious challenges to the preservation of the Catholic hospital's identity and medical service. Yet such challenges do not automatically preclude on moral grounds the possibility of these types of mergers and affiliations. The ERDs offer several directives pertinent to assuring that proposed mergers and affiliations of Catholic and secular hospitals are done in a morally justifiable manner.

Directive 67 states: "Decisions that may lead to serious consequences for the identity or reputation of Catholic health care services, or entail the high risk of scandal, should be made in consultation with the diocesan bishop..."[6]

7. Conclusion

7.1. In 2003, Blessed John Paul II wrote in his message on the occasion of the World Day of the Sick in Washington, D.C.: "Catholic hospitals should be centers of life and hope which promote – together with chaplaincies – ethic committees, training programs for lay health care workers, personal and compassionate care of the sick, attention to the needs of their families and a particular sensitivity to the poor and marginalized."[7] A Catholic hospital that strives to promote the mission articulated by the late and beloved Blessed John Paul II is desperately needed in a changing world that is becoming increasingly secular and indifferent to the Gospel of Life.

Notes

[1] Planned Parenthood of Southeastern Pennsylvania, *et al*. vs. Casey, Governor of Pennsylvania, *et al*., June 29, 1992.

[2] Patient Autonomy can be defined as "the governing of one" self according to one's own system of morals and beliefs" (Veatch, Robert M. *Medical Ethics*. Washington, D.C.: Jones and Bartlett Publishers, Inc. 1989).

[3] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Health Care Services*, Fifth Edition. Washington, D.C.: USCCB, 2009, p. 102.

[4] *Ibid*., p. 2.

[5] *Ibid*., pp. 4-5.

[6] *Ibid*., p. 31. Also see Directives 68-71, pp. 31-32.

[7] *Dolentium Hominum*. Proceedings of the XXVI International Conference. "Pastoral Care in Health at the Service of Life in the Light of the Magisterium of the Blessed John Paul II. (Editrice Velar, Gorle (BG), p. 75.

4. Central and South America

H.E. MSGR. SEBASTIÁN RAMIS TORRENS T.O.R.
Bishop of Huamachuco, Bishop Responsible for Pastoral Care in Health, Peru

A Look at Reality

The State recognises that there the structures and human resources of hospitals are twenty-five years out of date. We suffer a shortage of basic medical products and antiretrovirals, principally in the provinces, as well as of medical products to combat tuberculosis, especially for multi-resistant or extremely resistant cases. Specialist care is concentrated in the regional capital cities. The State has steadily withdrawn from the responsibility of assuring health for the whole of the population and prefers, instead, to encourage private mechanisms.

As regards Catholic hospitals, in South America these are responsible for 15-20% of health care and for even a higher percentage in the case of psychiatric hospitals, centres for elderly people, orphanages, centres for teenage mothers and centres for the chronically or terminally ill. At the present time there is a preference for works of a small size and involving accompanying, and for primary health services for the poor sectors of the population. In addition, an increasing difficulty is encountered in the provision of services according to the current neo-liberal model, and this has placed many of the Catholic clinics and polyclinics of the region in a state of crisis, forcing them to try to finance themselves or to close, if they are not successful in this. In the state hospitals there is also a shortage of chaplains and Catholic volunteers.[1]

Illuminating Reality

In the Gospel of Matthew (4:23) we read that 'Jesus went about all Galilee, teaching in their synagogues and preaching the gospel of the kingdom and healing every disease and every infirmity among the people'. We thus see that Jesus is concerned not only about the health of individuals but also about the health of the whole population. He promotes public health.

Formation of the Heart

A hospital is a space of action and promotion for pastoral care in health[2] and it is important that this is done with basic social organisations, community leaders, families and associations of sick people.

A hospital is a school of formation for future health-care professionals. It is also important that people are made responsible when the formation of pastoral workers, families, patients and healthy people takes place. A 'formation of the heart' is required (*Deus caritas est* 31a) as well as preventive health.

A Privileged Place for Evangelisation

In the Gospel of Luke (10:31), Jesus describes two figures: a priest and a Levite who 'pass by' in the face of situations of pain and the loss of health without giving priority to a person in need.

Catholic hospitals and clinics must bear in mind that they are privileged settings for evangelisation where the health-care personnel should be marked by a solid human, Christian and social formation.

Challenges

One should not pass by in the face of situations where there are sick people and their families.

One should, instead, promote humanisation and integral service.

In the management of hospitals the human and spiritual aspects must be of priority importance compared to the economic and administrative dimensions.

When cooperation exists with government health-care institutions, one should 'assure that conscientious objection is integrated into legislation and verify that it is respected by the public administrations' (*Documento di Aparecida*, 469 i).

The organisation of hospital pastoral care should be a part of the overall pastoral care of dioceses and the pastoral care in health of bishops' conferences.

One should not lose from sight the profound corporeal, affective, intellectual, spiritual, social and environmental unity of human beings.[3]

One needs a medicine that sees and serves the whole person; a medicine that has the person at its centre.

One needs a health-care system with a human face that promotes this new culture which takes into account the sick person and the healthy person in order to prevent illnesses.

One should organise and be a part of hospital ethical committees. One should promote knowledge about bioethics starting with the criteria of the Magisterium of the Church.

Humanisation

Individual humanisation: through openness to everything that helps us to understand a person, his or her interiority, his or her world, and his or her culture.

Social humanisation: through the direct use of all health-care workers and pastoral workers in order to: promote, each one in their own context, conditions suitable for health; improve institutions; foster the right distribution of health-care resources; and ensure that health-care policies have as their goal the good of the human person.

The New Evangelisation

This requires the participation of all baptised people in various pastoral contexts, including fraternal relations with other Churches, bodies and movements that work in the vast world of health and health care in order to make the message of Christ, 'I came that they may have life, and have it in abundance', a reality.

Notes

[1] H.E. Msgr. Carlos Aguilar Retes, Bishop of Texcoco, Mexico; President of the Latin American Bishops' Council, CELAM.

[2] Discípulos Misioneros en el Mundo de la Salud, *Guía para la Pastoral de la Salud en América Latina y el Caribe* (Consejo Episcopal Latinoamericano, 2010), pp. 96-97.

[3] *Dolentum Hominum* n. 76, 2011: '*Caritas In veritatis*. Towards an Equitable and Human Health Care'.

5. Europe

H.E. MSGR. EDOARDO MENICHELLI
Metropolitan Archbishop of Ancona-Osimo, National Ecclesiastical Assistant to the A.M.C.I. (Association of Italian Catholic Medical Doctors), Italy

My paper is organised around three points. First of all, in my capacity as national ecclesiastical assistant to the AMCI, I will dwell upon the figure of the medical doctor and the Catholic medical doctor as well, in a Europe and an Italy that appear to be increasingly secularised.

1. What Role Can and Should a Catholic Medical Doctor have within Health-Care Institutions?

Firstly, a brief look at European countries. As we know, legislation appears to be increasingly less respectful of human life, above all during its initial and final stages.

This raises a serious problem of a moral nature which goes beyond individual laws and once again involves the conflict between legal norms and ethical norms.

Law, which should be a guarantee of morality for the common good, encounters difficulty in still being such, given that it seems to be placed at the service not of the common good but of an individual good. This conflict, whereas in past times it involved events and laws that later received the unanimous rejection of the community (I am alluding obviously to the race laws), today involves existential choices, such as abortion and euthanasia, which are meeting with increasing assent within society, above all in so-called 'extreme cases', such as, for example, the conception of a child with incurable pathologies or a long terminal stage to a person's life. This does not exempt us from two responsibilities.

First of all, that of an *educating nearness* which, as believers, we are always called to exercise even, and above all, in relation to those who engaged in error. It would be a grave mistake to transform the Church into a tribunal which afflicts humanity by declaring its guilt.

The Gospel is the proclaiming of truth and of grace, and thus of mercy. Those who err must always find in us the merciful face of the Father and not the severe face of

a judge. And since such events take place in various forms in the health-care world it should be specifically health-care workers who bear witness to the truth and the mercy of God.

Secondly, the – albeit incumbent – emphasis on the problems of the beginning and the end of life should not make us neglect what is between this beginning and this end, that is to say life in its wholeness.

Unfortunately, at times our voices are raised only in relation to problems which, we could say, revolve around the fifth commandment, neglecting the grave moral transgressions of the other nine: we may think of honesty in work, of corruption, of the very many and new forms of theft, of neo-Nazism disguised as ethnocentrism, of policies that do not take the family sufficiently into account, of the unresolved problems of young people, of the very many and diversified forms of illegality…

What have medical doctors to do with all of this we could ask ourselves?

They are relevant to the extent that they defend and experience, as citizens and as professionals, the uni-totality of the mystery of life. For that matter in one of the versions of the oath of Hippocrates the physician promises: 'I will defend the patient against everything that is unjust'.

2. And now our Italy

In this approach I would like to highlight three points which in my view appear to be of a certain urgency:

a. The Christian identity, which runs the risk of no longer being motivating and illuminating. This happens not because of increased and different cultural presences but because believers no longer 'realise the hope that is in them', as is observed in the first letter of Peter (cf. 1Pt 3:14-17).

The Christian identity does not in any way fear cultural and religious dialogue, nor even less does it fear falling into homogenisation. The Christian identity has the strength to engage in dialogue with other religions and with a dialogue that is respectful, fruitful and educating. A privileged setting for such a dialogue is specifically a hospital or a 'health-care territory' given that, as appears evident, today not everyone goes to church but everyone passes by way of this temple of pain.

b. The professionalism of health-care workers is by now heavily bound up with technology and increasingly distant from that *humanitas* that is an integral part of the '*ars curandi*'. It is of urgent importance to unite knowledge and knowing how to do things with the third component part of professionalism, that is to say 'knowing how to be'. It is true that people speak much about the 'humanisation of care' and of 'narrative medicine', of 'high-tech' and 'high touch', as the English say, that is to say of high technology united with high humanity. However, it has to be observed that this does not seem to be achieved in a capillary way.

c. Working witness requires competence, seriousness, correctness, presence, dialogue and self-giving. This testimony is not confined to a place (I am thinking here of ecclesiastical health-care institutions) but, rather, to the person, to his or her lay vocational riches, and this is specific to a medical doctor and every member of the lay faithful. This is what the Second Vatican Council proclaimed when it entrusted to the laity the 'Christian animation of the temporal order' (cf. *Apostolicam Actuositatem* n. 7). The words of the physician and saint, Giuseppe Moscati, which he addressed to the ward sister who constantly asked him to go to church for a religious celebration are instructive This holy medical doctor, in the face of her insistence, answered: 'Sister, one serves God by working'.

In addition, this witness must be illuminated by hope. As the Holy Father Benedict XVI reminds us in his encyclical letter *Spe Salvi*, the Christian is always and whatever the case a man of hope (cf. *Spe Salvi,* n. 31). This hope, which is tangibly nourished by very many daily and often unknown examples of humanity and holiness, is especially requested of those who are near to sick people who are often wounded and tempted by hopeless. This is certain way not only for the witness, but also for the holiness, of the medical doctor.

3. I will now allow myself a third perspective which I like to think is a new great task in relation to which everyone, and in particular men and women who base themselves on the Gospel and build their life choices on it, should pay attention.

a. Our Western society, as is well known, is secularised and places an exaggerated emphasis on economic realities and efficiency. In my way of seeing things, the organisation of health-care, which cannot be subjected to the criteria of mere productive efficiency, cannot be allowed to fall into this circle. The more a sick person is cared for and retrieved for society, the more that society grows. From this point of view, expenditure on health care is never 'useful' expenditure. It seems absurd that in some quarters there is a wish to communicate to the patient who has been discharged not only the treatment that has solved his or her problem but also the cost of that treatment. The Association of Medical Doctors should be a voice of dissent as regards everything that would like to make the recovery of health simple a matter of economics.

b. This subject also bears upon health-care institutions which are under the authority of the Church or which are managed by religious families.

I will not specifically enter the subject but I believe that it would be an example of absolute human and Christian witness if one retrieved the message of chapter 25 of the Gospel According to St. Matthew (the famous Works of Mercy) and also the charitable genius of certain saints who founded religious Orders or Congregations and who saw in a sick person the figure of the suffering Christ.

I understand that the subject is a delicate one and would need to be explored outside this meeting. However, I cannot but remind myself and all of you that 'gratuitousness' and 'co-participation' would give a new image to the 'holiness' of our days.

6. Oceanie

H.E. MSGR. DONALD SPROXTON
Auxiliary Bishop of Perth, Bishop Responsible for Pastoral Care in Health, Australia

Your Excellencies, Reverend Fathers, Brothers and Sisters in Christ, it is a great joy to be with you today – in this Year of Faith for the Universal Church, and a Year of Grace for the Church in Australia, the Great South Land of the Holy Spirit – to talk of the role of Catholic hospitals in a changing world. I also wish to recognise the presence today of Rowena McNally, the chair of the Stewardship Board of Catholic Health Australia, who has joined us for these important deliberations, and thank her for her attendance.

In many ways, Catholic hospitals – along with Catholic schools, aged care and social services agencies – are becoming the place where the rubber meets the road in the Church in many Western countries. As societies change, and religious adherence along with that, our hospital, schools and care agencies become some of the most visible signs of Christ's love in the community.

For the Church in Australia, the provision of health care – with a preferential option for the poor, the weak, the vulnerable and the marginalised – dates back more than 180 years. And, unlike in some other parts of the world, the Catholic health system is growing. Around the turn of the century, there were 55 Catholic hospitals in Australia. There are now 75. Our 550 aged care services are also growing rapidly as we, like most of the world, deal with an ageing population. Our services employ somewhere in the vicinity of 40,000 employees, almost all of whom are lay.

That is one aspect of how a changing world, in which fewer women, in particular, are entering religious life, is also changing the provision of Catholic health care. While our hospital wards were, just a few short decades ago, full of religious sisters who had chosen that as their path to glorify God, today it is a committed group of lay people that is carrying on that legacy in a manner that makes those sisters extremely proud and grateful.

St John of God, which has been providing health care in Western Australia – my home state – for almost 120 years, is a great example of how the Sisters of St John of God created and operated health services for people in need after arriving in a new outpost thousands of miles from the established centres of Sydney and Melbourne.

Today, the lay leaders of St John of God Health Care are continuing the mission of the Sisters and Brothers of St John of God and we are just weeks removed from the commencement of work on a 307-bed public hospital in a less affluent part of Perth, to be operated alongside a new 60-bed private hospital.

During a competitive tender process set up by the Western Australian Government, a number of hospital providers made their case for why they would be the best choice as the Government's partner. St John of God, with its history of providing care to the needy, was indeed a fine choice for an area like Midland, where – in a booming economy such as Perth's – some of the most disadvantaged people live, and entered into a 23-year contract with the state to care for that community. One thousand new jobs will be created as part of the hospitals' positive impact on the people of Perth when the hospitals open in 2015.

In many ways, what St John of God is being able to achieve in Western Australia is something that other Catholic health providers in Australia's eastern states have been doing for decades. In the three main centres on Australia's eastern seaboard – Melbourne, Sydney and Brisbane – Catholic hospitals have established themselves as outstanding providers of care and are often people's first port of call when seeking medical attention.

Across Australia, 5 per cent of all public hospital beds are in Catholic-run facilities. In the Australian Capital Territory, Catholic hospitals provide 40 per cent of the public beds serving a population of around 350,000. Elsewhere, Catholic hospitals provide major proportions of services – maternity in our Mater Hospitals in Brisbane, for example. And, when we combine our renowned private hospitals to the equation, Catholic providers account for one in 10 of all hospital beds in Australia.

In addition to the quality of care, our health care organisations are also seen as valuable partners because they have been proven to deliver services in a more cost-effective manner than government-run hospitals. In the case of St John of God's Midland Campus, it is predicted the Western Australian Government will save $1.3 billion over the life of the contract – a 20 per cent saving on the forecast Government expenditure.

This model of publicly funded hospitals being operated by Catholic providers may therefore become more and more commonplace. Indeed, the Government in Australia's most populous state, New South Wales, has held discussions with Catholic health care networks to see if very tight state budgets might go farther with the engagement of Catholic services. The Church in Australia is well equipped to co-operate with such a model.

Of course, not all people living in a changing world – with the rising influence of secularism and atheism – are receptive to such a system. As St John of God observed, some in society are uncomfortable with the idea of a faith-based health provider. Outspoken politicians and atheist groups were among those who felt the Church's unwavering respect for life was somehow incompatible with the provision of public

health care. They made that case that only an organisation that provides a full suite of services should be able to operate a public hospital, seemingly oblivious to the fact that virtually no hospital in Australia – private or public – actually provides every possible service.

It is likely that other Catholic providers invited to operate public hospitals elsewhere in Australia will face similar opposition, but we remain confident that such voices are seen as representing a small sector of the community. The success stories of Catholic public hospitals around Australia provide proof that the partnership model works.

Another way in which the world is changing and affecting the role of Catholic hospitals is the impending drastic change in the country's demographics. With Baby Boomers soon to enter their retirement years and birth rates hovering around replacement level, the proportion of older Australians is set to rise dramatically and create a strain on the country's resources.

I am proud of the leadership Catholic Health Australia, on behalf of the 550 Catholic aged care services around the country, provided in response to the care implications that flow from that demographic shift. In fact, Catholic Health Australia was a leading voice on behalf of all providers in seeking aged care reform that would allow older Australians to enjoy the level of care, compassion and dignity that they deserve, all in a financially sustainable system.

As in other aspects of care for the human person, Catholic providers were working hard to ensure that any proposals being considered by the Federal Government were scrutinised based on their possible impact on the poor, the weak, the vulnerable and the marginalised within Australia's older demographic.

An associated consideration Australia faces with the ageing population is who will care for those people in their later years.

Catholic hospitals already play a major role in the education of the doctors and nurses of tomorrow, and in the practical training of nurses in particular. Some Catholic hospitals are already assisting in the medical internships of new doctors, but in the past few months, some have offered to help address the lack of available training places for medical graduates. Given the demands on hospital staff, there has to be some creative thinking done about how best to offer that training, but those plans are already being formulated.

Catholic health care is obviously about more than just caring for a person's body, though. It is also about caring for a person's soul, and the changing world is presenting its own challenges in that area.

As with the declining number of religious, Australia is experiencing a drop in the number of priests in our country. From a pastoral perspective in a medical context, that obviously has some implications, most significantly in the area of chaplaincy and the administering of sacraments.

While the Church has been fortunate to find a number of committed people – some of whom are theologically trained – who are willing to carry out many of the pastoral care tasks that ordained ministers have previously carried out, there are clear delineations between what a priest can do and what a lay person can do. Only priests can administer the last rites or Extreme Unction – what the Church now more commonly refers to as the Anointing of the Sick. And while extraordinary ministers can offer Communion to those who are infirm and unable to attend Mass, only a priest can celebrate the Eucharist for those who are able to attend Mass in the hospital or aged care facility's chapel. This is an issue that is exercising the mind of Bishops in Australia, and no doubt in other countries also.

The changing world also leads to a much more diverse mix of patients and residents in Catholic hospitals and aged care facilities. The days of the vast majority of patients being Catholic or a Christian of another denomination are increasingly a thing of the past. The stellar reputation of our facilities means that people from all faiths or no faith often seek out a Catholic hospital because of the care – medical and personal – they know they will receive. That means Catholic hospitals are often seeking partnerships with chaplaincy services from other churches and other faiths to ensure any patient or resident has their spiritual needs addressed in a culturally appropriate fashion.

In many ways, that is a living out of many of the principles the Council Fathers were espousing 50 years ago in this place during the Second Vatican Council. Those visionary men saw how the world was changing and saw how the Church could shape and brighten that world by greater engagement with society and, in this context, with people of other beliefs. Some might have seen it as unthinkable, just 50 years ago, for a Catholic hospital to have a Buddhist or a Hindu chaplain walking its halls, but that is today's reality.

Christ himself showed us the way in his parable of the Good Samaritan – the parable that inspires the Shared Purpose Statement that was recently adopted by Catholic Health Australia. The role of a Catholic hospital or aged care service is to see the woman in need, to see the man calling out for help, and to be the person that lifts them up and places them on the metaphorical donkey and seeks to provide physical and spiritual wellness.

That is a vision that is shared by Catholic health care providers around the world, and we are therefore supportive of the idea the Pontifical Council is set to consider about the re-establishment of an international federation of Catholic health associations. The Catholic Health Australia model in Australia has proven incredibly successful, and we believe an international group will be a valuable network.

So we find ourselves, in this third millennium, responding to the challenges of the time with an authentically Catholic response. Our Catholic hospitals and aged care facilities are a source of great pride for the Bishops of Australia, caring for those whom we serve in a world that is changing, but is still moved by those carrying out the compassionate and loving work of Jesus.

III. The Spirituality and Deaconate of Charity

The Hospital Chapel: a Beating Heart of the Mission of the Church for the Sick

FRA RENÉ STOCKMAN, F.C.
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Introduction

When we talk about a Catholic hospital, one of the quintessential features is the pastoral care that is provided there. A Catholic hospital that dedicated itself to provide good medical care, and that succeeded in doing so, but that did not pay any attention to a pastoral framework, would fulfil only part of its mission and should in fact be given an unsatisfactory mark across the board. This applies to countries where health care is generally well-developed and where Catholic hospitals maintain their reason for existence today, in addition to providing quality therapy and care that puts the patient first, exactly by paying extra attention to two areas, namely pastoral care and a medical-ethical policy, which is oriented in Catholic morality. Particularly in Western countries, it is a real pitfall to solely focus on high quality therapy and care as a Catholic hospital and even withstand the competition with other hospitals, to possibly still have extra attention for the availability of care for the poor, which certainly remains a hot topic in the US, and with which a Catholic hospital can still create a distinct profile, but to act neutrally ethically and relegate pastoral care to the margins. It is even becoming very difficult in certain countries to maintain an ethical profile according to the guidelines of Catholic morality, and one must dare to go against the current and, at times, get into a tussle with the legislative government, who is also the care financier. There are often no means available for pastoral care in a health care system that is increasingly and purely determined by finances. In countries that still lack a primary provision of care and where the Church still has a pioneering role when it comes to health care, the same maxim applies: here, the field of health care is a pre-eminent place for the Church to be with an adapted pastoral supply, while not being limited to the pure development of care in itself.

The title that I got from the organisers, "La Cappella dell'ospedale, cuore pulsante della missione della Chiesa per gli infermi", even though it sounded a bit strange to me at first, even a bit scary, entails a huge challenge around which we wish to develop this contribution: how can we, as a Catholic hospital, continue to create the necessary space for pastoral care to be present like a beating heart?

1. How can we describe pastoral care today?

Pastoral care can generally be described as the Jewish-Christian-inspired, existential, and spiritual care for people in their pursuit of meaningfulness in their everyday existence and in their struggle with the ultimate existential questions[1].

This description already presents two angles or perspectives starting from which pastoral care can be approached: the general human desire for meaningfulness in life and the Jewish-Christian inspiration that attempts to provide an answer.

On the one hand, pastoral care can be approached from that general human desire for meaningfulness and the existential struggle with the ultimate life questions. People always try to make their existence and their co-existence into something meaningful, and in certain moments in life, people start explicitly asking questions about the meaningfulness of life. In sickness and suffering, these questions arise with great intensity, and it is important that a person can find another person who is willing to listen so as to vent these questions. This is clearly about the existential-spiritual dimension in life, which demands a direct and distinct approach, just like the somatic, the mental, and the social should be approached through individual ways and angles. We know the health care pitfall of listening to existential questions but wanting to answer them through psychotherapy. Existential questions are being psychologised at that point.

On the other hand, pastoral care can be approached starting from the faith in the meaningfulness of life in spite of everything, and the ways that are offered to us by the faith to find and continue to find

meaning in all circumstances of life. The answers that are offered to this general human desire by our Jewish-Christian tradition, and particularly the theology of salvation that Christian religion offers us, gives a person perspectives that no other life ideology can provide. People can generously draw from this for their personal dealing with their existential questions, and in the liberating relationship with God, which is the essence, they can find strength and inspiration.

Pastoral care in a hospital will always involve these two dimensions: creating a climate and an effective space for expressing and listening to the questions for the meaning of life in life-threatening situations, which sickness and suffering do bring on, and, on the other hand, offering answers in an appropriate way in the form of words, symbols, and rituals, without wanting to impose these answers yet also without wanting to withhold them. It will always be about being close, in a humble way, without being deterred by this humility or without being restricted in the offering, uttering and particularly in the sharing of our faith.

2. How can we experience and live pastoral care today?

Pastoral care always starts from what we call a pastoral basic attitude: humbly listening to the questions that arise in people and then with profound respect referring to the framework in which we want to place these questions in the hope that answers might grow from there that can give solace to people and that might support their own answers.

Pastoral care is made up of different moments, call it functions that have their own value and that are part of what we call pastoral care. We should mention in advance that pastoral care is of course a separate discipline within the hospital setting and therefore requires an individual framework with specialised people yet on the other hand, all health workers are expected to have pastoral attention, and it cannot be that a sick person is referred to another caregiver when he or she asks a deeper question. After all, it is known that certain carers have difficulty dealing with existential questions as these questions always touch on the carer's own existence. Others believe that, as a caregiver, one must stick to one's own discipline and never enter into questions of faith because of the so-called therapeutic neutrality and the therapeutic distance that the person requiring care and the caregiver should keep. Still others feel embarrassed and simply cannot find the words to pursue such questions because everything that involves existence and faith is no longer part of their life territory due to their heavily secularised background. Therefore, that which we cite as functions of pastoral care applies to both the specialised pastoral worker and the caregiver as such if caregivers wish to continue to honour the ideal that they are there for man in his entirety, not just for his sick body!

In pastoral care, everything starts in the loving and respectful presence with the sick person. One listens to the patient's daily living situation and one shows the willingness to dwell on it. We might call this pastoral care of the incarnation, pastoral care of everyday life. Recently, a new theory was developed on this matter that, in my opinion, fits in very well with our reflection on pastoral care: the presence theory[2]. This theory that mainly focuses on people with mental problems is about being there for a person, being present in his everyday life in a very active way, by actively listening and by taking seriously everything that this person puts forward. One will always be there as a caregiver with one's own backgrounds and one's own discipline, however this is set aside at first. One does not use one's knowledge, one's theoretical and theological frame of thought but one simply listens and makes time for the sick person. Again, we have arrived at a very intricate point in our current health care system; many caregivers no longer make time to listen to the sick person. I know a rest home for the elderly where carers have 9 minutes to attend to each resident. You try and do that! I also notice how difficult it is to have a quiet conversation nowadays and not be constantly interrupted by mobile phones. When I was on the bus here in Rome the other day, I noticed that almost everyone was talking, but no one was talking to each other, they were all on the phone, and I was able to hear everything that was being said, I even overheard a family argument. There has probably never been a time of so much communication yet so few still really listen to each other. Certain hospitals have become medical companies, medical centres where technically good care is provided but where everything is reduced to the most efficient treatment of the illness possible and the sick person as a human being is barely considered. It will be very hard to apply the presence theory, and practise pastoral care in such surroundings. Pastoral care workers will have to experience so-called moments of slowing down, of relaxation, just visiting the sick person without doing anything. The presence theory continues by saying that one should not act as a specialist but simply as a fellow man, a neighbour. This is also quite difficult in a hospital environment where one enjoys walking around wearing white or a different colour and a badge and clearly showing patients and colleagues that one has got something to say on a professional level. At this stage, the pastoral guide should not be a pastoral guide in the strict sense of the word but someone who is unconditionally there for the other, specialised in the use of everyday events, stories of the moment, in order to pave the way for further pastoral guidance. Finally, the presence theory says that one should have an open agenda, not directly focused on solving the problem but just to be there for the other.

And so, the way for the actual pastoral work is paved. Now is the time to go deeper: enter deeper into a certain problem, a certain question that needs clarifying. This is also the moment when the pastoral guide can bring forward something of his own re-

ligious background, yet always careful not to formulate answers for the other too quickly. At this stage, it is very important to repeat the things that the sick person puts forward in order to make it clear to him or her that you are on the same wavelength. The field of psychotherapy provides us with the term 'counselling', which is described as follows by the well-known psychotherapist Rogers: "The counselling relationship is one in which warmth of acceptance and absence of any coercion or personal pressure on the part of the counsellor permits the maximum expression of feelings, attitudes and the problems by the counsellee. In this unique experience of complete emotional freedom within a well-defined framework, the client is free to recognise and understand his impulses and patterns, positive and negative, as in no other relationship."

It is therefore good that pastoral care workers in their training and formation learn about this presence theory and counselling as basic attitudes in pastoral work as such.

We do not enter into liturgical and catechetical pastoral care in order to keep the classic arrangement. This will certainly get a place within the hospital framework. I think that it would be more interesting to dilate upon the different functions of pastoral care: healing, assistance, guidance, and reconciliation[3].

The healing function of pastoral care actually dates back to Jesus himself, who, by profession and practice, acted as a healer. People are broken by their suffering, by their illness, by their mortal fear, and want to be able to vent it and find comfort in a word or a gesture from another person who tries to understand them. In healing it is very important for people to express their fears and hurts and to be guided into the depths of the wound. The pastoral counsellor can in this case, as part of his training and formation, find support within the fields of psychotherapy and logotherapy without needing to be a psychotherapist or a logotherapist. It is about obtaining the skills necessary to act as a healer.

Sometimes healing is not possible, only assistance, consolation. At that point, the pastoral counsellor can do little else but stay with the other person, watch over the other like a shepherd, a pastor, to be close to him and offer solace. It is the image of the friends of Job who went to him to offer him consolation, even though they were more 'lamenting' consolers at times. Saint Paul urges us, through perseverance and comfort, to have hope (Rm 15:4). Comfort and hope do belong together: it is maintaining the perspective of hope in difficult situations.

Pastoral care also means to guide, and we are talking about the spiritual guidance that is offered to people starting from a certain framework, from a philosophy of life in the hope to find answers to existential questions. Spiritual guidance is always a delicate matter: on the one hand, something should be offered, yet on the other it should not be imposed. One should be more than a reflective mirror, and always be cautious that one does not start to think for the other and in fact delude the other person. Perhaps we can use the image of the relationship between the Father and the Son from the New Testament: how Jesus always refers to the Father to know the Will of the Father, yet he reaches decisions by himself and carries them out. This is the ideal of guidance: offering, listening, growing, deciding. The pastoral counsellor should be the sick person's 'brother' or 'sister', not the man or the woman who knows everything, but the one who inspires trust, who can listen and give space, who is reliable and who stands for what he or she says, a kind of person of reference, better yet, a person to identify with.

Finally, pastoral care means to reconcile. People become strangers to themselves, to others, to God. It is the brokenness that is present in every human being because sin controls us. In situations of sickness and severe suffering, one can feel as though one is falling to pieces. Every sense of wholeness and unity is lost. At that point, it is a matter of helping people in order to come to terms with oneself, with the other, with God. This is the work of reconciliation: being able to be reconciled once again with a sick body, being reconciled with long gone failed relationships, being able to discover God again as a merciful Father who is there with this forgiveness, etc.

Healing, assistance, guidance, and reconciliation; we could refer to it as pastoral care's four-leaf clover, and pastoral care will always need to have these elements.

Other divisions of pastoral care are of course possible, however I believe that, owing to our limited time and taking into account the topic as such, we cannot examine the matter further. What we can do, is refer to the abundantly available literature on this topic.

And so, we arrive at our final question:

3. What space can and should we give to the religious aspect as such in our pastoral care?

Pastoral care means more than and is different from social work or psychotherapy, even though social work and psychotherapy will always be involved. As we have said in our definition, pastoral care will involve existential questions but these existential questions will have to find a religious framework in which they will find an answer. And this religious framework should be offered through pastoral care.

In this, I would like to formulate two remarks.

First of all, about the person of the pastoral carer. Working in pastoral care demands an individual spirituality. Those who truly wish to be a pastor for a dying patient for instance will never be able to be one if he is not capable of facing his own death and of dealing with this inevitable reality in a Christian way. Pastoral care demands a constant renewal and a deep spiritual life, a prayer life to be able to indeed be that healer, guide, and reconciler. The main question is: as a pastoral carer, how do I get the strength to be someone like Saint Paul, who, through all trials and tribulations, remains an

integrated man because of his unshakeable faith in Christ? Pastoral care and spirituality can therefore never be detached from one another, and in addition to the different skills that one needs to have, which can be obtained in training and formation, the greatest need in pastoral care remains the development of one's own spirituality. On this topic, Nouwen said: "Pastoral care is not a nine-to-five job; it is essentially a way of life. In our time, there is a great hunger for a new spirituality that exists in a new experience of God in our own life. Praying becomes living; prayer and pastoral care converge and can never be separated"[4]. That which is particularly true for the pastoral counsellor should in fact also be true for every caregiver in a Catholic hospital: the attention that he or she should have for his or her own spiritual life in order to be able to deal with suffering on a daily basis without falling apart or lapsing into cold indifference. Nursing the sick remains a vocation above all else, and just like any other vocation, it can only grow if it is nurtured by a spiritual life.

Secondly, a word about offering faith within the pastoral relationship. Faith can never be imposed, we all agree on that, but have we not become too bashful these days when faith is barely being discussed, even in a pastoral relationship? It is as though one is stuck in the preliminary work, never reaching the actual task. In other words, should we keep the wealth of our faith and the extraordinary power that faith emanates in moments of sickness and suffering from people, should that not be the most beautiful flower, the most characteristic therapy that can bloom and be offered in a Catholic hospital? Christianity has offered wonderful models of people who, exactly starting from their faith, were able to give their illness, suffering, and death a profound meaning. I am always struck by how young people like Chiara Badano, experience spiritual growth in their suffering in which they see their suffering as a pure act of love in the end, and truly consider themselves as fellow saviours on the cross of the Lord. The Blessed Pope John Paul II was a powerful example of this for many people. During his life and particularly during his pontificate, he knew a great deal of suffering, and he wrote about it in his encyclical 'Salvifici Doloris', in which he tries to describe the Christian meaning of suffering in a magnificent way. This encyclical should be a required read for everyone who works in a Catholic hospital, and perhaps it is the task of the pastoral care workers to guide their co-workers in this. However, it is mainly in his times of illness, and in his long period of suffering that he wrote an encyclical without words, as it is so beautifully phrased in the book 'Let Me Go to the Father's House' with a powerful testimony by Cardinal Dziwisz[5]. Looking back on the attempt on his life on 13 May 1981, Pope John Paul wrote the following in his final book 'Memory and Identity': "The suffering of the Crucified God is not just one form of suffering alongside others… In sacrificing himself for us all, Christ gave new meaning to suffering, opening up a new dimension, a new order: the order of love. The passion of Christ on the cross gave a radically new meaning to suffering, transforming it from within. It is this suffering which burns and consumes evil with the flame of love. All human suffering, all pain, all infirmity contains within itself a promise of salvation; evil is present in the world partly so as to awaken our love, our self-gift in generous and disinterested service to those visited by suffering."[6] In reference to this text, Pope Benedict made the following observation during his Christmas message to the Curia in 2005: "We must also do the utmost to ensure that people can discover the meaning of suffering and are thus able to accept their own suffering and to unite it with the suffering of Christ."[7] The mysticism of the cross is not a cheap mysticism but exactly requires a fathoming of the essence of our faith: that Jesus became man to deliver us through his suffering and that this work of salvation continues today, which makes it possible for us to place our own suffering on the cross with Jesus. Pastoral care can then be the place where this great perspective, call it joy, may be shared. Let the chapel of the hospital continue to be an open space where, the sick, their families, and their caregivers can go to be with the Lord in prayer and receive the only true consolation. Yes, the chapel as the beating heart of the mission of the Church to the sick. ■

Notes

[1] Heitink, G., *Pastorale zorg: theologie, differentiatie, praktijk*. Kampen, Kok, 1998, p. 41.

[2] Baart, Andries, Een beknopte schets van de presentietheorie. Onuitgegeven tekst 2010, pp. 4.

[3] Heitink, Gerben, *Pastoraat als hulpverlening.* Kampen, Kok, 1979, pp. 412.

[4] Nouwen, Henri, *Pastoraat en spiritualiteit*. Tielt, Lannoo, 2010, pp. 349.

[5] Dziwisz, Stanislaw, a.o., *Let me go to the Father's house*. Boston, Pauline, 2006, p. 33.

[6] John Paul II, *Memory and Identity.* Weidenfeld and Nicolson, 2005, p. 189.

[7] *L'Osservatore Romano,* December 23, 2005, p. 4.

Vocation to Consecrated Life and Charismatic Witness in Places of Care

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This paper of mine seeks to be a contribution to a reflection on ways of bearing witness to the Camillian charism in places of care today. This involves referring to the meaning of the 'charism' of Camillian consecrated life and thus of saying how women Camillian religious are called to express it today in places of care in a secularised society. The two points to remember are the Camillian 'charism' and the world of health and health care today.

All the charisms of the Church arise from the heart of God who 'calls' some of His sons and daughters to express something of His 'care' for humanity. The mission, therefore, that springs from a charism has its origins in God and a person is called to receive and assimilate the feelings of God and 'bear witness to them', that is to say to express them and to implement them in relation to the recipients of that mission.

Scientific and technological progress as applied to medicine has over recent decades engaged in giant strides forward. Scientific medicine has broadened the concept of 'health/illness' and has witnessed its structuring into a plurality of dimensions: the organic, the mental, the social and the spiritual. And so reference is made to holistic or psychosomatic medicine which thus includes the totality of the human person. It is the human individual in his or her entirety that is in a state of 'malaise' and not only one of his or her dimensions.

However, such progress has not been matched by suitable attention being paid to the specifically human dimension of the patient. The critical point of Western medicine today lies in its low level of 'humanisation'. Health-care workers, today more than ever before, 'do not have time' to listen a sick person very much…A great deal is said and written about this phenomenon, but the remedies are still weak.

In this paper, starting with the experience of the Institute of the Daughters of St. Camillus, I will confine myself to proposing some points for thought about the specific contribution that consecrated life, called to take care of sick people, offers in the process of the 'humanisation' of the art of medicine and nursing nowadays.

If all health-care workers, believers and non-believers, are called upon to increase the attention that is paid to this factor, what kind of 'humanisation' is offered by a man or a woman who is 'consecrated' through a profession of religious life to this service? What is the *proprium* of humanisation that comes from a 'consecrated' person?

When speaking about religious profession the Second Vatican Council explicitly stated that the faithful by a vow 'bind themselves to the three aforesaid counsels…By such a bond, a person is totally dedicated to God, loved beyond all things. In this way, that person is ordained to the honour and service of God under a new and special title… he is more intimately consecrated to divine service' (*LG*, n. 44a). Religious life, therefore, in its essence is to give oneself totally to God and to dedicate oneself fully to His service. In *Perfectae caritatis* the same concept is emphasised: 'The purpose of the religious life is to help the members follow Christ and be united to God through the profession of the evangelical counsels' (n. 2e). 'Members of each institute should recall first of all that by professing the evangelical counsels they responded to a divine call so that by being not only dead to sin (cf. Rom. 6:11) but also renouncing the world they may live for God alone' (n. 5a).

Dialogue and Humanisation

Today the sciences of language have demonstrated how much the 'humanisation' of a person depends on interpersonal communication. The self becomes aware of its own identity in front of a 'You'. It is the other who awakens the self-consciousness of the self. This takes place in encounter through listening and speech. By this way one discovers that the anthropological structure of a human individual is 'dialogical'. A child grows and matures in his or her identity through his or her relationship with his or her mother, with his or her father, and with other members of his or her family.

But this applies in a different way also to an adult. It is only 'company', being with others, and participation in social and community life that allows a man to mature in his self-perception and that also allows him to know and develop his potentialities. Closing in on oneself is the most deleterious thing there is for the development and conservation of an adult and mature personality that is capable of integration in a constructive way into the fabric of human life.

Dialogue with Sick People

There are, however, circumstances in life that can impede or anyway obstruct this dynamism of communication. Situations in which an individual runs the risk of going back to self-closure. The reasons for this can be of the most varied nature – loneliness, imposed isolation, marginalisation, failures, mental or neurological

problems, misfortunes, mourning, etc. Physical illness also causes a self-centred inward folding because of the simple fact, some scholars of the phenomenology would say, that it 'commands attention', that is to say that it leads to 'self-attention', so as to be treated. Every pathology of a certain gravity tends to deteriorate the interior space of an individual profoundly. Everything becomes problematic and confused. The future appears to be closed off and it is not possible to plan something. Everything is a turbine of thoughts, of concerns, and of fears that rain down on the individual. 'Whys' follow each other, anxiety invades the soul, and insecurity projects life towards an emptiness of meaning…

How should the person who is called to 'take care' of this person react and respond? Here one clearly sees that the medical or nursing act cannot be reduced to a health-care service. Because, as I have already pointed out, illness alters the human person in his or her entirety: body and spirit, organic dimension and mental dimension, and relational and spiritual dimension.

Perhaps a reference to the behaviour of a mother towards her child can help us to understand this. A newly-born child, experts say, has an apparatus designed for the vision and understanding of external reality but on his or her own he or she cannot actuate it. The empathetic mediation of the mother is needed. She knows how to deal with the needs of the child and to respond to them in a suitable way.

Does not something similar also happen to an adult when he or she is agitated and worried, when a grave fear or serious illness threatens him or her and he or she strongly feels the need to confide in someone and does not always manage to express himself or herself correctly? In such a case the other, if the other really listens to him or her – that is to say receives that state of mind, those apprehensions, and does not hurry in wanting at all costs to understand and to understand everything or block that person with a judgement, with a sentence that seeks to be an exact interpretation – in such a case the other, as I was saying, constitutes a sort of 'sounding box' which contains the madness of emotions, of feelings and of fears that have invaded the spirit of the suffering person. And this last, gradually, becomes calm: that being listened to has allowed an organisation in a new form of his or her emotions, his or her interior world, opening him or her up to a future of meaning and of hope. Let us try to apply this highly humanising mechanism to Christian faith.

Dialogue in Christian Faith

In what way can this process be read in Christian faith? How is it expressed in the believer and in those who live Christian faith as a 'consecrated person'? In what way does it correspond to his or her 'vocation' to 'bear witness to his or her charismatic identity?

Obviously, the first answer is that God Himself educates the disciple in dialogue: God speaks and man listens, and vice versa. This is the central imperative of the Bible: 'Listen, Israel!'. In the New Testament a disciple of Jesus is described as a 'listener to the word' (Rom 1:5; 15:18; 16:26). 'All scripture is inspired by God and profitable for teaching, for reproof, for correction, and for training in righteousness' (2Tm 3:16). Charisms, which are a constituent part of the various religious institutes, are 'experiences of the Spirit' (*Mutuae relationes* n. 11) which make people encounter Christ 'in contemplation on the mountain, in His proclamation of the kingdom of God to the multitudes, in His healing of the sick…' (*Lumen gentium*, n. 46). In finding in the tests of revelation that specific face of Christ that expressed the characteristic of his or her own institute, a consecrated person assimilates those feelings of the Lord that he or she then expresses in the exercise of his or her mission.

Bearing this truth in mind is of fundamental importance. For a choice of this kind there is no other justification than God and His Christ. Were the opposite the case, whenever one was faced with some important change, some deficiency at the level of organisation, some limitation due to the insufficiency or rigidity of institutions, or perhaps some special obedience (for example a daughter of St. Camillus who rather than having a hospital ward as a place of 'work' has instead the room of the financial administrator of the Order; or a 'missionary' sent to a house of formation; or a 'hermit' appointed a procurator!), one would enter a state of crisis and call one's vocation into question. 'We would like you', said Paul VI to a group of sisters, 'to bring to the four corners of the world the belief that one religious profession commits a person at a level of such profundity that changes at an institutional level or in activities have only a relative importance, even when suffering takes place because of this. The essential is to conserve a very alive awareness of the call of Christ who himself chooses his own friends'.

A religious vocation arises from an encounter that is so intimate and personal with God and with His Christ that the soul is stolen. The pattern that takes place in falling love is repeated: the faithful feels that he or she is taken so profoundly that he or she can do nothing else but adhere to Him alone and forgo, therefore, everything else (*VC*, n. 19). Just as the person who is in love says to his or her beloved "you are my life", so the person who is called feels that he or she can repeat in the fullest way the words of Paul: 'For to me to live is Christ' (Phil 1:21). In strict terms, one does not forgo such valuable and necessary goods in order to be more ready to engage in a specific activity, however noble it may be, but it is because one has forgone that one is more ready to act, and one has forgone because one has been called and taken by Christ. The forgoing of everything else is only a consequence of a direct experience of God, of total conversion to Him. This is lived in faith, in hope, in love, as a supreme possession, as a supreme destiny.

A Camillian sister well knows that the central core of her charismatic identity lies in 'bearing witness to the living mercy of Christ'[1] towards those whom she is 'called to care for'. One should note the statement 'bearing witness to the

loving mercy of Christ': she must bear witness to, and actualise, the love of Another, of Jesus Christ. A 'charism', indeed, is a 'gift' that comes from Another. Those who receive it are called upon to welcome and assimilate the feelings of Another, that is to say Jesus Christ.

The '*proprium*', therefore, of the help that a sister should offer to a sick person lies in expressing, in bearing witness to the involvement of God, of Jesus Christ, in this provision of care. It is no accident that the apostle Paul, when speaking about the 'comfort' that a disciple of Jesus should offer, declares that this is a matter of being able 'to comfort those who are in any affliction, with the comfort which we ourselves are comforted by God' (2Cor 1:3-4). It is, therefore, that kind of 'comfort' that the consecrated person experiences in his or her encounter with God that he or she must now provide to those whom he or she is called to take care of.

But here one must be clear: this reference to the action of God does not mean a denial of what the human sciences have told us. Rather, it pre-supposes it: the dialogical dynamism illustrated by the human sciences should be integrated into theological dynamism. And it is specifically this human dynamism that God 'needs' for His help to be able reach sick people. God acts through the mediation of those who care for others. A believer 'knows' this truth differently, perhaps, from those who do not believe or do not think about it… This is something known about by a consecrated person: he or she is aware of the 'treasure' of the action of God that he or she bears within him or her, in his or her 'earthen vessel' (2Cor 4:7), that is to say in his or her frailty and weakness, in the poverty of human language. Faith attests to him or her, and assures him or her, of this mysterious action of God within him or her. And the consecrated person experiences this during times of prayer and of contemplation in order to then transmit it in the exercise of his or her mission.

If, indeed, in the Bible there is a statement on 'care' for illness, it is the declaration of the Old Testament that God is the 'Lord who heals',[2] who 'takes care of':[3] healing and care come from God, who uses men and women mediators, both men and women 'of God' (prophets) and 'physicians', as we find in the books of history and of wisdom.[4]

In the New Testament Jesus is also presented as a healer. If the healings are seen, in the gospels, as 'miracles', 'powerful works', the truth of his message and his divinity is thereby demonstrated. Indeed, they are also signs of his mercy and compassion, signs of his concern and tenderness towards suffering humanity. This means, observes an eminent exegete, that his deeds of healing 'have a more intimate relationship with the Kingdom of God', that is to say with the presence, within him, of the salvific and merciful acting of God.[5] The more frequent use in the gospels of the term *terapeuein* (to treat) than *iasthai* (to heal) in the judgement of many exegetes means that Jesus, in addition to, and even more than, healing, 'took care of, treated, served and honoured' sick people.

The emphasis of the gospels on the ministry of care and healing of Jesus enables us to understand the importance of his dedication in affirming the presence of the Kingdom of God in the world. And thus the exegete that I have already quoted is able to add: 'all consecrated people who work in the world of health and health care can find here inspiration and encouragement'.[6]

The 'com-passion' that Jesus during his life demonstrated towards the sick and the suffering reached its apex when Jesus himself was 'suffering', that is to say his passion. The 'priestly prayer' that we read in the gospel of John (17:1-26) reveals that Jesus saw his passion as a consecration, 'for them I consecrate myself' (17:19), that is to say 'having loved his own who were in the world, he loved them to the end' (Jn 13:1), which means: to the point of giving his life for them (Jn 15:13). And this is the reason which justifies, for we women Camillian religious, the profession of the 'fourth vow': to serve the sick 'even at the risk to our life'.[7]

This is possible only and inasmuch as a sister truly assimilates this approach of Christ which leads her to see 'Christ as present in a sick person' – 'you did it to me' (Mt 25:36-40) – and 'Christ as present' in the person who engages in service in his name (Lk 10:29-37).[8]

Just as a Christian vocation does not exist in the abstract but only when concretely embodied in a specific personal vocation, so there is no religious vocation that is not embodied in a Congregational charism which in its turn each member can love personally.

But the Congregational charism will also have as its own and central contents not a particular style of life based upon specific virtues or a special service to be performed, but, rather, the person of Christ. If this were not the case, it would not be a Christian vocation, which is always a call to live in Christ so as to become, like him, sons, and thus to share in the Triune life.

The Second Vatican Council helps us to understand the specific charism of an institute when, in taking up a thought previously expressed by Pius XII in his encyclical *Mystici Corporis*, it observed: 'Religious should carefully keep before their minds the fact that the Church presents Christ to believers and non-believers alike in a striking manner daily through them. The Church thus portrays Christ in contemplation on the mountain, in His proclamation of the kingdom of God to the multitudes, in His healing of the sick and maimed, in His work of converting sinners to a better life, in His solicitude for youth and His goodness to all men, always obedient to the will of the Father who sent Him' (*LG*, n. 46 a).

From these words one can easily deduce that the charism of an institute does not consist simply of engaging in certain works but, rather, in representing Christ who engages in them. One is dealing, therefore, with a particular conformation to Christ who lives some aspect of its mission. One is dealing, in other words, with conforming oneself to Christ who in chastity, poverty and obedience preaches the Gospel, converts sinners, welcomes children, heals the

sick, etc. St. Camillus did not embrace poverty, he embraced Christ in sick people; St. Francis did not embrace poverty, he embraced the poor Christ; and St. Dominic did not embrace preaching but the preaching Christ. All the so-termed saints of Charity were conquered by Christ who showed himself to them in that specific approach of service; they fell in love with him, they conformed themselves to him and they continued to show that he was present in history, or, to put it better, to show that Christ through them continued to make himself visibly present.

It follows from this that it is not enough to have a particular inclination to engage in a specific humanitarian service, for example caring for the sick, to speak about a Camillian vocation. There should be a special attraction by Christ and towards Christ, first and foremost.

But it is not even sufficient for there to be present a call to live in charity, poverty and obedience like Jesus to be able to speak about a Camillian vocation. It is also necessary to encounter and share in Jesus in an approach of compassion and devotion to the sick. Those who do not share in this perhaps may have a vocation for another institute but not a vocation for the Daughters of St. Camillus. It is this way of loving Jesus (compassion!) that a Daughter of St. Camillus must share in and then transmit to the sick. It remains true that she must be able to see Jesus in the other, but it is above all true that she must go with the love of Jesus towards the other. She must feel that she is a bearer of this love. But she can do this only if she receives it from Christ through a deep personal communion. Understanding this is of fundamental importance. Before serving the sick Jesus in the other, one should bring the merciful Jesus to the other. This, in essential terms, is the specific content of this mission: to bring Jesus and to make him known about as merciful love. And to do this one should be conformed to him, almost identified with him. If this does not take place, at least at the level of being a profound wish of the heart, one could, perhaps, be a good woman nurse but one would not be a true Daughter of St. Camillus.

It is important not to confuse noble and important activity, such as caring for the sick, with the charism of the institute. A person may have talents that make him or her particularly suited to practising the profession of a nurse but this does not mean that he or she has a Camillian vocation. At the base of everything there must be conformation to the merciful Christ and the passion to make him, today, visibly present in history.

At this point one would have to open a new sub-section in order to answer the question: how should a 'place of care' be made a space of 'bearing witness to the charism of the institute' when, together with the women religious, lay people, both believers and otherwise, also work in it?...In such a context, indeed, it becomes more difficult to express the specific 'logic' of the witness of consecrated life, which is gratuitousness. Today, the health-care world is becoming increasingly complex and requires specific skills and a high number of health-care workers which women religious on their own cannot always sustain…But that, indeed, is another chapter which cannot be addressed in this paper. ■

Notes

[1] *Costituzione delle Suore Figlie di San Camillo*, art. 1.
[2] Ex 16:21; Ps 103:3; 107:20; Tb 5:4.
[3] Ps 8:5; 144,3; James 7:17-18; Heb 2:6-9.
[4] 2 Kings 1:1-17; 20:1-7; 5:1-19; Sir 1-15.
[5] A.Vanhoye, *Vita consacrata sanitaria*, in: AA.VV., *Dizionario di Teologia Pastorale Sanitaria* (Ed. Camilliane, Turin, 1997), p. 1391.
[6] *Ibid*., p. 1392.
[7] *Costituzione delle Suore Figlie di san Camillo*, art. 12.
[8] *Ibid*., art. 13.

Home Care for the Sick

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First of all, I would like to express my gratitude for having been invited to this conference. It is a great honour and privilege for me and for my organisation. It is also a major challenge, as representing the Standing Committee of European Doctors (CPME), the European association of the most representative national medical organizations, I know that in our present economy- saturated times it is harder and harder for us to see the ethical dimension, or simply the human dimension, of health care. Also medical organizations, sometimes rightly, are being accused of only a one-sided representation of the particular interests of the profession. However, the CPME during the fifty years of its existence has placed the good of patients, their safety when they are treated and the quality of health care, very high in its activity. Also, medical ethics as an integral dimension of the practice of medicine has been always one of our priorities.

I very much appreciate that the organizers of this conference asked me to speak about home care for the sick. The fact is that the vast majority of research and

reports in health care and medicine is being done in the field of medical intensive hospital care. What happens to the patient after discharge to his or her home is a field that is much less known about or described.

On the other hand, it is known that the vast majority of people's lives, and not only in health but also when they are sick, are not spent in hospitals but in their home environments. As a family doctor who has practised for thirty years I know how much many of the chance elements and challenges are associated with this fact. A family doctor takes care of his or her patients in their home environment, families, schools and neighbourhoods for many years. This means that in addition to a medical aspect of his or her practice he or she must also take into account other dimensions of care: good contact with the families of his or her patients and often supporting those families, knowledge about the patient's environment (home, school, workplace, etc.) and so on. He or she may also, in the essential meaning of this word, become their friend.

There are several models of care for patients who due to different reasons remain in their homes. There are European countries in which it is the family physician who is the person responsible for such care, as the coordinator of the team of other health and social professionals as well. There are other solutions where care for patients at home is entrusted more to professionals and institutions outside the health-care system. Without prejudging which solution is better, I would like to focus on my personal experience as a family doctor in this field. In Poland, it is still the family doctor who is the person who visits the sick in their homes.

Those who require care at home can be divided into several groups:

– patients bedridden by acute illness (among them patients after acute hospital treatment);

– persons with mobility disability who have a health problem;

– patients with chronic illnesses who, because of their conditions of health, are not able to visit a doctor;

– the terminally-ill (among them patients of all ages – including seriously ill and dying babies and children); and

– residents in nursing homes.

A family doctor visits patients who are generally healthy but due to an acute illness ask for medical care in their homes. In addition to giving advice, a doctor in such situations has an excellent opportunity to understand better the patient and his or her environment. This can prove to be valuable information and experience for future reference, useful, for instance, in diagnosing psychosomatic and family-created problems and seeking that support of family members that is needed for care. Observation of the patient in his or her own home, surrounded by members of his or her family, makes a doctor see a lot of things that now and in the future can determine the patient's health problems.

Under the care of a family doctor there is always a group of people with physical disabilities who need medical attention from time to time. When visiting these people in their homes, a doctor can better identify their real needs for essential social services and organize neighbours and the supportive environment that is necessary for medical care in the future. It is important that their disability does not become a cause of poorer health.

An increasing number of patients require home visits from their doctors because of physical disability caused by chronic illnesses and ageing. Due to their disability which increases over time, they require not only medical and nursing care but also support from other professionals. The best way to provide them with permanent loving care is to assist family members who try to help them through their own efforts. If a patient lives alone, the family doctor becomes his or her best friend and sometimes the only partner for serious dialogue about life, family, the future and so on.

The big challenge for a family physician is care for the terminally sick and dying. They or their carers often need assistance outside hours of work (e.g. by telephone). A physician should be ready for this. The moment when a doctor begins to realize that a patient needs to have more care and symptomatic treatment (such as reduction of pain, depression, nausea and vomiting, dizziness, itching, constipation, etc.), rather than intensive diagnosis and treatment, is extremely challenging. Tactfully informing about the patient's health condition, coming to a decision to go to palliative care, is a must, but it is not an easy task. This is also a place where one must decide about preparations for dying at home. Trust at that point has to be 'earned' earlier by a doctor through caring and competent care in the past. From that moment onwards, the increasing importance of a close relationship with the patient emerges, and not only having enough knowledge and medical skills. The doctor's ability to engage in an empathic attitude and to accompany the patient and read his or her real needs counts more. There is also a place for a tactful response, conducted with great sensitivity, to the sometimes hidden emotional and religious needs of the patient. A doctor should not take the attitude of imposing his or her views, but there is no reason to hide them. A relationship based on openness and truth is definitely best for the patient. It is obvious that this is also a time to testify to the importance of the patient and to the sanctity of life regardless its quality.

Visiting patients living in institutional care homes is a difficult task for a family doctor. These patients often suffer from numerous illnesses, they recover slowly and with difficulties. Well-seen problems in their cases are loneliness and longing for a real home and their loved ones. The task of a doctor and other caregivers cannot be just medical care – these patients need a second person, his or her closeness and friendship. These patients, perhaps more than others, also need spiritual support, to talk about the most serious issues, and deep contact with another human being.

As has been seen from the above examples, a family doctor, in addition to an obvious obligation to the best fulfilment of his or her pro-

fessional tasks through his or her knowledge and skills, must be able to deal with his or her suffering patient as a friendly guest and supporter in another person's home. Long-lasting relationships of mutual acquaintance make it easier to understand the needs of a concrete patient, but at the same time they increase the emotional involvement of the doctor and this often becomes truly exhausting. A family doctor should not flee from entering into a closer relationship than just professional contacts with his or her patients, especially when visiting seriously ill people in their homes. In order to increase his or her chances for reaching friendship with them he or she must be a good man. Then he or she can also bear witness to his or her faith.

A family doctor does not operate in a vacuum. Not forgetting that each patient has a right for autonomous decision-making about his or her health and care, a physician should assume the role of the friendly coordinator of care. He or she has to collaborate with other health professionals, social workers and spiritual care-givers (parish priests and lay helpers). He or she should seek to maximize the involvement of the relatives of the patient and encourage them to care for their sick relative while supporting them in their difficult situation. Often, despite the willingness to help, they feel helpless in the face of the suffering and disability of their loved one. The physician and other professional caregivers should help them perform this difficult role. Preparing the family of the patient for a time of dying, and the death itself of their loved one, should not be omitted.

To summarise: a suffering patient requiring home health care of course first of all deserves fully professional medical care. But due to his or her unique situation often he or she desperately needs simply another human being. Medical professionals, especially family physicians, should be prepared to undertake this task.

And to end, three quotations from John Paul II, which, as always, in the best way possible, show the right direction to be taken, especially when dealing with the terminally ill:

'How should one face the inevitable decline of life in old age? How should one act when facing death? The believer knows that his life is in God's hands, and he accepts from God the need to die. Man is not a master of death, just as he is not a master of life' (*Evangelium Vitae*, 46).

'Death is something entirely different from the experience of hopelessness: a door which opens wide on eternity and experience of participation in the mystery of Christ's death and resurrection' (*Evangelium Vitae*, 97).

If care-givers reach this level, it will be possible that even in the most difficult situations: 'death can also be a source of life and love' (*Fides et Ratio*, 23).

Are we preapared to bear witness to this to our patients?

The Hospital Chaplaincy

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Introduction

I extend my greetings to all those taking part in this international conference of the Pontifical Council for Health Care Workers, whose President, Msgr. Zygmunt Zimowski I sincerely thank for the opportunity he offered me to be able to share with you my experience as a hospital chaplain.

I have been a brother of St. John of God for some years and my formation and my spirituality have been much marked by providing assistance to the sick and the needy. At the present time I work in the service of religious care at the San Giovanni Calibita Hospital, which is better known as the Fatebenefratelli Hospital of the Tiberine Island here in Rome. My service as a chaplain forms a part of the spiritual and religious team on which the hospital relies. This team is made up of two chaplains who work full time and one chaplain who works part time, a sister and a woman volunteer. Fourteen extraordinary ministers of the Eucharist and the members of the three religious communities connected with the hospital also work with this team and are engaged in various initiatives that are organised by the team.

I have to say that to be a chaplain in a hospital is not in the least easy since following sick people pastorally in a hospital context has begun to be a very complex activity for various reasons. It is complex because of medical advances and the applications of state of the art technology which are making therapeutic processes ever more effective. But also of relevance in this complexity is that fact that today people work with new models of care that see the person in the plurality of his or her dimensions. This whole reality means that the service of care for spiritual and religious needs must profoundly reflect and

at times supersede models that are already obsolete in order to find space in which to implement the mandate of the Lord Jesus who sent out his disciples to cure the sick in an integral approach of all the aspects that bear upon a sick person – the somatic, the psychological, the social and the spiritual – as the medicine of the twenty-first century requests.

1. Evangelising in the World of Health and Illness

Pastoral care in hospitals has advanced with the passing of time since we cannot engage in pastoral care in health that is solely centred around the administration of the sacraments. We are walking towards team pastoral care that accompanies the processes involved in personal situations of especial vulnerability. For this reason, when we speak about a 'chaplaincy' we must mean a pastoral team that works inside a health-care institution.[1] For this reason, at times it would be better to speak about a pastoral team constituted by the shared responsibilities of those who are sent by the Church and attend to pastoral care for sick people.

A hospital is not just a building, an organisation or advanced technology. It is a much more complex reality since this term refers to people and pathologies, experiences, and the patients and the professionals who treat them. And all of this during an existential stretch of time that is especially critical for sick people and their environment.

As chaplains and as a team we often pose to ourselves questions to which it is not easy to give answers: how can one evangelise in a secular environment or in a highly qualified and technological professional context? How can one ensure that sick people experience Christian salvation as an offering of integral health and full life? How can one embody in this world of health the values of the Gospel, always respecting the autonomy of earthly realities and legitimate personal options? The service of spiritual and religious care of the hospital wants to give answers but always with sufficient humility to recognise that the answers are not so clear and that some times we are accompanied by silence, 'to let love alone speak'.[2]

The service of pastoral care attempts to make itself present in the same way that Christ did, embodying salvation in signs that bring health, being a universal sacrament of salvation, which is effective and credible, bringing to concrete reality the signs and the deeds of health, embodying them and involving them in the events that we live through every day.

For a hospital chaplain it is important to reflect upon and to listen faithfully to the words that Jesus addressed to his disciples: 'When you go into a city…heal the sick that you find there and say to them, "the kingdom of God is near' (Lk 10:8-9). This is the charge that we receive: to enter the city, to enter a hospital – to which most people go because they are undergoing grave pathological processes – to heal and to free today's sick people.

In the light of the behaviour of Jesus towards the sick we seek to enter into harmony with this hospital world. Nobody doubts that the Lord Jesus demonstrated nearness to the world of sick and defenceless people. Jesus drew near to these people, to those who did not count in this world, to those who were beyond the boundaries of normality, and to those who felt enmeshed in pain and sent to the margins of society. He drew near to these people, he welcomed them, he touched them and he healed them. And he did this with total gratuitousness (cf. Mt 10:7-8). Jesus was not moved by a professional duty or by interests involving proselytism: he acted moved by love, a profound love for the defenceless. And he did this by drawing near and seeking encounter with the person. We could say that from the outside he was able to enter the deepest interiority of the sick person, offering integral care for both the body and the spirit.

Jesus welcomed, listened and understood the sick and the marginalised. But above all else he transmitted to them his faith in the Father, in whose goodness and mercy it is always possible to find welcome. He freed them from sin with the possibility of reconciling themselves with God, offering them forgiveness (cf. Mk 2:5).

Jesus' contribution to health takes place at a deep level, freeing the person from everything that threatens his or her true humanity. And this action that frees the sick constitutes, we could say, the essential core of the kingdom of God. These liberating deeds of Jesus reveal that this sick world contradicts the designs of God and proclaims total and full salvation for all men.

2. The Church and the Sick

With her mandate from Jesus, the Church has continued to evangelise the world of pain and illness with the liberating and saving force of the experience of salvation that the whole of the person who evangelises lives.[3]

In a hospital a good evangelisation will not exist if there are no believers involved in this living experience of the salvation that God gives through Jesus Christ. Our service has its foundation in Jesus, in being servants of the gospel in the world. And we cannot impoverish or reduce all of our activit to a health-care service or professional work alone.

All of those of us who work in pastoral care in health proclaim what we have seen, heard or experienced, and our witness must refer back directly to our Saviour and Lord, he who it is said 'went about doing good and healing' (Acts 10:38).

But our most radical question as servants of the Gospel, as preachers of the Gospel, is this: can we offer today what Christ offered?

I will now stress three fundamental approaches of the Church of today. Each person who is sent out to evangelise must reflect upon his or pastoral action in the world of health and health care, following the example of Christ.

Evangelising with Love

Jesus acted when he saw sick people because he was 'deeply

moved'. All of the action of Jesus comes from love and is done through love. He was concerned about the sick person and wanted to him or her good. If will not be easy to care for someone if we do not put into this all of our conscience and affectivity because, for Jesus, healing someone was a way of loving.

Evangelising in gratuitousness

Jesus did not act out of economic self-interest or a sense of professional duty but, rather, because of the love that he showed for all sick people and defenceless people. Our action in the world of pain should be like that. We cannot proclaim that God is near if we do not do so with a gratuitous service because this is one of the most important signs by which to make God, who loves us gratuitously, present. Our readiness to help and our nearness will be evangelising deeds that say much more than fine words. Love and service, tenderness and affection, words that animate and reassure, offered gratuitously, are signs of the always gratuitous love of God.

Evangelising by assisting the person in his or her totality

Jesus does not only offer biological health, he also offers integral healing aimed at the totality of the human being. We should not help a sick person seeing only the somatic processes of the pathological process but, rather, by seeking the healing of the whole person, in all his or her dimensions. We are called as pastoral workers to help to heal everything that produces pain in the life of a sick person, what dehumanises him or her and wounds him or her in any dimension of his or her being as a person, fostering healthy relationships with other people and with God. If we draw near to a patient with an approach of service and total readiness to help, he or she will make us discover what his or her needs are and what the 'Good News' of which we are the bearers on behalf of the Lord Jesus can achieve for him or her.

Our mission as continuators of the mission of Jesus as evangelisers now must be accompanied by gratuitous love, by total respect for the person, by patience and a great deal of affection. Those who seek to speak in the name of God must be aware of the deep mystery of each human being. We should seek to gather together and to transmit through our lives this unfathomable love of God to all people, and especially to the sick. Our work should always be done with humility, with patience, and also with faith and hope in God, who can give us salvation in all fullness.

3. Those who Provide Religious/Spiritual Assistance in Hospitals

The charge of Jesus to assist and cure the sick is addressed to the whole of the Church because we make up the Christian community. All of us participate in a jointly responsible way in this mission according to the various charisms, ministries and services that the Holy Spirit brings forth in the Church.

The bishops are the first to be responsible for promoting and organising pastoral care in health in their dioceses.

Christian professionals, who in virtue of their baptism share in the mission of the Church, have an irreplaceable role. The exercise of their professions is transformed through their nearness to the sick and witness, and this is an authentic service to evangelisation. They have the task of providing an attentive professional service, of assisting the sick with humanity, and of ensuring that health-care organisations always have at their centre service to the sick.

Volunteers with their supportive spirit and their witness to gratitude, provide valuable help to the sick and can also be inestimable agents of evangelisation, visiting, listening to and accompanying the sick and their family relatives.

Through their presence and their service, the extraordinary ministers of the Eucharist complete the work of chaplains, bringing to the sick the Bread of the Word and the Bread of the Eucharist, manifesting the nearness of Lord Jesus who strengthens and gives peace.

Sick people themselves through their personal experience, through their sufferings and through their struggles with serene acceptance of their limitations, through faith and love, can help other people to place their trust in the Lord of Life, opening a horizon of hope for those who at times live in anxiety and in pain. Chaplains who are near to those who suffer are also through their very presence a sacrament of Christ. In celebrating the sacraments, in offering the Word of Life, and in facilitating spaces of prayer and of deep dialogue. chaplains bring the name of the Lord, health and life, peace and health care to sick people.

4. A Spirituality with its Gaze Turned Towards the Lord Who Heals and Does Good

When we reflect upon the spirituality upon which the agents of pastoral care in health must base themselves, our gaze turns towards the Gospel in order to discover in it the approach that Jesus had towards all the people who encountered him and especially towards the sick. This approach is transformed for us into an imperative expressed with vigour and need at the end of the parable of the Good Samaritan: 'Go and do likewise' (Lk 10:37).

Drawing near to the gospels demonstrates in all clarity that Jesus consecrated a large part of his time to people afflicted by various kinds of illness, and when he sent out his disciples on a mission he charged them with comforting and healing the sick. It is well known that in that context sick people were also frequently marginalised because of social and religious prejudices. The solicitude of Jesus towards the sick, his actions of healing and his words of comfort were a manifestation of God. Through his deeds of compassion and mercy Jesus revealed to us that God is a compassionate Father who is full of tenderness and knows the sufferings of His people. He wants to save His People. Today, as well, the mission of the Church, through her agents of

pastoral care, is a revelation of the love of God that heals and rehabilitates, prolonging in time the mission of Jesus and his special devotion to those who, for any reason, suffer.

Thus an agent of pastoral care must be an evangeliser capable of responding to the troubles of the men and women of today, illuminating life with the light of the Gospel and being responsible through a commitment of faith for making Jesus Christ present in the world. The role of the agent of pastoral care has three important aspects:[4] 1) his or her identity is understood through his or her adherence to Christ; 2) he or she lives supported by the experience of faith; and 3) he or she is involved in service to other people.

An agent of pastoral care lives and manifests a special spirituality so as to follow Jesus and live according to the Spirit, which we can summarise as having the following features:

– He or she has as Christ as a reference point, accentuating the dimension of healing and liberation of the gospel message, expressed in the words and deeds of the Lord Jesus, and he or she feels anointed and sent out with a concrete mission.

– He or she is centred around the paschal mystery. The cross which illuminates suffering and the resurrection which motivates and inspires efforts for health and life.

– He is or she is forged though his or her own experience of suffering, with its wounds, which makes the agent of pastoral care able to draw near to and to help those who suffer, in the dynamic of the incarnation (cf. Heb 4:15).

– He or she is enriched in concrete service to the sick and their needs.

– He or she measures himself or herself by the values of the Kingdom which are not efficacy or success but recognition of what is apparently insignificant, the density of daily life, the person and his or her concrete realities, and the option for the needy.

– He or she recognises the sick and those who draw near to them in the name of Christ as representatives and recipients of pastoral care. Both give and receive and for this reason a pastoral agent allows himself or herself to be guided by the sick and to be evangelised by them as well.

– He or she lives and cultivates a community sense of his or her mission, he or she feels sent out by the Church to assist the sick and the needy and does not work in isolation but in union and coordination with the rest of the community.

– He or she looks for spaces for celebration and for prayer, for reflection and study at both a personal and a group level. His or her pastoral service is a source of happiness and of joy and is an opportunity for personal growth. Basing himself or herself on the way that Jesus acted and embodying all the traits that I have pointed out as specific to his or her specific spirituality, a pastoral worker is able to express in his or her life and the pastoral activity that has been entrusted to him or her those approaches that we see as being fundamental in the carrying out of his or her mission in the Church, which are: generous service, gratuitousness, solidarity, hope, taking up the cross, and mercy.

5. The Recipients of Pastoral Activity in the Hospital Context

The religious service in a hospital accompanies the members of the Christian community, but it also enters into contact with people who belong to other religious confessions and even with people who do not believe. For all of these people, with words and deeds, a pastoral worker must be a witness to the Gospel of Jesus Christ.

The principal recipients are the *sick* to whom the pastoral worker draws near with respect, with an approach of listening, attentive to their spiritual needs, ready to help them to live their illnesses with meaning, also offering advice in ethical decisions which may be problematic.

Experience of illness is not lived in solitude. In addition to the patient, those who feel most afflicted by the illness are his or her family relatives. One cannot understand what is good spiritually if one does not take into account the families of sick people, bearing in mind their needs and offering them that pastoral care that they need at every moment. One should provide very special care at the most critical moments of the process of illness, including help in accepting the loss of loved ones and working through mourning in a suitable way.

Our service must also provide care to all of the personnel, attending to the human and spiritual dimensions in professional practice as an important contribution to personal growth and to achieving higher quality in the service that is provided to sick people.

Our gaze must also reach the hospital *institution*, contributing to sensitising the whole of the organisation to providing integral assistance to the sick, their families and the staff, working to ensure that the patients always occupy the central position that they should have and working together to humanise assistance.

6. Concrete Pastoral Activity

Our pastoral care in based upon the style in which Jesus treated the sick. I would like to emphasise above all the nearness, the tenderness, and the offer of integral healing that characterised the behaviour of the Lord Jesus towards sick people. We know that the process of an illness marks a critical point and a very important experience in the lives of individuals.

On many occasions it is a key moment by which to make contact with the religious experience so as to reawaken, accompany and help the process of drawing near to faith. In this experience one can engage in the following activities of pastoral service.[5]

The pastoral visit

Emphasis should be placed on the great importance of the meeting with the patient and for this reason our visits must be made with suitable preparation and with a certain method that helps us and makes them gratifying both for the patient and for the pastoral worker. In the visit it is advisable

to distinguish the various needs that exist for each patient and to make to each patient the most appropriate visit possible, which is what we may call a 'friendly visit' or one directed towards pastoral help. A sudden visit should not be made but one that belongs to the pastoral plan, one of the fundamental policies of which is to facilitate meetings with pastoral workers.

In the visit of great importance is utmost respect for the religiosity of each patient – a statement that I see confirmed by my own daily experience as a chaplain – with respect for his or her personal rhythms and with no imposing of our styles. Such a meeting is very often an opportunity to go on a journey together, which is not the journey of the pastoral worker but the journey that God wants in order to bring the patient to a meeting with Him. A constant exercise must be engaged in of drawing near to the varying situations of faith (even the absence of faith), placing oneself with humility and simplicity near to the sick person, principally to listen to him or her. During this visit evangelisation must truly take place because a personalised meeting, often with a trusting dialogue which is respectful and free, allows one to arrive at the innermost parts of the person and open him or her to the experience of faith.

Prayer with and for the patient

It has always been said that illness is a propitious moment for prayer. The need to pray arises spontaneously in a sick person and also in his or her family. This prayer takes many forms, with emphases that have a great deal to do with the personal pathway of faith and the situation of the moment, but it acquires in the patient great profundity and sincerity. For all of these reasons, prayer is one of the most important instruments that exists for the pastoral worker because through prayer we can create a climate of trust and peace, finding in prayer the strength to bear the pain and tribulation that accompany illness. Prayer that also opens to joyous recognition of the gifts that have been received. And hope, when the patient is preparing to take the decisive step towards the house of the Father.

As it is one of the most important moments, prayer with the patient highlights certain points which I believe we should not avoid:

– It must arise from the needs and the wishes of the patient.

– One must know how to listen to the patient in relation to his or her experience, his or state of mind, and help him or her to express in prayer everything that he or she is living in his or her interior world.

– We must bear in mind the experience of faith of the patient and his or her way of expressing it in prayer without forcing him or her at the level of methods or style.

– The emphases of prayer must be in harmony with the existential situation of the patient who prays, expressing lament, gratitude, trusting devotion, supplication and intercession, the action of the graces and praise.

– Our model for prayer is always that of Jesus. We must base ourselves on him, and it is he who accompanies us in helping the patient.

We must also attend to prayers for the patient, a dimension that the Church has always cultivated with especial attention. Pastoral workers pray with the patient, but they also know to pray for the patient.

The Celebration of the sacraments

The sacraments that accompany a Christian in the experience of illness are reconciliation, the Eucharist-communion and anointing of the sick. We must value these sacraments in all of their meaning, going beyond reductionist ways of understanding them. They are signs that demonstrate the love of God for the patient and also the nearness to him or her of the Christian community, a dimension that must be taken into account when they are celebrated in the context of a hospital.

The offer of the celebration of these sacraments must be done paying attention to the situation of faith of each patient and his or her sacramental life. A patient must be the protagonist and it is he or she that must ask for, and accept, the sacraments. We know that this is not always the case and in some cases it is the family that asks for the celebration of a sacrament. One must carefully discern the various situations that exist with the greatest respect for the sick person, offering, as well, an opportune catechesis so that the sacraments are understood and experienced in a suitable way. This is a task that has to be performed over a longer time period and which influences all of the process of formation in faith.

Pastoral care for the families of patients

This is an essential aspect since families are very much influenced by the illness of a loved one. Nearness, listening and attention to his or her spiritual needs are also the task of the pastoral worker who must know how to value families as a very important pastoral aid in order to serve the sick person in a suitable way. One should work with families in an intense way so that they can face up to the most painful situations, in many cases helping them to prepare for the moment of separation from the patient with hope and peace. Our service takes practical form in offering them a respectful nearness, listening and guidance, making available to them the aids of faith. The situations and the experiences that they go though are very diverse and for this reason care must be personalised and suited to each case.

Pastoral care for the health-care personnel

Providing care to people who are dedicated to caring for others is an important duty in relation to the health-care personnel as well. This is an indirect way of contributing to a better service for sick people. Our pastoral care takes practical form in a readiness to work together in a team and in the respectful and simple way in which we offer our Christian vision of life. A pastoral agent can

contribute to giving meaning to the work engaged in by professionals by enabling them to discover the ethical and spiritual values that must direct their activity and by sharing with them spaces of reflection on questions of an ethical-spiritual character that may emerge. The pastoral team must contribute to creating a model of a humanised hospital which far from suffocating the person in its structures values the efforts of professionals and is always directed towards better care for patients. And all of this, fundamentally, is accomplished by close and assiduous contact, also knowing how to appreciate the meetings that are planned and even offering spaces for prayer and celebration for those within the hospital institution who share the Christian faith.

Our contribution as pastoral workers to subjects of an ethical character is to illuminate these situations with a Christian philosophical perspective, following the approaches of the Magisterium of the Church and cooperating in the ethical formation of the professionals. We must also be in a condition to offer ethical consultation to the patients, to their families, to the personnel and to the institution itself, when this is asked of us. Certainly, this is one of the most delicate and difficult missions within the context of a hospital which requires suitable formation at both a theological-moral and a scientific level.

Cooperation in the humanisation of the hospital institution

One of the greatest challenges today for any hospital institution is that it should really be a setting for hospitality and welcome where a sick person does not feel an outsider. The team for pastoral care of a hospital should be sensitive to this task and cooperate in contributing all the newness of the Gospel to the way in which a patient is treated and assisted. To achieve a good humanisation one needs the dream to come true of the patient really being at the centre of the whole of the organisation. Political and ideological interests, and even technology itself should not have this centrality, which falls to the patient alone.

The team for pastoral care can cooperate in performing this task through its witness to humanity and professionalism, but also by supporting all those activities that come from other areas and should be directed towards humanisation.

7. Towards Integral Care

We pastoral workers must cooperate in the search for the total and integral health for all people. For integral care to exist one needs on the part of everyone interdisciplinary cooperation where the patient is assisted in his or her totality. We cannot ignore the spectacular advances that have been achieved by medical science and which bring so many benefits. But one should also foster dialogue with other disciplines such as anthropology, psychology, ethics, theology etc in an anthropological understanding that recognises that what is human has a plurality of dimensions. Today, interdisciplinary cooperation needs an appreciation of the multidimensional character of care for the sick, with each sector accepting its specific responsibilities as regards integral care for the person.

We know, for that matter, that every sick person whatever may be his or her vision of life, his or her faith or his or her religious confession, has the right to be respected and helped in his or her requests of a spiritual character. It often happens that sick people go through strong experiences that mark the person in his or her innermost self. A sick person feels the need to address some of these needs which we say are of a spiritual character and certainly it is during these delicate moments that one must heal this dimension which we say is spiritual, as an extra service in health care that is directed towards the totality of the person.

We have the obligation as pastoral workers to facilitate for every sick person the spiritual assistance to which he or she has the right. We affirm the value of the person in any circumstance and we do this with a spiritual accompanying with the help that is necessary so that everyone can live in a more worthy, responsible and hopeful way, whatever their existential situation may be. The ultimate meaning of, and reason for, our service in a hospital is to offer the saving grace of Christ to men who suffer.

Conclusion

I have attempted to describe the work of our team for pastoral care in hospitals which is at the same time an evangelising task and an attempt at humanisation in the world of health and health care. The centre of attention of this attempt should always be the sick person because, as Fra Pierluigi Marchesi, Father General of the Brothers of St. John of God argued, ‘If the sick person is not the centre of a hospital, the centre of the concerns of all those who act for him, others take his place’.

The breadth of the subject and the diversity of approaches that can be encountered led me to present my experience within a hospital chaplaincy with certain strong approaches and models of work that are broadly shared.

A pastoral worker who works with a team in a hospital must be suitably trained at a theological-spiritual level but he or she must also be able to establish deep dialogue with the culture of the world of health and health care. Pastoral activity in a hospital must not be improvised. It must be planned using the instruments that are available to us and going forward in the belief that the good performance of the whole of the mechanism depends in large measure on the ability to work in a team both with other pastoral workers and with the other professionals of the hospital, taking part in a multidisciplinary team which attends to all the dimensions of the person.

The integral care which today is one of the fundamental instruments of the world of health and health care reminds us that our model of assistance is interdisciplinary. And this requires suitable organisation, work methods that make this model possible, and a very fine sensitivity towards care

and assistance for people seen in an integral way.[6]

Spiritual assistance, pastoral care, is a right which the sick person cannot be deprived of in the context of a hospital institution. And the Church, faithful to the mandate of the Lord, must devote all of her commitment and her efforts to being near to people who suffer because of illness, thereby continuing the mission of Christ the Good Samaritan, who today as well draws near through the ministry of the Church 'to the man who suffers in body and spirit, and cares for his wounds with the oil of advice and the wine of hope'.[7]

Notes

[1] Edoardo Gavotti, "La cappellania come modello di azione pastorale" (Convegno Internazionale Camilliano, Rome, 2005).

[2] Benedict XVI, *Deus Caritas est,* n. 31.

[3] See for this sub-section, José Antonio Pagola, *Evangelizar el mundo de la salud y la enfermedad* (Madrid, 2004), pp. 149-168.

[4] Cf. AA.VV., 'Pastoral de la salud. Acompañamiento humano y sacramental', *Dossiers CPL*, 60 (1993), p. 181.

[5] Cfr. COMISION EPISCOPAL DE PASTORAL DE ESPAÑA. *La asistencia religiosa en el hospital: orientaciones pastorales* (Madrid, 1987). Some of the points listed here are based on this document.

[6] Cf. *La Orden Hospitalaria, comunidad evangelizadora, desde los excluidos* (Fratelli di San Giovanni di Dio, Provincia San Rafael, Barcelona 2003).

[7] *Misal Romano*, 'Prefazio Común VIII', Spanish edition, 1988.

The Human and Spiritual Formation of Hospital Voluntary Workers

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Your Excellency, Ladies and Gentlemen, Participants in this Conference,

What does a person who works in the world of illness need in addition to professional formation? We can understand how necessary human and spiritual formation is from a fine insight of Msgr. Zimowski, the President of the Pontifical Council for Health Care Workers: 'To entrust oneself to divine Providence thus means to continue to a give a meaning and a purpose to our lives, notwithstanding the pain. However, many times hopelessness seems to grip a sick person, a hopelessness where it is not easy to bring words of help. Words seem to be empty and do not manage to create a relationship: only a presence and deeds can express something. But specifically starting from this situation of absolute poverty, perhaps recognising the hands of God in the presence and deeds of a professional or pastoral worker, God can be recognised and loved'.[1]

If presence and deeds can make people recognise and love God, those who work, whether they have been professionally trained or are simple volunteers, have a great responsibility to be, in human and spiritual terms, predisposed to relate to sick people as the bearers of hope.

Hospital Voluntary Work as Commonly Practised

I wanted to centre my paper around the hospital voluntary world not in the classic sense, that is to say volunteers who work inside hospitals, but in a broader sense, taking into account the development of the figure of the hospital volunteer who attends to long-term admissions or disabled patients in institutions such as hospitals or institutes, but also in local areas, with a nearness that does not take into account the place but, rather, the person and the endemic evil of this era of ours which is loneliness.

I will, therefore, speak about hospital voluntary work as is it is commonly practised, starting with the experience of the association whose president I have the honour to be, namely UNITALSI,[2] which during the 110 years of its existence has undergone a development in its way of understanding and providing service to sick people, the disabled, the elderly, the poor, and the alone.

This is kind of voluntary work which more than other can be defined as being 'Christian'.

'Voluntary work', understood as the free provision of a service to those people who are in some state of need, in order to have the connotation 'Christian' must have as its foundation and model Jesus Christ, who, 'always had the nature of God, but he did not think that by force he should try to remain equal with God. Instead of this by his own free will he gave up all he had, and took the nature of a servant. He became like a human being and appeared in human likeness'.[3]

He gave us an example of service by washing the feet of the apostles[4] and he gave us the 'new commandment' that 'you should love one another as I have loved you'.[5]

This specific observation 'as I have loved you' constitutes

the originality of Christian love which must be a freely-given love, a love of donation and a love of transforming and universal sharing.

This is an action inspired by charity and we can say together with Msgr. Pompili: 'The action of the Church inspired by charity is confirmed as the hardcore of resistance to the spreading phenomenon of secularisation, but it is even more. It is the founding principle of Christianity. And the pre-condition for humanity surviving itself'.[6]

Ever since its beginnings, UNITALSI has based the service of its stretcher-bearers, sisters of assistance, medical doctors, men nurses and chaplains on the style of those who work in hospitals. Thus a train, with stretcher carriage, became a hospital train; the places receiving sick people in Lourdes (Accueil and St. Frai) were authentic hospital wards; and the timetables and turns were run according to a hospital institution.

Over the years this way of seeing things evolved. It was understood that a volunteer engages in a service of nearness which goes beyond a hospital institution and thus the methodology that was employed by activities within the framework of UNITALSI was defined above all else as greater 'nearness' and the possibility of entering into a relationship in order to know about the needs that a person in a state of difficulty sees as being of priority importance, and this so as to construct a relationship that can be a stimulus for a subsequent project for the improvement of a person's life conditions.

This is because Lourdes is in every home, in every family, and in every place of care, whether a hospital or a nursing home or a hospice or a protected residential complex, where frail people are cared for and taken responsibility for (they are not only treated). And they are loved and respected for what they are.

The operative instruments have been:

'*Welcome*': this is unconditional and without any kind of contract.

– '*Listening*': this is understood as empathetic listening directed towards the recognition of the person and an understanding of his or her malaise, ending his or her interior dialogue so that he or she can draw near to the person in front of him or her, without judgements and without requests, recognising and referring to the other responsibility for his or her needs.

– '*The relationship*': this is installed through contact directed towards the satisfaction of the needs that have been expressed by the person concerned.

– '*Mediation*' in the relationships between the beneficiaries of the service, those who implement it, and voluntary workers in general.

– '*Working in a network*' directed towards the mapping and activation of local communities and realities that can promote actions to provide support and inclusion to people in a state of difficulty.

This evolution in the way of seeing things has been strengthened through daily work because it emerged clearly through contact with the people who were encountered that they rarely expressed a single request or were the bearers of a single need.

It is often the case that the limits of our actions are to be found in meeting the requests of people in accordance with sectors, thereby privileging only the 'problem' that is directly related to us, where it is obviously not possible to take responsibility for a problem *in toto*. The challenge for many voluntary workers is to activate both the resources and the skills of the person who is involved as well the entire network in order to try to solve the problem to hand.

The Process that Led to the Construction of a 'System of Services'

At a national level, from an analysis of the data worked through following a survey that was carried out by means of a questionnaire which was directed towards bringing out the use of free time by sick people, disabled people and/or elderly people, as well as the frequency/quality of social interactions, it was clear that many of these people are excluded, in the contexts they live in, from social life and that they only occasionally take an active part in social life. They often can only count upon a small network of friends and their families are not always involved in recreational activities but concentrate, instead, on the meeting of their primary needs, as a result of which the need is seen to develop strategies to work against exclusion through actions that envisage ongoing social activity, exchange, and the activation of good practices.

Actions of the System that have been Implemented

UNITALSI has worked to create the basis of the system of services by achieving the following objectives:

– The creation of a shared pathway for voluntary workers which has allowed all participants to implement their knowledge as regards the phenomenon of social exclusion and to acquire skills relating to the problems often borne by people who are in a state of difficulty.

– The setting in motion or the implementation, starting with a photograph of existing realities, of good practices that are useful in providing indications as regards the promotion of processes of autonomy, the taking advantage of important opportunities for recreation by disabled people, through experiences of temporary community accommodation as well, activating as much as possible their residual capacities.

– The creation of services of relief for the family relatives of disabled people.

Some Services that have been Established

In particular in Rome, UNITALSI works with the Baby Jesus Hospital and the Gemelli Polyclinic, and in particular with the paediatric wards of these hospital institutions.

During these recent years of strong cooperation we have fos-

tered interaction between the health-care personnel, family relatives and those voluntary workers engaged in providing assistance. At the centre of the synergic work there is the primary and exclusive interests of the children and their families.

Those voluntary workers who come into contact with the reality of the illness of a child are first trained from a number of points of view. We are concerned to provide them with instruments which can be useful in their relationships with the family relatives and with the children themselves.

For this reason, in recent years we have taken part in various courses, all of which have been directed towards formation and in-depth analysis. In particular, we have paid especial and incumbent attention to the psychological and emotional repercussions that this kind of service can provoke, especially in the youngest of the voluntary workers.

The best way by which to support, in the best way possible, situations of extreme difficulty and pain is certainly that of conserving, where this is possible and as far as this is possible, the psychological and emotional equilibrium of those who have chosen to serve their neighbours in this particular field.

All the courses and the meetings that we organise are opportunities where voluntary workers can acquire basic information that is useful for their service in addition to skills as regards relationships. It is never easy to enter into a relationship with people who are living situations of great and grave difficulty.

For those who engage in service in homes of the children's project we conceived of a specific formation. Indeed, the presence of voluntary workers must sustain and support, but it must do this with due discretion, which is indispensable in allowing the families to have autonomy and intimacy.

It is also necessary to be trained to answer at the call centre with its the green number, not only to be able to provide correct information but also, and this is an important point, to establish immediately a familial contact. The callers must be able to perceive from their first contact a reality of service that is understood as total and free self-giving in a Christian logic.

What we do is not mere welfare or a simple kind of voluntary work. It is an experience of service following Christ, imitating the charitable spirit that animated Jesus and the apostles and animates all those who in his name carry on the work of building up the Kingdom of Heaven.

This is our horizon; this is our charism. We work for the needy so as to be that portion of the Church that walks at the side of our friends, both young and old, who are in a state of difficulty.

The courses of formation, which are useful and at times indispensable, are an instrument to be taken advantage of so as to serve. But the engine of our service is faith, it is following Christ, the servant out of love.

For this reason, of great importance is the spiritual formation of our voluntary workers so that they can receive nourishment from the Word of God and from the Eucharist, so that their work can always be directed towards the principles of the Magisterium of the Church.

Respect for the person, for the dignity of every individual, respect for one's own body as a temple of the Spirit: these are only some of the points that have been addressed and on which each participant has been able to reflect and reason and bring his or her own experiences.

Formation, therefore, is not the prerogative of voluntary workers: it is for everyone, for those who receive our service as well, specifically because through a daily sharing of experiences and problems it is possible to construct a climate that is truly familial in character, and it is this that is the objective of our association.

The activities engaged in by the volunteers of the Tuscan UNITALSI at the Meyer Children's Hospital, which today is commonly called the 'Meyer Children and Families Project', are the result of a long journey that began more than ten years ago.

The problem was posed of how to manage to offer these people, sick people and their parents, who perhaps more than any others truly needed it, the opportunity to engage in a 'wonderful experience of faith and sharing'.

It is certainly the case that the most suitable place for us to launch this proposal was the Meyer Children's Hospital of Florence which every day sees pass through its wards a very large number of people afflicted by suffering but who at the same time are always searching for hope.

But the matter was not a simple one. We encountered great difficulties in managing to launch 'our proposal'. We tried to get into contact with other associations which were already present within the institution but we did not manage to find people who really spoke our language. There were those who did not want only to engage in service inside the hospital but, in contrary fashion, as was the case with us, they wanted to bring some words of hope, to be near others without asking for anything or seeking anything. And to speak about God, perhaps with discretion, but to speak about God.

And as often happens in life, the occasions, the opportunities, present themselves only when the times are ripe and perhaps when the Lord decides that the most suitable moment has arrived. And all of this often happens in the simplest, most spontaneous way, not because 'those at the top' decide it but because people encounter each other, meet each other, appreciate each other and decide together to begin a pathway.

This is what happened with Giulio and Federica, the parents of the little Andrea who had a genetic illness, and Father Guglielmo, the chaplain of the Meyer Hospital.

Federica, who is today the president of the Pistoia branch of UNITALSI, had the idea of remembering what she and her husband had experienced some years previously when, after the birth of her child, she was told that the illness that had struck her child was 'incompatible with life'.

Federica remembered her wish of that time which was to take her prayer to the Grotto of Lourdes, a prayer which, because she was

unable to leave, she entrusted to her friends of UNITALSI.

Hence the idea, which was immediately embraced by the Tuscan UNITALSI and the chaplaincy of the Meyer Hospital, to promote in the wards of the hospital the initiative which was called 'Little Witnesses to Faith'.

This was a simple idea but at the same time a brilliant idea thanks to the contribution of the voluntary workers of certain branches to assuring at the hospital a continuous presence during which there could be proposed to children and their family relatives the possibility of leaving behind them a thought, a prayer, or even simply a drawing or a photograph in a 'White Book'.

White in the true sense of the word because the volume, or better the volumes given that in the end only one volume was not sufficient, were progressively written by children and their parents with their prayers for help and prayers that gave thanks to Mary.

This initiative was looked upon with great favour by the chaplain, Father Guglielmo, and by his helpers of the chaplaincy we felt welcomed with open arms and thus we began to flank them in their service. Since then this service has not been interrupted. Today various branches of our association, even though they are distant in a physical sense, alternate in various ways in being present at the Meyer Hospital.

Authentic service requires a marked human and Christian sensitivity: it is a matter of knocking at a door behind which one does not know what kind of suffering could be encountered. But we will certainly find suffering, that suffering which is the most difficult to accept and to understand, I mean the suffering of children.

This is not a matter simply of entertaining children with games. It is also a matter of entering on tiptoes often to listen to what the children and their parents have to say and perhaps to say a prayer together. Then there is the proposing of the white book which is rarely rejected even by those people who do not have a conscious faith or perhaps do not speak your language. Each person is free to write or to draw what he or she believes is appropriate. The result is a splendid collection of praises to God and to Our Lady which is of a beauty that cannot be described.

You find yourself in front of what you would never have expected: a very great deal of suffering but also a great deal of hope and desire to live.

In this way UNITALSI is a guarantor of giving to Mary these books that are full of suffering but also of hope as well, books that are fill of dismay but also of prayer, during Holy Mass in the Grotto of Pilgrimage in Lourdes in the month of June, which is characterised by the presence of children and their families, thereby extending the spirit and the intrinsic vocation of the association, which is to take sick people to Lourdes

Our constant presence inside the hospital is a factor behind the inspiration that lies behind very many new ideas.

One of the most recent and finest ideas has been to make the children who have been admitted to the hospital to make drawings on the mysteries of the rosary which can then become illustrations for a short book which is being produced as a result of an initiative by the national vice-assistant of UNITALSI, Don Danilo Priori.

This short book is a very important support for the saying of the rosary during the pilgrimages to Lourdes carried out by UNITALSI whose pastoral theme was that proposed by the sanctuary itself: 'Praying the Rosary with Bernadette'.

In this case, as well, the imagination of the children in interpreting the various mysteries of the rosary has led to the collection of authentic 'small masterpieces' which are not only artistic in character but also works of true faith.

Actions in the Local Area

The spread of conditions of physical and material malaise has accompanied the development of cities and metropolises, and many people with specific needs, but with a series of factors in common such as grave situations of poverty, social isolation, the fracture of social and family ties and physical deterioration, often run the risk of producing grave situations of marginalisation.

The approach to these situations is always complex and for this reason it requires specific interventions of a social character according to a logic of welcoming, of service and of the protection of people in difficulty.

The services that have been activated, specifically because of their capacity to enter in relationships with people who live in conditions of malaise, have been confirmed to be especially suitable in reaching the most unreachable people who are without protection, offering them an opportunity of being able to move out of their situations. For this reason, the many disabled and/or elderly people who have used this service have been able to regain their social spaces as well as important cultural, sports, recreational and spiritual opportunities, which have certainly generated significant pathways of inclusion.

Relations with the City Network

It should be emphasised, therefore, that the idea of creating or strengthening a network of flexible and sustainable services, organised around the idea of solidarity and managed with voluntary personnel, has shown itself to be a winning policy, not least because in many contexts it has worked to place within a network the skills and resources of UNITALSI, other associations and public institutions. This has allowed engagement in synergic actions of social inclusion directed towards people who often are in contact with all these various bodies.

In some contexts external relations have been strengthened with institutions and with the network of city organisations which deal with social malaise, and in particular that of disabled or elderly people, also trying to define forms of cooperation and forms of recognition, and defining fields of competence and promoting com-

mon operations, in a way that respects individual roles and forms of autonomy.

During the course of these activities, both during the organisational and assessment stages and during the more operational stage, the goals and the objectives to be achieved at that particular moment, in that specific context, have always been borne in mind.

The construction of relationships with the target people and the voluntary workers who engage in this activity has been a fundamental element which has allowed: the guiding, sending and accompanying of many people towards certain services of the local area; reaching and containing certain situations at risk; providing information and instruments for the protection of the person; strengthening the network of services; and building a working bridge that is useful in managing in a more effective way requests and needs involving people who live in conditions of difficulty because of their physical conditions or because of their age.

It also emerged that the newness of the work at the outset provoked a certain concern about the approach of the administrative work that was requested and a notable initial 'hurry' as regards the management of the accounts relating to the activity engaged in at a local level, which had always been carried out in an informal way.

It is certainly the case that this work has also been useful in knowing about, experimenting with, and developing a system of communication and collection as regards data which are more precise and careful.

This led for the first time to acquiring 'true' knowledge about the multiple activities engaged in within the national territory and allowed all the subjects involved to understand the real amount of work engaged in for sick, disabled or elderly people who are assisted every day by the volunteers of the association.

Formation

This pathway, in addition to having as its purpose the activation of a complex of actions to protect and foster the inclusion within society of disabled or elderly people, has shown that it is also able to restore to them human dignity and to assure the implementation of their rights of citizenship.

The commitment of UNITALSI is first and foremost to continue to construct pathways of encounter and recognition – recognition of the person who is always and whatever the case a person in whatever condition he or she finds himself or herself because a person is never everything and only what he or she does or the condition in which he or she lives: he or she is first of all a *person*, with problems and potentialities, resources, a will and capacities, which at that moment, in that specific context, are activated in varying ways.

The need for recognition is the first need of children, as it is for adults: an individual who is not recognised as a man/a woman becomes invisible, marginal, and dies.

For UNITALSI, this is very important: recognising people in their totality and complexity, not thinking of them in terms of the problems they bear but only and solely as persons to be encountered, known and recognised.

In order to construct these pathways of encounter and recognition one should of necessity attend to the human and spiritual formation of voluntary workers because formation can well be seen as one of the leading columns of a culture of high quality.

We often perceive a authentic cultural backwardness, often confusing formation with training and aiming at providing a series of notions without being concerned to involve the voluntary worker who must be able not only to acquire the data that are necessary for his or her action and knowledge of Church documents but also to be placed in a condition where he or she can pour into his or her service all his or her own spirituality, intelligence and capacity for cooperation.

An interactive formation, therefore, which is not only a matter of a teaching chair but which must also stimulate and involve, which must also judge, and which also involves costs in the choice of people responsible for formation. 'If you believe that formation is expensive, try ignorance'.[7]

A formation that is certainly ecclesial and not neutral, which operates on all fronts, and certainly not a formation whose objective is to convince members of the validity of the decisions taken by the leaders of associations; a formation that has space for criticism, as a constructive contribution to the achievement of an ecclesial association that works for the poor and suffering, where our 'governing class' overcomes the approach of 'direction by authority' and moves towards 'direction by agreement'.

It is certainly the case that one is dealing with a profound cultural mutation which requires first and foremost the credibility of the leaders of associations and a condition of serenity.

But it is specifically the moments of crisis of participation, such as the moment that we are now going through, that offer the greatest opportunities to undertake or accelerate this process of cultural and organisational mutation.

One should always bear in mind that formation must produce a spiritual and cultural elevation in the broad sense inasmuch as the pursuit of quality is an approach to our duty in all the actions of our lives. Indeed, if one aspect of quality is a higher civic level, it is inconceivable to think that a person can behave in an ethical way, as is requested by quality, only within an association.

It is certainly the case that formation goes well beyond group meetings or the reading of support material. It requires a continuous wish and a constant will to be nourished at the spring of faith and it calls believers to a convinced participation in the lives of parish and diocesan communities, becoming agents that advance pastoral care as well as active members of the entities to which they belong.

'The local Church is the place where the economy of salvation enters more concretely into the

fabric of human life…The catechesis is the central moment of every pastoral activity, of every solidarity and ecclesial institution, of every institution that can contribute to the building up of the Mystical Body of Christ'.[8]

The catechesis is not everything but everything within the Church needs the catechesis: the liturgy, the sacraments, witness, service and charity.

An Indispensable Premiss: Commitment and Membership

'A voluntary worker is a citizen who freely, not carrying out specific moral obligations or juridical duties, basis his life – in the public and private worlds – on goals of solidarity. Thus, after performing his civic and state duties, he makes himself disinterestedly available to the community, promoting a creative response to the emerging needs of the local area with priority attention being paid to the poor, to the marginalised, and to the powerless. He commits energies, capacities, time and any means he may have to initiatives of sharing, engaged in preferably through group action. These initiatives are open to a loyal cooperation with public institutions and social forces; they are carried out with a suitable specific grounding; they are actuated with a continuity of interventions, intended both for immediate services and the indispensable removal of the causes of injustice and every kind of oppression of the person'.[9]

In the various analyses that are engaged in emphasis is not placed on gratuitousness and it is argued that the specificity of an organisation engaged in voluntary work lies in the construction of relationships: this is what differentiates the authentically voluntary action from charitable work or philanthropy. 'The strength of a free gift does not lie in the thing that is given or in the quantum that is given…but in the special human quality that the gift represents because of the fact of being a relationship'.[10] This means that a voluntary action constructs new relationships marked by reciprocity, gratuitousness and solidarity. This action is thus a pre-condition for a society that is more human; it makes up, so to speak, its most evident soul.

Indeed, there is a great, minor and unknown, world of works of good that contributes in an equally relevant way to the quality of social life. One may think here of those who direct their activities of work to the public good and to public service, or specifically of widespread voluntary work in hospitals, where workers dedicate their lives to assisting people in need, working silently to listen to people's sufferings, to attenuate contrasts, and heal wounds.

'When man develops the earth by the work of his hands or with the aid of technology, in order that it might bear fruit and become a dwelling worthy of the whole human family and when he consciously takes part in the life of social groups, he carries out the design of God manifested at the beginning of time, that he should subdue the earth, perfect creation and develop himself. At the same time he obeys the commandment of Christ that he place himself at the service of his brethren'.[11]

Every journey of Hope[12] starts with the revelation of a Beauty that steals the soul: dazzled, there is the risk that we will remain adolescent vagabonds of faith without ever becoming adult pilgrims aware of our goal and our commitment… our 'rite of passage', as wanderers and pilgrims, must lead us from the emotion of an extraordinary event to the enthusiasm of daily festivity, establishing as an indispensable pre-condition a precise choice of belonging… belonging to the Church and to the association!

Our membership of the Church originates from baptismal promises which render each one of us a 'prophet, priest and king':[13] a prophet of proclaiming, a priest in living offered up to God, and a king in serving. Our membership of the association originates in the same promises and generates the same commitment: to be a prophet, a priest and a king!

The pathway of membership of our association is bureaucratically defined: it begins from the chance of an encounter, it passes by way of the qualification of being an auxiliary member and draws near to the desired qualification of being an actual member, which, today, substantially means being an elector and a person who can be elected.

To be electable one has to pay attention to a person's situation in terms of the civil register and to the state of one's family; to be an actual member one must have paid one's dues and travelled on trains (or aeroplanes!). The rest is a discretional space which at times is used and abused! Being a prophet, priest and king, seems to me to have little to do with the pre-conditions that are requested!

I believe, instead, as also happens in other associations, that a pathway of growth and 'drawing near' should be defined which leads from a promise to actual commitment.

The organisation of the stages involved already exists, just as already envisaged is the move from a state of waiting and of formation to a state of consolidated belonging. The problem lies in filling in the contents of this existing structure, defined with courage as a journey that one has to have completed, as values that have been projected, as experiences that have been lived through, and as tests that have been passed, in order to be able to be and 'feel' actual members and thus living members of our associative body.

The actual member says a spousal 'Yes' to a reality that changes his or her life; he or she says an aware 'Yes' after knowing to the utmost the reality of the association and after understanding the scale of his or her commitment; and he or she says an informed and 'enlightened' 'Yes' to the universal Church and to the local Church!

'Voluntary work appears intimately marked by the dimension of the Advent… But for Christian voluntary work to employ all of its potentialities and to produce all the fruits that it bears within itself it has to retrieve its constitutive dimensions', so as to avoid being reduced to an 'organisation of services' that entirely absorb the 'value of human promotion'.

The association has the re-

sponsibility of making available the instruments of formation and of assessment so as to be able to complete correctly the pathway of going from being an auxiliary member to being an actual member: culturally sensible and theologically founded formative proposals, opportunities for service and knowledge about projects, occasions for communal prayer and reflection, and half-way and final assessments. A novitiate, that is to say, which can be transformed into membership with a solemn promise, which is the same for everyone, formally defined as well.

To follow this pathway (which should be assured by the local leaders of the association) but also go achieve many other things, it would be advisable, in my opinion, to rely upon the supervision of a group of people who think with the same heart, who adhere to the full to the same project, and who act as a link between the leaders and the grassroots: people who provide formation, people who provide information, witnesses, communicators, messengers…and, as far as this possible, prophets, priests and kings!

Many problems arise from an objective difficulty in communication which leads, as in the game of played by people of telephones without lines, to a distortion of the original message.

The overall project, instead, should reach everyone in its authenticity, avoiding filters and censures, because the 'Yes' requested of voluntary workers must be preceded by correct information because a homogeneity of opportunities and of conditions should be assured, because no potentiality should be wasted.[14]

Although one has to submit to the logical of local areas which want the leadership of an association to look more at geography than at people, one can, nonetheless, imagine a technical-operative (but thinking!) structure which is intermediate and directly connected with the presidency, which moves in the local area and which assures a dual transmission from the top to the grassroots and vice versa.

As regards the 'middle ranks', obviously the conditions requested of the members should be acquired and shared facts for those who are called to services of responsibility in the association. Indeed, the capillarisation of the project (relating to formation as well) is entrusted to local people of reference who must be witnesses and teachers for the members and for the community.

An 'updating course' for leaders is required in a logic of ongoing formation that should be easily accepted and should not offend the susceptibility of anybody!

The Formation Pathway for Leaders

UNITALSI is in the Church and is of the Church but it is defined by its vocation and ministry. Our formation project must, therefore, start from our baptism, yet it must also take into account our origins as an association; it must start from knowledge about the 'universal sources' but without ignoring knowledge about 'our sources'.

The orientations of the Church after the Second Vatican Council, addressed to the Eucharistic community and the community of the baptised, are set forth in ten-year pastoral plans which are assessed during the course of the great national ecclesial conferences held in the middle of each decade.

They mark in an unequivocal way, for all the faithful and for every association, the road to be followed to be 'in' the Church and 'of' the Church.

– In the 1970s: the pastoral plan entitled 'Evangelisation and Sacraments' – the conference in Rome (1976) on 'Evangelisation and Human Promotion'.

– In the 1980s: the pastoral plan entitled 'The Italian Church and the Prospects for the Country' – the conference of Loreto (1985) on 'Christian Reconciliation and the Community of Men'; the encyclicals *Sollecitudo rei socialis* and *Salvifici doloris*.

– In the 1990s: the pastoral plan entitled 'Evangelisation and Witness to Charity' – the conference of Palermo (1995) on 'The Gospel of Charity for a New Society in Italy'.

– In 2000 the Great Jubilee – *Tertio millennio adveniente* and *Novo millennio Ineunte*.

– The first decade of the twenty-first century: the pastoral plan entitled 'Communicating the Gospel in a Changing World' and the conference of Verona (2006) 'Witnesses to the Risen Jesus, Hope of the World'; the encyclical *Deus caritas est*.

– The second decade of the twenty-first century: pastoral orientations 'Educating in the Good Life of the Gospel', *Caritas in veritate*.

The Official Sources

The nature, contents and method of a pathway of formation are defined by the *Italian Catechistic Project* which starts from the four theological Constitutions of the Second Vatican Council: *Dei Verbum*, *Lumen Gentium*, *Sacrosantum Concilium* and *Gaudium et Spes*.

This pathway is summarised in the basic document entitled '*Il Rinnovamento della Catechesi*' ('The Renewal of the Catechesis') which was published by the Italian bishops in 1970, and in the subsequent '*Lettera di riconsegna*' of 1988 and in the eight volumes of the '*Catechismo per la vita cristiana*' ('Catechism for the Christian life') in its various editions until the edition of the year 1997.

The most recent publication for a more immediate understanding is the '*Compendio del Catechismo*' ('Compendium of the Catechism').

Evangelii nuntiandi, *Apostolicam actuositatem*, *Catechesi tradendae*, and *Christefideles laici* in an unequivocal way lay down the guidelines for every project for the lay apostolate. *Comunicare il Vangelo in un mondo che cambia'* ('Communicating the Gospel in a Changing World') indicates the pastoral directions of the Italian Bishops' Conference for the first decade of the twenty-first century within which should be outlined each individual and associative pathway of the believer.

The 'Pastoral Note' of Pentecost 2005 of the Italian bishops

on the '*Primo Annuncio del Vangelo*' ('The First Proclaiming of the Gospel') reconfirmed the call to evangelise, which is the task of every Christian.

Il Direttorio Generale ('The General Directory') for the catechism asserts without any possible doubt: 'The catechesis always draws its contents from the living source of the Word of God, transmitted in Tradition and in Scripture, since Holy Tradition and Holy Scripture constitute the only inviolable deposit of the Word of God, entrusted to the Church'.[15]

Il Documento di Base ('Basic Document') points out the following journey: 'At the foundations is the law of faithfulness to the word of God and faithfulness to the concrete needs of the faithful. Faithfulness to God and faithfulness to man: these are not two different concerns but, rather, a single spiritual approach that leads the Church to choose the most suitable ways by which to exercise her mediation between God and men'.[16]

'Modern catechistic experience confirms once again that first come the catechists and then come the catechisms; indeed, even before them comes the Church communities. Indeed, just as a Christian community without a good catechesis is not conceivable, so a good catechesis without the participation of the whole community is not thinkable'.[17]

Which Pedagogy?

Faith is a relational fact and is born and develops in freedom with the gratuitous initiative of God and man's readiness to receive. Outside this dynamism there is no faith, even though there can be religious instruction. Thus a proposal of catechesis to adult individuals, already rooted in roles involving responsibility, requires a pedagogic strategy 'of accompanying' towards this different mentality that opens up to encountering a God with a historical, relational and communitarian face.

A voluntary worker narrates through works his or her vocation and his or her choice for God; his or her model is the face of Christ who suffers in the Passion and rises in the Resurrection, giving Hope to everyone.[18] The pathway of the catechesis, therefore, should be strongly rooted in the concreteness of works, based on the theology of hope and of charity and open to an active and creative message.

A search for God as a transcendent being outside time tears man away from the concreteness of his affairs. God, instead, reveals Himself though a history woven with events and words and sends back man to his weekdays and daily life. The Christian faith, in its first and in its final Testament, proclaims the face of a God that is read to man by placing in front of everyone His Son and calling man not to a 'mystical shipwreck' but to a free and responsible relationship.

The commitment for us, therefore, is to narrate a God who in communicating Himself without reserve and remaining Himself provokes a historical, responsible and fraternal relationship.

Our spirituality radiates out beginning with the face of Jesus who was profoundly man but totally God. Our history is woven with actions that are at times dramatically concrete but which are guided by the irrational certainty of the possibility of a miracle. Our act of faith accepts the scandal of pain and the certainty of Hope.

A hospital voluntary worker (as I have defined him or her, that is to say as he or she commonly is) has chosen to narrate God-Man-Jesus with his or her own hands as well and by remaining within history. Thus it is only by respecting this dynamism that a proposal for formation can have an answer.

It is certainly the case that there is no proclaiming that does not spring from the Word. The Church is born from the listened to, celebrated and lived Word. But proclaiming should be liberated from an excessive ritualisation. It should retrieve, instead, the relational dimension of faith.

Indeed, the Word is always the revelation of an appeal to human freedom as a response to God who communicates Himself in the Son. Thus a form of pastoral care should be retrieved which is increasingly based upon personal relationships, upon experiences of relationships, and increasingly less upon institutions.

Which Providers of Formation?

There should be an attempt to 'make of a lay character' proclaiming, making the catechesis move out of an intra-ecclesial syndrome and entrusting to adult lay people the role of narrating the Gospel of salvation of Jesus Christ, outside a metaphysical language but anchoring it in the experiences of life and of service.

'But the laity likewise share in the priestly, prophetic, and royal office of Christ and therefore have their own share in the mission of the whole people of God in the Church and in the world. They exercise the apostolate in fact by their activity directed to the evangelization and sanctification of men and to the penetrating and perfecting of the temporal order through the spirit of the Gospel. In this way, their temporal activity openly bears witness to Christ and promotes the salvation of men. Since the laity, in accordance with their state of life, live in the midst of the world and its concerns, they are called by God to exercise their apostolate in the world like leaven, with the ardor of the spirit of Christ'.[19]

The providers of formation should be figures who are no longer conceived in terms of a delegation. They should, instead, be understood as an expression of accompanying that is offered to the community and they should be capable of sustaining 'extrovert' pastoral action which, although organised in different places, situations and circumstances, always assures the homogeneity of proclaiming.

Which Objectives?

The leaders are asked to give a full and convinced 'Yes' as regards membership of their association, which can prescind from an unconditional agreement as to

programmes but which must originate in a full adherence to the project of God for us: God wanted us to be brethren in the same community.

They should have an in-depth knowledge of the overall project and of the individual projects of the association, and agree with the ways in which they are implemented, their goals and their meaning.

They should be open to the policy as regards formation of the association and be ready to engage in a personal journey of growth so as to be able to be a reference point and guide for the members.

They should live in an active way in the parish and diocesan communities, bearing witness to the charism and ministry of the association.

They should live the life of the association, its local and national approaches, to the full.

Conclusion

A human and spiritual formation should have stages, or to put it better, moments of assessment and advance which I see as two particular moments.

1) Moments of dialogue of the providers of formation in order to meet the local leaders, and thus update the impetus to evangelisation according to the pathway followed and the returns that have been made, and a wider assembly for a policy of homogenous journeying that leads from promises to commitment (a sense of belonging).

2) The drawing up of 'itinerary maps of a lay character' for the fields of experience and of service and for spiritual and doctrinal reflections, to be set in motion periodically and which start from the subjects addressed in the national meetings. They should be 'popular' proposals in order to conjoin the quality of formation with a simple communicative form suitable for everyone and which the local leaders could employ as an outline for work with voluntary workers.

The formation that we intend to pursue wants to gather together all the colours of charity, colours that spring from very many personal and associative activities, starting with the white of our baptism and going on to the blue of Mary, the green of Hope, the red of Love, and so on so as to create a rainbow of the Gift that leads to a Faith embodied in works.

Notes

[1] Msgr. Zygmunt Zimowski, *Sulla via dell'uomo che soffre* (Libreria Editrice Vaticana), p. 65

[2] The *Unione Nazionale Italiana Trasporto Ammalati a Lourdes e Santuari Internazionali*, founded in 1903 by G. B. Tomassi and recognised by the Italian Bishops' Conference in 1997 as a public ecclesial association.

[3] Phil 2:6-7.

[4] Jn 13:15.

[5] Jn 15:12.

[6] Msgr. Domenico Pompili, Under-Secretary and Director of the Office for Social Communications, launch in Rome on 14 June 2012 of the volume *Opere per il bene commune*.

[7] Derek Bok, the former President of Harvard University.

[8] *RdC*, n. 143.

[9] L. Tavazza, the entry 'Volontariato', in *Nuovo Dizionario di sociologia,* edited by Demarchi F., Ellena A., and Cattarinussi B. (Paoline, Milan, 1987).

[10] S. Zamagni, *Volontariato ed economia sociale: quale rapporto* (Studi Zancan, 1, 2002).

[11] The Second Vatican Council, *Gaudium et spes*, n. 57.

[12] Cf. Benedict XVI, *Spe salvi* (LEV, 2007) n. 2: ''Hope', in fact, is a key word in Biblical faith – so much so that in several passages the words 'faith' and 'hope' seem interchangeable'.

[13] *LG*, n. 10.

[14] Pastoral directions for the first decade of the third millennium: *communicate the Gospel in a world that is changing*, already emphasised as… *faith is born from listening to the words of God contained in Holy Scripture and Tradition, transmitted above all else in the liturgy of the Church through preaching, at work in the sacramental signs as a principle of new life* and thus…*it appears to us to be an absolutely primary task for the Church in a world that is changing and that is looking for reasons for being joyful and hoping, should be and should always remain the communication of faith in Christ under the guidance of the Spirit, of the precious pearl of the Gospel*: cf. *EPISCOPATO ITALIANO, Comunicare il Vangelo in un mondo che cambia* (Paoline, 2001)*, nn. 3 and 4*.

[15] *DGC*, nn. 94-96.

[16] *RdC*, n. 160.

[17] *RdC*, n. 200.

[18] Benedict XVI, *Deus caritas est* (LEV, 2006), n. 32: 'As our preceding reflections have made clear, the true subject of the various Catholic organizations that carry out a ministry of charity is the Church herself – at all levels, from the parishes, through the particular Churches, to the universal Church'.

[19] Decree on the apostolate of the laity *Apostolicam actuositatem*, n. 2.

Spirituality as a Resource in Situations of Illness in a Secularized Society

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In response to chronic illness and life threatening diseases, patients are confronted with the question of meaning and purpose in life, with that what may give hope and confidence. For several of them, spirituality/religiosity (SpR) is a relevant resource to cope – even in secular Europe.[1-7]

However, we have to face the fact that an increasing number of patients reject institutional religiosity, particularly in secular societies, while they nevertheless may have specific spiritual needs which are in most cases neither addressed nor recognized by the health care system.

In our studies enrolling German patients with chronic diseases (i.e. chronic pain diseases, cancer, and others) patients indicated that they regarded their SpR as helpful to manage life more consciously, for a deeper connection with others and the world around, feelings of inner peace, promotion of inner strength, better coping with illness, and to restore mental and physical health.[8] Whether these perceptions can be objectified or not, the crucial point is that patients regard their spirituality as helpful to manage life, illness and suffering.

Although research has shown that religious engagement can be beneficial,[9] we cannot ignore that secularization and individualization proceeds in Europe. Up to 50% of our patients would not regard themselves as religious (despite their Christian denomination, 82%). In fact, 42% regard themselves as R-S-, 8% as R-S+, while 32% state to be R+S- and 18% to be R+S+.[3] Also among 17/18 year old students from Christian academic high schools, 65% would not regard themselves as religious (despite their Christian denomination, 92%), i.e., 53% are R-S- and 12% R-S+, while only 23% regard themselves as R+S- and 11% as R+S+.[10]

Thus, we have to state that a large fraction of German individuals would not (cognitively) regard themselves as religious. Maybe we could assume that they have turned away from institutional religiosity, but might nevertheless be interested in individual approaches of private spirituality?

To address who of our patients are in *Search* for SpR as a source, and who may have *Trust in* higher support, we have analyzed data of 848 patients with chronic diseases. The SpREUK questionnaire, which was used in these studies, avoids specific terms such as God, Jesus church etc., and thus can be used also in individuals who may have problems with institutional religiosity.

We have found that only 29% are in *Search* for support or access to SpR, while 53% already do have *Trust* in higher guidance/source. For 51%, disease may have a positive connotation, i.e., they are able to regarded illness as a hint to reflect what is essential in life and which priorities might be of relevance.[1,11] Although there were significant differences with respect to gender and age, most differences can be explained by patients' religious denomination.[11] Univariate analyses indicate that denomination rather than (female) gender, age and education had the strongest impact on patients' *Search* and *Reflection*, while for *Trust* both denomination and (higher) age were of outstanding relevance.[11]

In line with this observation, when asking for patients' engagement in spiritual/religious practices**,** it is evident that religious or (spiritual) mind-body practices are of lowest relevance, while humanistic or existential practices and also gratitude/reverence were of higher importance.[12,13] It is obvious that particularly those who regard themselves as R-S- have the lowest scores for gratitude and reverence – which is simply an issue of the 'emotional heart'.

What should we know about these non-religious/non-spiritual patients?

If we look at patients' belief in Guardian Angels (Table 1), which are quite popular also in secular societies, it is clear that religious individuals are often or frequently relying on this emotional source of support; but it is quite surprising that also 38% of R-S- patients do believe often or frequently in Guardian Angels (Büssing *et al*., submitted for publication). Of course there is and cannot be scientific proof that Guardian Angels do exist, but even the skeptics have this hope to be guided and sheltered by a 'higher being' who unconditionally cares for them. This could be interpreted as an implicit 'proof' of their ongoing hope that there might be a 'higher plan' which would imply meaning in life and illness.

To clarify the impact of an R-S- attitude, we focused on relatively young patients with multiple sclerosis (Wirth *et al.,* in preparation). This disease is characterized by the fact that the next acute phase can occur more or less arbitrarily, and that there is no cure for multiple sclerosis. About 70% of the 181 German patients (mean age 42 ± 10 years) investigated so far would regard themselves as

Table 1: Belief in Guardian Angels

Belief in Guardian Angel	Gender *		SpR self categorization **				All (%)
	Women (%)	Men (%)	R+S+ (%)	R+S (%)	R-S+ (%)	R-S- (%)	
never	16	29	7	9	30	**32**	20
rarely	24	23	16	26	16	**30**	24
often	31	26	**31**	**32**	**24**	28	30
frequently	28	22	**45**	**33**	**30**	10	26
all (n)	401	150	110	174	50	216	551

N=576 (mean age 51.3 ± 15.4 years; 75% chronic pain conditions, 7% cancer, 15% psychiatric disorders, and other).
Results differ significantly with ** p<0.0001 and * p = 0.013 (Pearson´s Chi2)

R-S-. While life satisfaction and positive life construction was similar in the SpR groups, it was striking that those who lack a spiritual attitude have significantly lower abilities to see illness as a chance to change and personal development when compared to religious/spiritual patients. Moreover, the ability for gratitude and reverence was significantly lower in R-S- patients.

To shed some further light on these patients we asked for their resources of hope, orientation and inspiration in life (Wirth *et al*., in preparation). However, 49% had no such resource (or at least they did state one), only 22% stated children, family or partner, 12% stated faith or God, and 17% stated other beneficial sources (i.e., love, life itself, hope, happiness, karma, nature, doing good, etc.). It was striking that those lacking such a resource were predominantly R-S-. The self-ascribed benefit through the own spirituality respectively resources of hope and orientation was highest in those who stated faith as such a beneficial source. While life satisfaction did not differ with respect to the different sources, it became clear that faith was the resource with the strongest beneficial impact on the ability to see illness as a chance for changes, new priorities in life and also for personal development; moreover faith as a source had a significant impact also on patients' feelings of gratitude and reverence which were highest in those with faith as a resource of hope and orientation in life.

Thus, although several reliable resources of our tradition seem to be forgotten, and although religious rituals and symbols may have lost their meaning for several Western individuals, and although praying, attending a service, reading the scriptures etc. may not be adequate for all patients, their beneficial value could be 'reanimated' and learned anew. We only have to foster patients' vital experiences!

There was an interesting quote which might be important for your reflection:

I was never a religious man
So why should I put my faith in you?
You burned your bridges a long time ago
I'm a heathen, searching for his soul
Alan Averill (Primordial): "Gallows Hymn"

What hinders was the rationalistic intellect and the impression that God has 'burned the bridges' which indicates a lack of vital experience. Self-evidently, the author knows that something important is lacking, but he can not find a way to get access to his 'soul'.

What could we do to help this archetypical 'lost soul'? Who helps to move the mountains when the lost soul is suffering? Archbishop Zimowski clearly addressed one of the important problems (Stockbridge, Massachusetts; May 6, 2011): Though medicine manages to identify and treat physical suffering, it does not always identify and reach moral suffering, which is the pain of the soul.

Spiritual Needs in Health Care System

Health care focuses on patients' physiological needs. Of course, patients' informational needs are clearly recognized as an important issue in health care (i.e., regarding treatment options, health promotions, side-effects, outcomes, perspectives etc. to enable a 'shared-decision making'). Yet we have to state that patients with chronic and advanced diseases often have specific needs. There was an important study from the US that 72% of patients with advanced cancer reported that their spiritual needs were supported minimally or not at all by the medical system, while 47% felt minimally or not supported even by a religious community which could be seen in charge for this issue.[14] Of importance was the fact that spiritual support was significantly associated with patients' (psychological) quality of life.[14,15] Thus, a majority of patients have unmet spiritual needs – and no one seems to care for.

This means that physicians should at least know that some of their patients may have unmet spiritual needs. Even in secular Germany, the majority of tumor patients wanted their doctor to be interested in their spiritual orientation.[16] Our studies among patients with chronic pain diseases found that 23% would like to talk with a chaplain about their spiritual needs, 20% had no one to talk with, and for 37% it was important to talk with their medical doctor about their spiritual needs.[3] Yet medical practitioners may lack the necessary time, skills or even interest to uncover and address these needs.

Most of the research on spiritual needs was done among patients with advanced stages of disease or dying, while only a few studies address spiritual needs of patients dealing with chronic, primarily non-fatal diseases. To deal with these needs we would refer to a conceptual framework which

Table 2: Categories of spiritual needs related to Alderfer´s ERG model

Categories of spiritual needs[17]	Needs according to Alderfer´s ERG model [18]
Peace (inner peace, hope, balance, forgiveness, distress, fear of relapse, etc)	**Existence** (Safety)
Connection (love, belonging, alienation, partner communication, etc.)	Relatedness
Transcendence (spiritual resources, positive/negative relationship with God/Sacred, praying, etc.)	
Meaning/Purpose (meaning in life, self-actualization, role function, etc.)	Growth

Table 3: Specific needs of 213 religious 'skeptics' and 'non-skeptics'

	Respective needs among		p-value (Chi2)
	skeptics (%)	non-skeptics (%)	
pray with someone	7	33	**.035**
someone prays for me	10	33	.076
pray by myself	13	42	**.003**
attend religious service	13	32	n.s.
read spiritual/religious books	3	28	**.005**
turn to a higher presence	8	40	**.001**
forgive someone	**27**	36	n.s.
to be forgiven	**24**	33	n.s.

can be related to Alderfer's ERG model (Table 2).

According to this model we have developed an instrument suited for both religious and a-religious patients with chronic diseases, the Spiritual Needs Questionnaire (SpNQ).[19,20] Using this instrument, we found that specific needs related to states of inner peace and connectedness were scored the highest among German patients, while religious needs including forgiveness were scored the lowest. Using categorizing factors, it is obvious that Religious Needs and Existential Needs were of relevance especially for patents with cancer, but not for patients with other diseases; instead, needs for Inner Peace and active Giving/Generativity were of relevance.[20] Similar results were found in the predominantly a-religious patients with cancer from China, while in Polish patients, who were all Catholics, also Religious Needs were of outstanding relevance (Büssing *et al*., in preparation).

The aforementioned needs for *Giving/Generativity* mean that patients intend to solace someone, to pass their life experiences to others, and to be assured that life was meaningful and of value. It seems that they would like to leave the role model of a 'passive sufferer', to become an active, self-actualizing individual able to give and help others (despite their own illness). This fits Erikson's psychosocial development stage 'generativity' which refers to the ability to care for others and guide the next generation.[21] Finally, this means that patients from secular Germany, a-religious China or Catholic Poland all feel a connectedness with others and a responsibility to care for them.

Religious Needs of Skeptics

What about the religious needs of the 'skeptics'? Among 213 patients from Berlin with chronic pain conditions (Büssing *et al.*, in preparation), 28% stated that 'as a rational person', they do not 'need any belief in a higher presence'; 55% rejected the statement ('non-skeptics') and 18% were undecided (Table 3). Interestingly, 13% of these skeptics stated needs to pray for themselves and even to attend a religious service – although they identified themselves as a 'rational person' who does not need any belief in a higher presence. Moreover, they also expressed needs to forgive and to be forgiven. Although one may suggest that this intention to forgive must no necessarily have a religious connation, it clearly indicates a longing to resolve conflicting situations and burdening relations; the motifs are similar.

Perspectives

The crucial point is how we can offer spiritual/pastoral support when in secular societies up to 50% of patients with chronic diseases regard themselves as R-S-.[3] Still several of them do have spiritual needs.

When we in fact face Christ in each and every person, also in those who reject the Church as an institution, then we have to reconsider: How could we really meet and help them? Who should care for their spiritual needs? Do we have to change as caregivers and chaplains?

When patients have problems with the institution but still have specific spiritual needs, we should respect their situation – and offer our help to enable vital experiences. The findings of the aforementioned studies substantiate up to five main topics we could use as starters to support vital experiences of patients 'living in a distance', i.e.

Intention	Examples of Action	Reference
the chance to find hope, orientation and inspiration	offer and assist counseling talks/contemplation	John 14:7: 'If you really know me, you will know my Father as well. From now on, you do know him and have seen him.'
the ability to be open	enable and assist forms of reflexive prayer/contemplation	Luke 22:42: 'Not my will, but yours be done'
the experience to be guided	enable and assist to pray/contemplate	Psalm 25:5: 'Guide me in your truth and teach me, for you are God my Savior, and my hope is in you all day long.'
the willingness to forgive, to be forgiven and to change	assist guided reflexive prayers/meditation resulting to states of Inner Peace	John 8:11: 'Go now and leave your life of sin'
to encourage caring for others	assist and guide reflexive contemplation/meditation and concrete actions resulting in a vital experience of connectedness	Luke 10:33: '…and when he saw him, he had compassion on him'

Pope Benedict XVI clearly advised in his Apostolic Letter *Porta Fidei*: "Today too, there is a need for stronger ecclesial commitment to new evangelization in order to rediscover the joy of believing and the enthusiasm for communicating the faith. (…) Faith grows when it is lived as an experience of love received and when it is communicated as an experience of grace and joy."[22]

As medicals doctors, nurses, social workers, chaplains, bishops – as sensitive beings – we are in charge to help and assist others, we have to address their spiritual needs and to respond adequately. This remains a challenging task for a modern health care system – and of our Church! Yet we need the organizational structures to facilitate this, professional competencies, and compassion to act as 'Samaritans'. ■

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Notes

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The Mission for the Suffering of the 'Merciful'

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First of all, on behalf of the Union of the Merciful of Portugal, and as its national President, I would to like to thank the Pontifical Council for Health Care Workers and, specifically, its President, His Excellency Archbishop Zygmut Zimowsk, for the opportunity to come before you to exchange some thoughts on the work carried out by the Union of Merciful of Portugal in the area of health care over the last five centuries.

The first thought I would like to share with you is that our commitment to health derives from the work of mercy that instructs we Catholics 'to take care of the infirm'. No matter who is suffering – irrespective of colour, race, creed or income.

Indeed, since 1516, in the reign of King João the Second, to the present day, and without any interruption, the *Casas de Misericórdia* or the Houses of Mercy have taken care of the sick. In recognition of this, the Portuguese people began to refer to these houses as 'holy'. For this reason, across the parts of the world discovered by the Portuguese, the *Casas de Misericórdia* are known as the *Santas Casas de Misericórdia* or Holy Houses of Mercy. In Brazil, where there are some 2,200 Houses of Mercy, they are known as *Santas Casas* or Holy Houses and are a major player in the area of acute (hospital) care.

As I have already said, our presence in the health-care sector is the result of an ethical stance, the values of which are adopted as our mission. And because that presence goes back into the mists of the centuries, in Portugal, Brazil, Angola or São Tomé there is no need to explain what the Houses of Mercy are and what they do. Born within the communities, they are respected, loved and protected by those communities.

Following the Carnation Revolution of 1974, the Portuguese government decided to nationalise the premises and the management of our hospitals and created a public health system, a type of NHS. However, in the north of the country, 3 of the approximately 100 hospitals we ran escaped nationalisation and they rapidly gained a reputation for credibility based on the quality and humanisation of their health-care services. So much so that in the 1980s, the major democratic parties (the Christian Democrats, the Social Democrats and the Socialists) began to include in their manifestos the devolution of these hospitals to their rightful owners, the Houses of Mercy. Thus, slowly – very slowly – the devolution process was initiated.

Each devolved hospital became a success story. Success in terms of quality; success in terms of costs (they are least 30% cheaper than comparable public hospitals); and success in terms of humanisation. Today we operate 19 hospitals, and in September 2012 the government decided to initiate a process, which is currently in progress, to devolve a further 15 to 30 hospitals.

Before this, the Portuguese government had already decided to enter into an agreement with the Union of the Merciful of Portugal whereby the Houses of Mercy would be involved in setting up a National Long Term Care Network. In six years the Houses of Mercy have built and equipped some 120 units with a total of 4,000 beds, the equivalent of more than 50% of the national network. Some of these units are already certified by the International Joint Commission.

Finally, the Portuguese government has launched a study to evaluate the possibility of the social sector and the Houses of Mercy becoming involved in the National Primary Healthcare Network.

This, my friends, is a brief overview of our presence in the healthcare sector. As I have already stated, this is a constant presence over more than 500 years based on a set of values that we adopt as our mission. Hence, what may be of interest to you is our analysis of the reason for the importance of this presence, which, once again, is experiencing rapid growth.

The first reason is that people and governments are understanding more and more that 'looking after the infirm' is something that does not sit well with the nature of the private sector, irrespective of the adoption of management systems, rules and principles of great rigour and competence. It would appear evident to all that in the 'care' process there is a moment – in my opinion, several moments – where the nature of the mission and the organisation is not compatible with profit. Perhaps it is for this reason that in countries such as the USA, which has, legitimately, a long-standing capitalist tradition, the most qualified segments of the health sector are closely linked to the Third Sector and to the NGOs – as is the case of the Mayo Clinic, the John Hopkins Hospital or the Kruger Care Hospital Foundation.

For me, the second reason is the way we assure humanisation. It is clear that both the public and the private sectors have made a huge effort in this direction, and today in all health-care units we find professionals who are very committed to humanisation. But there is a clear difference between adopting humanisation as a specialist or as a value inherent in the nature, identity and culture of an organisation.

Thirdly, the Houses of Mercy, on account of their size and importance in the specific context of the health sector, constitute a unique case in terms of permanence over time, and for this reason, they would make good case studies. For me, it is in the interaction with the communities they serve that we can find the main reason why the Houses of Mercy have not been assigned to the annals of history. Time and time again people come back to the Houses of Mercy movement as an instrument *par excellence* of the concept of active solidarity. Indeed, it is in coherence with this thought that we always place our intervention in terms of solidarity and *subsidiarity* – be it with the State or with people. At all times bearing in mind that these principles take on particular significance if we understand them in the way the Holy Father Benedict XVI teaches us in *Caritas in Veritate*: '*The principle of subsidiarity must remain closely linked to the principle of solidarity and vice versa*, since the former without the latter gives way to social privatism, while the latter without the former gives way to paternalist social assistance that is demeaning to those in need'.

And finally, another justification for the importance of this presence can be found in the concept of selfless voluntarism. The preamble to the first memorandum of the House of Mercy of Lisbon, from 1498, made express reference to the founders being people who had no 'necessity'; in other words, they were ready to help others without expecting anything in return. Precisely because of this the Union of the Merciful memorandum is known as the 'Commitments', as whoever joins a House of Mercy undertakes to become involved in its mission which is attuned to the contemporary circumstances of the period.

At a time when the world is experiencing an unprecedented crisis at the economic level and in terms of values, and when the suffering are looked upon as those who have failed, institutions like the House of Mercy constitute and represent an anchor for communities and individuals.

Indeed, the fact that we are organisations that are rooted in an ethical approach with regard to voluntarism and have a strong basis in charity, while asserting the truth of Jesus Christ in society and having the certainty that development, be it social or economic, is not conceivable without '*caritas*', i.e. without love of one's neighbour: all of this places the work of the Houses of Mercy on a privileged level which is deeply rooted in the Church's Social Doctrine and is reflected in *Caritas in Veritate*. And our health-care units are a paradigm *par excellence* of that approach and that privileged position! Even for the people who do not directly turn to them for help, the simple fact that they exist, that they are there, is a kind of reassurance, an instrument of comfort that the private sector clearly cannot give, and the public sector, in many countries, is no longer able to give.

If you will allow me one more personal comment: the growing attention of the media, and even the renewed interest of intellectuals in what the Houses of Mercy are doing and saying, are an example of what I have been trying to say. The truth is that the commitment to civil dialogue, which the European Union asserts, is based on the principle of diversity – more so than the essence of life, as that belongs to biodiversity – which manifests itself in all human acts: from the economy to law, from religion to fraternity and on to health.

And recognition of this fact leads us to the reality that each human being constitutes, together with all others, a whole, a oneness, a '*solidum*'. And this idea that all of us, in our individuality, have a common nature, origin and purpose, is the consubstantiation of the basic idea of solidarity, of the relationship of co-responsibility between all members of one and the same '*solidum*'.

Without wishing to delve into the classification of established models of society – the subordination society, the coordination society and the togetherness society – it would seem evident to me that, given the failure of the first two models, we need to urgently invent/develop a new societal paradigm based on the society of togetherness, or, if you prefer, of fraternity, which, certainly without conceptualising, the Houses of Mercy have always adopted – naturally and in relation to the epoch and people.

Indeed, either we transform solidarity into much more than an ethical imperative or a torrent of emotions and give it a status based on true rights and obligations, or our common path will lead to completely unexpected upheavals, as the present clearly and unequivocally shows. *Caritas in Veritate,* as we have seen, is very clear on this and Portuguese Catholics see themselves reflected in those values, as our centuries-long attention to those who suffer shows.

The history of the Houses of Mercy has been, from its very beginnings, one that expresses its own dimension in the togetherness society, and this is, indeed, reflected in the centuries-old amalgamation of the concepts of the hospital (of the time) and the institution itself.

My friends: it is time to come to a close. But before doing so I would like to make three final observations. The first is that over the last thirty years, science, and medical science in particular, has pushed the limits of life much further. Today technology prolongs life; in certain cases it diminishes suffering and even increases well-being. State-of-the-art hospitals are complex institutions full of high-end, extremely expensive technology, that require a strong concentration of resources. But at the same time, that technology has made proximity treatments accessible, cheap and safe for a plethora of pathologies.

The second is that over the last thirty years we have witnessed a huge increase in human life expectancy. We have added years to life, now we give more life to our years. But there has also been a shift in terms of expenditure on health-care resources. In Portugal thirty years ago only 10% of health-care expenditure was for the chronically ill; today the figure is above 70%.

The third follows from the sec-

ond, again centring on the effects of increased life expectancy. Yes, we live longer, but the number of situations of dependency have also increased – be they in the physical or the mental sphere. For example, the increase in dementia has been exponential; in 2009 there were already 7,300,000 people diagnosed with the condition in Europe, 153,000 of them in Portugal. At this point I want to inform the conference that the UMP is finishing a Portuguese building for Alzheimer's patients

The National Long Term and Palliative Care Networks are increasingly becoming structuring pillars of the health system, given the incapacity of families to care for their infirm, be it because they do not have the resources, or the structure, or the necessary skills.

It is in this context of thousands of people suffering on a daily basis that our mission gains in size and takes it place as something distinctive in the health-care context. Providing good care, with quality and competence, giving affection to a child or an elderly person, taking the time to listen to a related memory, holding the hand of the dying: these are things that the Houses of Mercy do naturally and like no one else.

For all these reasons, we are proud of our past, we are attentive to the present and we are certain that we are institutions with a great future. In this holy place, I beseech Our Lady of Mercy, Our Lady of the Great Mantle, to protect us, as she has always done, down the centuries. ■

The Humanitarian and Missionary Role of the Order of Malta

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Member of the Pontifical Council for Health Care Workers,
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Firstly I wish to thank Msgr. Zimowski, President of the Pontifical Council for Health Care Workers, for giving me, as the representative of H.E. Albrecht Freiherr von Boeselager, Grand Hospitaller of the Sovereign Order of Malta, the opportunity to present the worldwide humanitarian activities of the Sovereign Order of Malta.

Let me begin with some general facts which can clearly illustrate the almost thousand-year commitment of the Sovereign Order of Malta.

It is the oldest chivalric Order. It was founded in the middle of the eleventh century with the mission to care for sick and wounded pilgrims in a hospital in Jerusalem. And it is the only Order of knighthood with continuous existence, right up to the present day. Its first constitution as a lay religious Order was approved by Pope Paschal II in the year 1113. Its vision was its humanitarian principle: to care for the poor and the sick, whatever their religion, their origin or their race – a principle that today we see as modern, but for the Order of Malta, is almost a thousand years old. Pope Paschal granted the Order far reaching independence from other authorities, and when the Order settled on the Island of Rhodes in 1310, this independence developed into sovereignty. After the loss of Rhodes in 1522, the Order became the sovereign of the Island of Malta. When Napoleon occupied Malta in 1798, the Order lost its territory, but its sovereignty was confirmed by the treaty of Amiens in 1802.

The first crusaders arrived in the Holy Land in 1099 and many of the knights joined the Order, which at that time was called the Brotherhood of St. John in Jerusalem. The military history deriving from this development is well known. But I wish to underline the fact that the Order's allocation for its charitable humanitarian tasks has never, throughout its history, fallen below 60% of its total budget at any time. This certainly is the main reason why the Order of Malta still exists. Its *raison d'être* did not disappear with the loss of the Holy Land.

Today the Order of Malta is extended across the world as never before. It has its own structures in 55 countries in all continents and activities in about 120 countries. The activities rely on 13,500 members, 80,000 permanent volunteers and some 25,000 employees. Many more volunteers join for special activities from time to time. The Order maintains full diplomatic relations with 104 countries, exchanges ambassadors with the European Commission, and has Permanent Observer missions at the United Nations.

The description of our activities poses a challenge. They are manifold and diverse. First: the structure of the Order is decentralised. The single national entities – Associations – of the Order hold the operational responsibility for what is done in their respective countries. Second: the Order is active in very diverse environ-

ments, from highly developed and rich countries to extremely underprivileged and deprived regions. We have adapted our activities accordingly, with the traditional emphasis on medical and social needs.

In Europe the focus is on running health-care and social institutions, for example, hospitals, clinics, and care-homes for the elderly and for the severely handicapped, and on managing volunteer organisations with paramedic and social missions. For instance, in Germany the Order runs 10 hospitals, in France it has 15 homes for severely handicapped or dependent people, in England 73 care-homes for the elderly, and in Italy a hospital and many clinics specialised in diabetes care.

The Order of Malta has for centuries been a pioneer in *medicine* especially in the treatment of injuries and dealing with infectious diseases. The word 'quarantine' derives from the time in Malta when the Order isolated patients with infectious diseases on an island in the harbour of Valletta for forty days. The island is still called Quarantine. But what the Order became even more famous for is the kind of care it gave to the sick. The rules dealing with care in the Order's hospital became famous. Centuries before this became standard in Europe, the Order insisted that every patient should have their own bed.

In modern times the Order of Malta has played an important role in fighting leprosy. In many countries in Europe we concentrate today on care for the *elderly*. In England and Germany care for elderly people who suffer from dementia has become a field where we again do pioneering work. The care homes in England have developed a special scheme to furnish rooms in a old fashioned style, common when the elderly were still young. They are called 'reminiscence rooms'. This innovation has a calming effect and a measurable reduction of medication.

In Germany the Order cooperates with the Swedish foundation Silviahemmet, created by Queen Sylvia to further care for elderly people with cognitive impairment. The Order has created a specialised centre for this purpose. In 2010 Queen Sylvia opened the first specialised department in a hospital to care for patients with different kinds of illnesses, but all suffering from dementia. It has become a model which is now visited by many specialists. In March a first day-care centre for dementia sufferers was opened in Germany. It is run by the Order. Geriatric hospital departments and palliative care units complete our field of end-of-life care.

Social care for the most deprived in another focus. I will give you a few examples from a wide range of the different services the Order provides.

Help for the *homeless* is moving increasingly into the foreground. In most European countries we now run projects for the homeless. The French Association has furnished an old *péniche* in Paris to host homeless people with dogs – it is the only place they can take their dogs. In Germany in a number of cities we offer the homeless special days, which we call '*Wohlfühlmorgen*' or 'wellness mornings', when they can shower, get their clothes cleaned, receive medical checks and basic treatment – and there are vets, too, to look after the dogs! The Australian Association supports the so-named 'The Coats for the Homeless Project', an international project involving the distribution of specially designed and manufactured all-weather coats for the homeless. In Belgium, in particular in Brussels and in Liege, Malte Assistance runs two la Fontaine Houses which provide medical care, showering and washing facilities, hairdressing, sewing, cafeteria and company to 18,000 homeless, with the help of 130 volunteers.

Care for *asylum seekers* and people who have immigrated illegally is another ever growing field of action in many countries. In Italy our medical personnel serve on the boats of the Italian coastguards to provide first aid to the boat-people who over the last few years have been arriving in their thousands. In Germany and Italy we run small clinics to treat people without legal status. Special arrangements with the local authorities and the police allow them access to our clinics without being afraid of arrest. Besides the humanitarian aspects of these services, they are crucial for safeguarding public health. The French Association of the Order, with its antennae in the French speaking countries of Western Africa, helps people who have been repatriated to their country of origin.

The Order also assists drug-addicted youngsters and lonely old people at home. The Roma and Sinti in Hungary and the neighbouring countries form another field of activity. Services to prisoners or their relatives are new activities in a couple of countries from Cambodia to the United States. Most of these services are carried out by *volunteers*. The work of volunteers who are not members of the Order makes a very important contribution to nearly all the Order's activities. Most of the volunteers are organised in the Order's volunteer relief organisations and ambulance corps. They carry out first aid missions, and provide disaster relief and social services. In addition, extensive youth work is being carried out in the relief organisations of 30 countries. Since the foundation of the first ambulance corps in Ireland more than 70 years ago (1938), the operation of relief services has developed into one of the Order's most important functions. There are also volunteer groups outside Europe, in both North and South America. On the African continent the first groups have now been established in Nigeria and South Africa. The foundation and development of volunteer corps has also been very successful in Central and Eastern Europe since the fall of the Iron Curtain. For example, there are now nearly 10,000 volunteers working in the Order's relief services in Hungary, the second largest group after Germany which can count on 35,000 volunteers and almost 9,000 young cadets.

The populations in the former Communist countries lived for two or more generations under a dictatorial regime in which it was impossible for them to organise themselves in private associa-

tions pursuing social purposes. In many of these societies the financial situation of the population is such that they often need to work at several jobs at any one time to be able to earn enough to support their families. In fact we find situations where there are wonderful examples of private solidarity and neighbourly help, but where there is no tradition of privately organised associations. It is a reality where volunteer work has little place compared to the need to earn your living. In this environment we aim to work for the creation and the development of a social volunteer commitment, specifically in the field of social work. Such social commitment is also one of the most important tools in building free, democratic societies. Social development and its attending benefits in these countries is therefore particularly important for the future strategy of our organisations. The importance given to the creation and support of free civil initiatives in the field of health and social care is one of the essential factors for a free society; the State has the great responsibility of supplying a supportive legal and financial framework.

Our young volunteers concentrate on activities with people who have *physical handicaps*. For the last thirty years, an international holiday camp for young handicapped people has been organised each year in a different European country. In 2011 it was held in Italy, this year the youngsters gathered in Hungary, and next year the camp will be in Ireland. A very special initiative in the Lebanon is the organisation of holiday camps for local youngsters with physical and mental handicaps. Participation in these youth camps may offer them a unique opportunity to share moments of spiritual reflection and to enjoy leisure and sport activities together.

In South America the Order's activities, besides those connected to disaster relief, are mainly focussed on humanitarian projects for children and mothers living in slums, providing them with medical care, social assistance and education. The Brazilian Association of São Paulo and Southern Brazil, through the Centro Asistencial Cruz de Malta, carries out several activities dealing with health, education, nutrition, social services for children, teenage mothers, young and elderly people.

I will turn now to our activities in the Middle East and then to our international humanitarian activities.

One of our lighthouse projects is the *Holy Family Maternity Hospital* in Bethlehem. Two years ago we celebrated the 50,000th baby born in the hospital since 1990. Over 3,000 babies are born there every year. The European Commission contributed financially to the renovation of the hospital and occasionally given other financial support. The Belgian government financed the equipment for a modern neonatal department. Many other institutions and private donors support this initiative. Nevertheless the Order has to contribute around €1.5 million to the running costs of the hospital every year.

Most of the Palestinian patients do not have health insurance and are unable to pay even the relatively low fees. The Palestinian authorities frequently fail to pay the fees for the patients they send to us. But the hospital is a haven of peace in a turbulent region. The rate of premature babies is high due to the permanent psychological stress their mothers are exposed to. The hospital also provides important jobs in an area with a high rate of unemployment.

Besides the afore-mentioned project for young people with handicaps in *the Lebanon*, the Order runs 10 clinics around the country, and in cooperation with other confessions and religions including the Druse, the Sunni and Shi'ite communities. In the south we cooperate with a Shi'ite foundation and you will probably be surprised to hear that the Shi'ite medical personnel wear a service dress with our Cross on it. Once confidence is created a lot can be done to further peace among different religious communities through common projects. Other examples of this kind are the Bosnian women initiative and a similar scheme applied in Afghanistan, both co-financed by ECHO. Unfortunately we had to terminate the projects in Afghanistan after three of our local staff members were killed by the Taliban.

The Order has various institutional bodies at its disposal to provide worldwide humanitarian and disaster relief, and development support to the developing world. They include: the Direction Internationale of the Order de Malta France, which runs health centres and hospitals especially all over French speaking West Africa; the CIOMAL foundation of the Swiss Association whose mission is to fight leprosy. Presently it is most active in Cambodia; Malta Belgium International has distinguished itself in the funding of hospitals in the Democratic Republic of Congo. And there are dozens of bilateral donor projects, where an Association directly supports a project somewhere in the developing world.

The most important of these organisations is *Malteser International*, the Order's worldwide relief service. Its purpose is the coordination and delivery of disaster relief and rehabilitation with a view to comprehensive and integrated development. It is active in the fields of health care, water and sanitation, disaster preparedness and prevention projects, livelihood and nutrition programmes, and microcredit and micro health-insurance schemes.

Malteser International is currently active in Africa, Asia and Central and South-America and has brought vital services to eight million people in 20 different countries.

As the Order itself does, Malteser International bases all its operations on strict political neutrally and its independence from political and economic interests. With the stated aim of helping people in need, it is a credible partner for all actors and partners in zones of conflict, such as its current work in South-Sudan, Eastern-Congo, and Pakistan, event in the Swat Valley. An open and transparent agenda and a record of reliability allow Malteser International to carry out relief operations in areas like in Southern Congo, where almost no-one else has safe access.

Maltese International has been permitted to operate in Myanmar since 2001, when it was still extremely difficult for foreign NGOs to work in this country. And this permission was given in spite of the health-care projects Malteser International provides for the Karen, who have left Myanmar for political reasons and live in refugee camps along the Thai-Burmese border. Thanks to this position Malteser International was one of the very few international organisation able to start an immediate relief operation after the cyclone Nargis hit the country.

The Order's international relief agency is also very active in favour of the so-called internally displaced persons (e.g. people forced to abandon their homes and lives because of conflicts, wars, natural disasters) by offering them a refuge in camps specifically built for humanitarian emergencies, medical and psychological assistance, hygiene-kits and food.

Just to mention only some of the Order's interventions in favour of IDP in 2012 we can recall its interventions in Myanmar in Rakhine State in which more than 90,000 people have been displaced due to ethnic conflicts; in Burkina Faso where more than 65,000 Malian refugees have fled following a political crisis in their country; and in the Democratic Republic of Congo where, after a series of attacks from armed rebel groups in January 2012, thousands of people have fled the Shabunda province in South Kivu.

At present Malteser International is deeply involved in helping refugees in Syria and the Lebanon. Since the beginning of July, in collaboration with its partner organisation the 'International Blue Crescent' it has been supporting 1,200 families fleeing to Damascus with emergency relief goods. Now, as the winter season is approaching, 500 families in the Syrian cities of Homs and Hama will be provided with warm clothes, blankets and stoves. In addition, more than 15,000 displaced persons in Aleppo, Damascus, Hamas and Homs will receive start-up and hygiene kits, including blankets, mattresses, kitchen utensils, soap, diapers and baby ointment. In the Lebanon, the Order will continue to support the Lebanese Association's socio-medical centre in Khaldieh, where Syrian refugees can receive free medical treatment. Almost 600 refugees have received treatment so far. Starting in November, 500 refugees will be given emergency relief kits and winter clothes.

In South Sudan Malteser International has been active since 1997 with its emergency programmes in favour of refugees and victims of civil wars. Since South Sudan became independent in 2011, Malteser International has been working to strengthen the local health-care structures, in particular in the Lakes and Western Equatorial states, by building a total of 35 new health-care centres equipped with latrines, wells and rainwater harvesting tanks in the Maridi and Rumbek regions and by offering state health-care employees training in topics such as drug management and maternal and child health.

As for the past, I wish to recall the activity of the Order in the Democratic Republic of Congo where, during and after years of civil war, civilians, often young women or even little girls and sometimes little boys, were the innocent victims of sexual violence and rape perpetrated by militiamen and rebels. Since 2007 the Order has been working with victims in Ituri, Haut Uélé and Bukavu/South Kivu to prevent or treat sexually transmitted diseases and to provide psychological counselling to cope with this additional level of trauma.

The Order is not only involved in the aftermath of wars, conflicts or political crises: it also intervenes with its national and international corps to help populations affected by natural disasters, like earthquakes, tsumani, floods... In the early stages of this kind of emergencies, the focus of any response is upon helping people in basic survival. Programmes focussing on emergency medical relief and the distribution of relief items – such as the means for water purification and storage, household items, shelter kits and basic food rations – are 'first response instruments'.

After these basic needs have been met, the next aim is to further reduce vulnerability and to provide communities affected by crises and disasters with sustainable reconstruction and rehabilitation programmes, promoting a strong development perspective. Respective programme components include the reconstruction of houses and public buildings as well as social rehabilitation measures such as psychological assistance to the survivors and the reintegration of refugees within their homeland.

The interventions after the earthquakes in Haiti in 2010 and in Italy in 2009 and 2012, after the earthquake and tsunami in Japan in 2011 and after the frequent floods and cyclones in several Asian countries (such as Cambodia, Myanmar, Sri Lanka) are only few examples of the activities carried out by the Order in the context or humanitarian emergency linked to natural calamities.

But these success stories should not hide our general concern regarding the observation of humanitarian principles in the modern type of armed conflicts. A hundred years ago 90% of *war victims* were soldiers; today 90% of the victims of contemporary armed conflicts are civilians. Time is too short to elaborate on this issue here. But the consequences of so-called asymmetric struggles, the misuse of protected civilian or religious facilities, the use of human shields but also the acceptance of collateral damage – the euphemistic wording is perfidious in itself – and the threats to humanitarian personnel, demand permanent observance and efforts to improve the observation of these vitality important humanitarian principles.

The Order is also starting a new initiative to improve the funding situation for forgotten needs. ■

Engaging Catholic Health Providers to Scale up HIV Testing and Treatment

MR. GREGG H. ALTON
Executive Vice President, Corporate and Medical Affairs, Gilead Sciences, U.S.A.

About Gilead Sciences

Gilead Sciences, Inc. is a research-based biopharmaceutical company that discovers, develops and commercializes innovative medicines in areas of unmet medical need.

For more than a decade, Gilead Sciences has been a leader in the development of antiretroviral (ARV) therapy for HIV/AIDS with an emphasis on improving and simplifying HIV treatment for patients. Gilead researchers have developed six commercially available HIV medications, which include the only complete treatment regimens for HIV infection available in a once-daily single pill and the first oral ARV pill available to reduce the risk of acquiring HIV infection in certain high risk adults. We are also advancing a robust pipeline of next-generation therapeutic options.

The Gilead corporate mission is to transform care for HIV and other life-threatening diseases. Gilead also believes that all people should have access to the medicines they need, regardless of where they live or ability to pay. To achieve these goals, we believe we must apply innovation not just to drug discovery but also to finding new ways to get affordable medicines to people in need as quickly as possible.

In this vein, we have established innovative programs and partnerships to expand global access to our medicines, recognizing that the greatest need for HIV treatment is in the least-developed parts of the world. Today, 4.3 million people worldwide receive Gilead HIV therapies, of which 3.5 million live in low- and middle-income countries.

Advances in HIV/AIDS Treatment

Because of social action and science, HIV has been transformed from a near-certain death sentence into a chronic, manageable disease. Effective ARV therapy for individuals provides benefits that include near-normal life expectancy and reduced need for hospitalization, and can allow many people with HIV to return to work and have an improved quality of life. Effective ARV therapy also provides significant benefits for families, keeping them intact, allowing parents with HIV infection to care for children, and reducing households' expenditure on healthcare.

What is more, effective ARV therapy begun early has the potential to lower the risk of HIV transmission. In May 2011, researchers at the U.S. National Institutes of Health (NIH) announced results from a landmark clinical study among heterosexual couples in Africa in which one partner was HIV-positive and one HIV-negative. The study found that for couples where the HIV-positive partners started treatment right away, the rate of HIV transmission to HIV-negative partners was 96 percent lower as compared to couples in which the positive partners delayed treatment.

Since that study was published in the *New England Journal of Medicine*, there has been growing support for the Test and Treat Approach among political, religious and health care leaders. According to Catholic News Service, in 2011, Archbishop Zygmunt Zimowski, who led the Holy See delegation to the 65th World Health Assembly, said he was intrigued by the evidence. World Health Organization Director Margaret Chan and former U.S. Secretary of State Hillary Clinton have made public statements endorsing the use of ARVs to reduce HIV transmission.

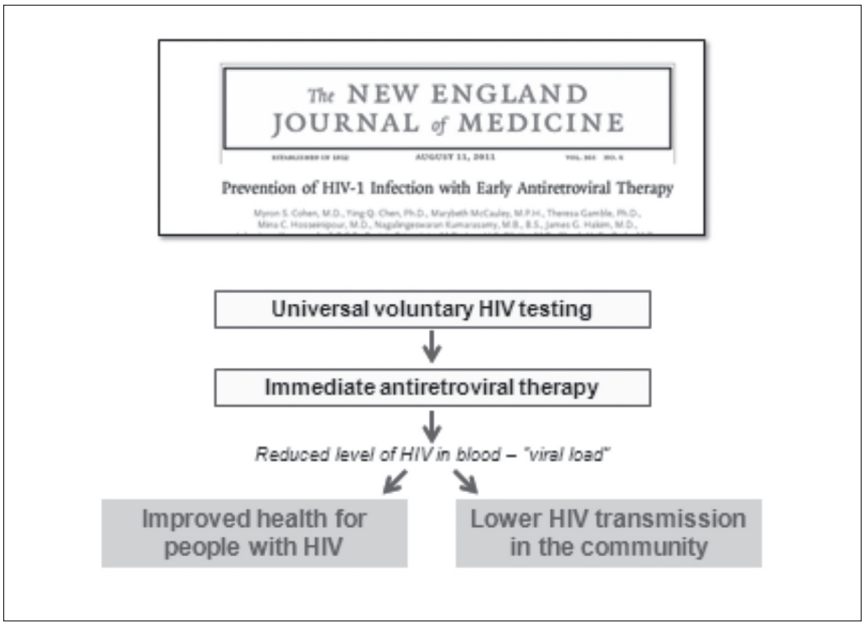
Over the past decade, the international community has made enormous progress in ARV treatment provision: Between 2002 and 2011, the number of people in low- and middle-income countries receiving ARV therapy increased 2,600 percent, from 300,000 to more than 8 million. Treatment has averted an estimated 2.5 million AIDS deaths since 1995.

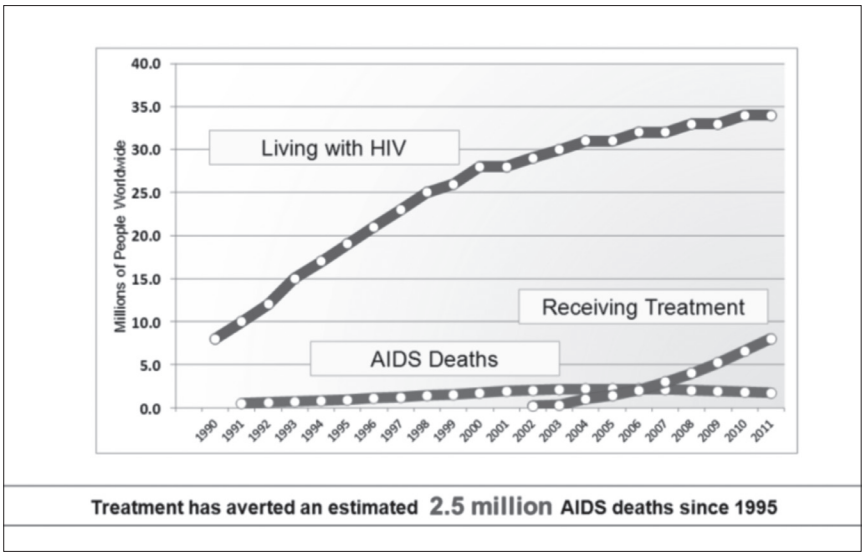
Yet substantial needs remain, and continuing to scale up treatment is a top health and humanitarian priority. The United Nations has set a target of reaching at least 7 million additional people with ARV therapy, to reach a total of 15 million people by 2015.

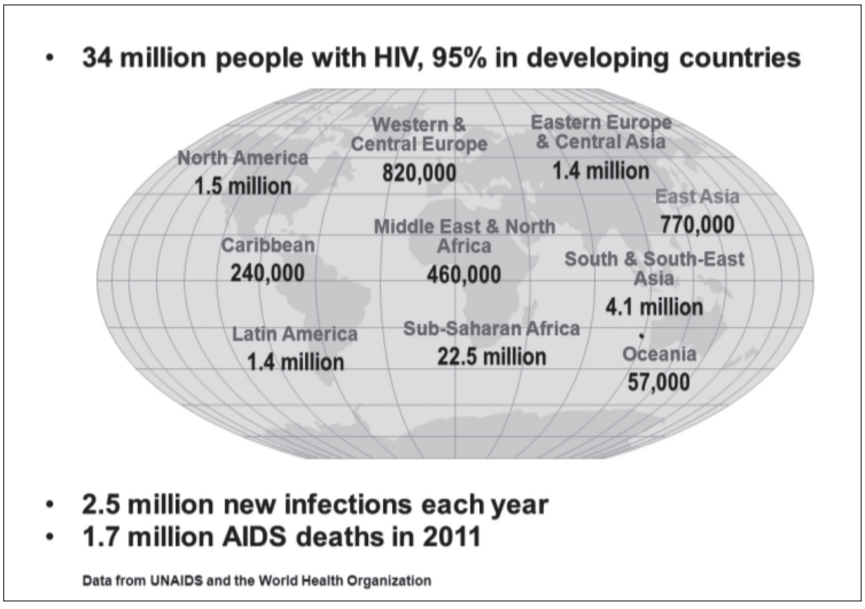
HIV Treatment Needs Persist

Thirty years since the first cases were reported, HIV/AIDS remains one of the world's foremost health challenges. Approximately 30 million people have died of AIDS, and more than 34 million people are now living with HIV.

Nine in 10 people with HIV reside in developing world countries and the vast majority of new infections occur in the developing world. HIV is a barrier to social development and economic growth as it reduces life expectancy, destabilizes families and deepens poverty. In the absence of a vaccine and cure, testing people for HIV and providing treatment to those who are infected is a primary strategy for controlling the epidemic.







The Catholic Church's Global Response to HIV

A vast Catholic health services network spanning more than 100 countries includes approximately 5,000 hospitals, 17,000 dispensaries and 15,000 houses for the ill and elderly, many of which treat people living with HIV. In fact, through this network Catholic institutions and charities provide health care to approximately 1 in 4 people worldwide with HIV.

The Catholic Church's engagement on HIV treatment has also involved its most senior leaders. Addressing an international conference in 1989 (Pontifical Council for Health Care Workers, IV International Conference), His Holiness Pope John Paul II stated that HIV represents a "double-edged challenge ... prevention of the disease and healthcare offered to those who suffer from it. Truly effective action … results from a constructive vision of the dignity of the human person." More recently, His Holiness Pope Benedict XVI in 2011 called for a "medical and a pharmaceutical response" to HIV/AIDS.

Collaboration on Tanzania Test and Treat Project

Gilead believes in strength through partnership. Collaborations of all kinds – with partners in science, academia, business and local and faith communities – are central to our work. Partnerships enhance our ability to develop innovative medicines and deliver them to people in need as efficiently as possible.

One ongoing example of this commitment with regards to communities of faith is a pilot project being carried out in collaboration with the Vatican and Tanzanian Episcopal Conference, conducted at a rural site in Bugisi, Tanzania. The Tanzania project is intended to demonstrate how, by implementing voluntary universal HIV testing in health care facilities and immediately connecting those treated to effective ARV therapy, providers can reduce viral load, improving health for people with

HIV infection and lowering HIV transmission in communities.

In Bugisi, the project aims to increase HIV screening in Catholic health care facilities across 35 villages, home to approximately 75,000 individuals, with direct referral to therapy for patients diagnosed with HIV. We expect that the project will treat 20,000 patients, providing the direct benefits to patients as well as communities that result when we reduce viral load. Additionally, the program will provide key data for researchers to analyze that will help them design more effective test-and-treat initiatives in the future. Important questions the project will help answer include: how to effectively scale up testing, understanding the barriers to early initiation of ARV therapy, need for adequate infrastructure, including health workers, and how to continue optimizing ARV therapy to reduce costs.

We consider this collaboration to be a critical opportunity to demonstrate not only the effectiveness of HIV treatment-as-prevention, but also to show how industry and faith leaders can make tangible progress in addressing an epidemic that hits the neediest the hardest.

Conclusions

MSGR.
ANDREA PIO CRISTIANI
Founder of the 'Shalom' Movement, Italy, Consultor of the Pontifical Council for Health Care Workers, the Holy See

To sum up in a brief way the conclusions of such an extraordinary meeting, which this twenty-seventh international conference of the Pontifical Council for Health Care Workers has undoubtedly been, is without doubt a notable undertaking, both because of the international importance of the event during which all the five continents of the world were represented and because of the very high quality of the papers given by the various learned and distinguished speakers. The subject suggested by the Holy Father is topical and global: 'Hospitals as Places of Evangelisation: their Human and Spiritual Mission'. The subjects have been in full harmony with the extraordinary year of the faith, established to remember the golden jubilee of the Second Vatican Council.

We have at the level of ideas crossed the thresholds of the doors that humanity crosses when it falls ill and suffers.

We have directed out attention to the very many settings where illness is addressed. It is though we had come from sixty-five nations of the planet to ask ourselves whom we encounter beyond those doors and what it is exactly that we are looking for there.

Each sick person, with a state of mind imbued with fear and with hope, hopes for a warm welcome and effective treatment. Such is not always the case. It may happen that they are not treated as persons but as 'numbers', in relation to whom one should act spending as little time as is possible and with the lowest possible costs.

The globe is threaded through with hospitals, nursing homes and dispensaries which arose over the centuries because of the will of Jesus: 'Heal the sick' (Lk 10:9). The first thing that we must ask ourselves is whether those who enter our institutions really encounter Christ in these settings where 'still today as the Good Samaritan he comes next to every man bent in body and spirit and pours upon his wounds the oil of comfort and the wine of hope' (cf. *Prefazio comune* VIII MR).

Those who work as disciples of Christ in the world of health and health care do not work to acquire fame, prestige, or even less to become rich. 'Talents' have been given to them. The greatest proof of the goodness of the cause that these serve is the gratuitousness of their work. We are faced with a depressing spectacle when we witness speculation in relation to health, the cutting of research funds, of funds for health care, and of funds for welfare in general. It is always the least who bear the costs of this situation. For the rich and powerful, in the contemporary crisis as well, there will always be the best medical doctors and the best treatment.

This twenty-seventh international conference has not only been an exchange of views on various scientific, social, pastoral or spiritual questions and issues. It has also been, as is to be expected of a congress promoted by a pontifical council, an authentic 'theophany'.

We came from all the continents of the world of enjoy the universal dimension of this Catholic Church of ours which was founded by Peter. Leaving aside the papers that followed one another during the various sessions of the conference and the value of the religious and civil figures who honoured us with their constant presence, it was perceived that the only true chairman and animator was Jesus. The comforting and illuminating presence of his Spirit imbued all those who people took part.

The annual 'Pentecost' of our Pontifical Council began in the morning with the inaugural celebration in St. Peter's presided over by His Eminence Cardinal Tarcisio Bertone and it ended with the meeting with the Supreme Pontiff who encouraged all those who had spoken at the international conference with his illuminating words. This was a great sowing for the whole world which will undoubtedly bear abundant fruit.

The settings in which human health is cared for should be authentic 'sanctuaries', starting with universities where research should be understood as the identification of the multiple possibilities that the Creator has placed in nature, offering to human intelligence the ability to work healings in a progressive and exalting growth of successes. Just a short time ago some surgical operations, but therapeutic initiatives as well, would have seemed incredible miracles. In harmony with each other, the synoptic gospels tell us that Jesus entrusted the Apostles with 'casting out unclean spirits' (which were held to be the cause of maladies) and to heal every kind of illness and infirmity (Mt 10: 1; Mk 3:1; Lk 6:13). This mandate addressed to the Twelve is also a clear invitation to the whole of the Church to develop that knowledge that relieves human pain and improves quality of life, making life free and beautiful.

From the papers given to this international conference it emerged with clarity that to evangelise is a priority commitment of every Christian health-care worker. To evangelise is above all to denounce the scandalous differences between the innumerable very poor people and the opulent few. That a child should die because of the lack of an antibiotic in countries where life expectancy does not go beyond forty, whereas elsewhere exaggerated treatment no longer helps people but merely extends their sufferings, is a scandal. The principle of the equality of the human person and his or her inalienable right to health was as-

serted forcefully and repeatedly. It is as though the Church, strong in her social teaching, had outlined a world political project around which the intentions of national governments and religious and civil institutions could converge.

A condemnation of the vision of man upheld by nihilistic and materialistic neo-approaches sounded out in a strong way in the synodal hall. These philosophies reduce the human being to a low-level biochemical product, an accident produced by chance that took shape through a long evolution of cosmic magma, a 'simple' compound of cells that arranged themselves of necessity.

In animalism, which has become fashionable today, there is no difference in terms of rights between animals and people. In the confusion of the contemporary world, animals should die of old age whereas for humans euthanasia is advocated. On this subject, the breath of the Spirit, which blew in the hall, reconfirmed the Gospel of Man, his being which came out of the heart of God, made in His image and likeness, endowed with an immortal soul, with intelligence, and with freedom. The whole of his being is expressed in an immortal soul which is the seal of his uniqueness, unrepeatable nature, and eternity. It is his spiritual faculties that suggest to man a destiny beyond this earth. As Pope Benedict XVI observes in his *Jesus of Nazareth*, man awaits complete healing: 'Those who really want to heal man must see him in his wholeness and must know that his final healing can only be the love of God'. During this international conference, evangelisation appeared as an urgent need to restore to man his true dignity.

At the end of our deliberations it has been necessary to ask ourselves about the mission that awaits us at home, that is to say the mission of being the champions not only of an authentic vision of man but also of how God is 'incarnated' in sick people. Our task is to say to the world that to heal the sick is to worship God Himself. Contact with suffering people is like a sacrament, a source of grace and salvation. Those who have not received the gift of faith, but love and serve the sick with devotion, will also be saved, as the Gospel of Matthew tells us (cf. 25:31-46). The finest surprise will be for those who did not know this and did not realise that in the sick there was God. This is that 'when did we visit you?' which allows us to hope for eternal salvation for all those who give of themselves.

In the passage from the Gospel according to St. Matthew, the rewarding of the just is announced in three statements: the blessing of the Father, the inheritance of the kingdom, and eternal life. Connected with the performance of the 'vocation' to health-care service there is the real success of a life. In the final analysis we will not have asked of us the science that we produced or the healings that we obtained, and even less the amount of money that we accumulated: having reached the threshold of the doors of Eternity to welcome us we will find patients who have been treated and who, having cast off their 'earthly masks', will show us the shining face of the Lord who will say: 'It was me: you did it to me'.

Concluding Reflections and Recommendations

FR. JACQUES SIMPORÉ, M.I.
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Introduction

Today more than ever before, under the guidance of the science, of biomedicine, of modern biotechnology and of systems of numerical management, our hospitals are tending to lose a human face and steadily to become, for some health-care workers, places of business and, for the sick, spaces of anonymity, of loneliness, of anxiety and of death without hope. Some countries have legalised euthanasia and already practise it; other societies are presently agitating to validate it in order to reject the void or fill the emptiness of induced in the hearts of patients who have been admitted to hospital.

However, a hospital, which is a place where patients interrupt their stressing daily activities, should be a place of inner peace, of reflection about life, about the meaning of life and about the future of man.

In recent days, during this international conference, we followed with great interest a large number of papers such as 'The hospital as a setting for a new evangelisation; the role of hospitals in international health-care policy; the hospital as a temple for humanity and crossroads of peoples; the genesis of hospitals; biomedical research; telemedicine; spirituality and the deaconate of charity; ethics and humanisation…'. These multiple contributions to reflection demonstrate to us, on the one hand, how our sick brethren are followed and treated: neonates, young people, adults or the elderly, rich or poor, atheists or believers, and, on the other, how these patients suffer, recover or die in those 'temples of life' which hospitals should be.

As concluding reflections I will summarise, starting with the subjects of the various papers, the

challenges for today's hospitals. Subsequently, my recommendations for hospitals as health-care and life institutions will begin from personal reflections based upon the traditional African experience of care for the sick and the personalist vision of man.

1. The Challenges to be Met in Today's Hospitals

Modern science and medicine have revolutionised human health and have pusher it to engage in significant progress from the point of view of the quality of life and life expectancy. However, this search for therapeutic efficacy, using the modern instruments of research, has destabilised traditional medical care for patients in hospitals. There are a number of challenges which have to be met.

1.1. The challenge of drawing up a policy for hospitals based on local areas

Health policies (or health-care policies or public health policies) include the set of strategic choices of public and private authorities to improve the state of health of populations for which they have responsibility. One is dealing here with: 1. deciding the areas and fields of action: 2) specifying the objectives to be achieved; 3) make judicious choices as regards priorities; and 4) planning the means that will be used at this level of collective responsibility. The challenge to be met at this level is the drawing up of a policy for hospitals based on local areas which has on the one hand equal access to care and treatment throughout the whole national territory in order to fight against regional disparities, and, on the other, internal medical organisation and management which place the person of the patient at the centre of the interests of the hospital.

1.2. The challenge of the transformation of hospitals into 'business centres'

As the newspaper *Le Temps* emphasised on 21 October 2012, 'the world of health is in complete turmoil'. Hospitals and clinics have to face up to enormous challenges which can be met only through a targeted high-quality management. Because of today's competitiveness, hospitals and clinics . which are large, medium and small companies or public or private institutions – are forced to improve their efficacy by making public the quality of their results in a transparent way. Hospitals thus run the risk of becoming 'business centres', sector of commerce where a sic person can be at one and at the same time a customer and the object of negotiations. Each patient receives care and treatment according to his or her wallet. From this point of view, the quality of care and treatment becomes proportionate to the financial capacities of the patient!

1.3. The challenge of pharmacological-clinical experimentations

All biotechnological advances as regards 'dominion over life' as in the case of medically assisted procreation lead us to think of the famous phrase of Prof. Jacques Testard: 'We have left a horse without reins or bit in nature'. Here we are faced with new ethical challenges that were never suspected which bring into question the very foundations of general ethics, of our universal inheritance of wisdom!

1.4. The challenges of secularisation

Nowadays a 'secular' ethics has been decoded which does not have any foundation in the Transcendent and called 'global ethics'. It is undermining biomedical ethics from within and finds in hospitals a favourable setting for the spread of its principles.

1.5. The challenge of loneliness and desperation

In a hospital a sick person always becomes a number. Nobody calls him or her by his or her name. In addition, he or she is often abandoned by his or her parents who are too busy because of their social activities. At times, faced with hopelessness, only one solution remains: to ask to die in dignity. The alarming legalisation of euthanasia invites us to revisit the deep reasons for this social crisis. What suitable Christian answers should be given to the exclusion and loneliness which in numerous patients lead to desperation and suicide attempts?

2. Recommendations

2.1. *Starting with the vision of illness, sick people and the care and treatment that should be given to them of Africans, we could suggest some recommendations favourable to a better humanisation of the hospital world.*

In the view of Professor Joseph Ki-Zerbo,[1] 'Every culture bears within it the seeds of the greatest achievements, in faith as well. This is especially true of African culture which, despite some defects, has notably positive aspects in the field of dedication to the sick'. In his view, the physical commitment of Africans towards their sick derives from a civilisation that is principally agrarian. Thus in this Africa of other times, hospitals were everywhere and nowhere. There were no old people's homes for the elderly nor places to take in the mentally ill. In this sense, the very idea of the segregation of the sick was unthinkable both because there was as yet no precise idea of what infectious diseases were and because, and above all else, because it was a sacred duty to be physically near a parent or a friend who was sick. Thus in traditional Africa, every kind of obligation was forgone in order to help sick people physically, even though in normal life adversaries were involved. This was because in their view the grave illness of an adversary automatically marked a tie for a social truce. In all cases, thus physical commitment was to observed in body to body contact which an African accepted with a sick person as though challenging the illness rather than the patient. Do we not perhaps see men or women directly behind a sick person, putting him or her between their legs

or carrying them on their chests in order to relieve their pain, to feed them better, give them something to drink, precisely as was done with circumcision or childbirth? There was a pact, a sort of trilogy between the healer, traditional medicine and the sick person. Indeed, after receiving for free the therapeutic prescriptions from the gods, each '*tradipraticien*' ('traditional physician) asked for symbolic fees from his patients: three kola nuts or salt or three bales of tobacco. It was a contradiction, a confusion of language, to speak about a rich '*tradipraticien*' inasmuch as his priesthood was only for suffering humanity.

Starting with these observations about traditional African culture, what recommendations can we make about our societies and our hospitals?

1. For the health-care personnel: 'more heart in the hand'; placing the person of the patient at the centre of the interests of the hospital.

2. For the patient: living in hope because, as a proverb of Burkina Faso says, 'if God does not kill a sick person, the '*tradipraticien*' will not kill him at all' or 'the physician treats but it is God who heals!'

3. For society: organise things so that the patient is not left alone; always support the patient physically, morally and financially; say to society that: medical doctors have not yet discovered the elixir of immortality; life belongs only to God; and exaggerated treatment reduced the human aspect in man.

2.2. Starting with a personalist view of man, what recommendations can be formulate for hospitals as institutions of health an life?

According to the personalist approach, human life is a fundamental, sacred and intangible value. Life is a gift of God. And the human person created in the image and likeness of God is a psychosomatic being, that is to say body and spirit. In this way, for the personalist way of thinking, the human being is the most important value of the create world. His or her life begins with fertilisation and ends with his or her death.

Starting with the personalist vision of man, we can formulate a series of recommendations for hospitals: the formation and updating of hospital personnel in relation to new medical technologies; the formation of hospital personnel in relation to the principles, foundations and values of bioethics; the formation of hospital chaplains in relation to bioethics and pastoral care in health; the creation of pastoral teams made up of chaplains; the celebration of the sacraments in hospitals; the creation within hospitals of places for healthy recreation and entertainment for patients; the sensitisation of civil society to support for sick people in hospitals; the development of systems for the control of pain so as to block the way to euthanasia; the promotion of respect for life in hospitals: from the conception of the human person until death; and leading patients to live their illnesses in a Christian way so that they become, in their turn, evangelisers of their environment.

Conclusion

During the course of this twenty-seventh International conference of the Pontifical Council for Health Care Workers we have heard on a number of occasions that hospitals as settings for evangelisation, and thus for life and hope, should be welcoming and healing institutions that are full of life, of plants and of colour. Places where solidarity, solicitude, professionalism, humanism, prayer and meditation should be practised.

At the beginning of the 1990s the World Health Organisation proclaimed 'Health for All by the Year 2000' (WHS, Geneva, 1991) and the UN restated that every man has the 'right to health' (UN, 1949; WHO, 2003). We are by now in the year 2012! What has really been done? To bring all the peoples of the world, all nations, to the highest level possible of health we need to review in an urgent way our hospitals, our systems of care and treatment for sick people. Man is not only his body inasmuch as he also has a spirit and both of these components of what man is need care and treatment.

In his *Motu Proprio 'Porta Fidei'*, Pope Benedict XVI announced a 'Year of Faith'. Even though today we see, with regret, our churches, our sanctuaries, our cathedrals and our basilicas empty because many people nowadays pursue with ardour the world of business and have no time for God, the Teacher of Life is always patient – He awaits them at the threshold, in hospitals, 'Temples of Life' and crossroads of peoples, where one day they will rest, immobilised and with all the time they need, therefore, to speak to them 'heart to heart'.

Nowadays, seeing what is experienced and done in our hospitals, we are tempted to day: '*homo sapiens* has too much science and not enough wisdom'. For this reason, today the hospital world suffers because it needs a new approach to evangelisation which takes into account the reality of our epoch. Thus everyone in hospitals are afraid that they will be alone amidst the void. However, there is no fear without hope just as there is no hope without fear (the Blessed John Paul II).

Hospitals, 'temples of life', mirrors of society, guardians of life and settings for the encounter between heaven and earth, should be places of solicitude and not of loneliness. Beyond any political, philosophical, ethical and ideological tendency of a government, every nation should always promote not only the better organisation and management of hospitals but also practical measures so that each patient is well cared for and treated, surrounded by his or her dear ones, and can live his or her faith.

Acknowledgements

I thank Father Padre Joseph Sawadogo, of St. Vincent de Paul, of Burkina Faso, for his contribution in the writing of this paper.

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(per la Pastorale della Salute)

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Dio ha visitato il suo popolo. Sulla via dell'uomo che soffre

"Anche la clinica e l'ospedale, come ogni malato e sofferente, sono luoghi e persone interessati alla nuova evangelizzazione. È emerso nella presentazione, alla vigilia del Sinodo dei vescovi, di un volume di Zygmunt Zimowski (Dio ha visitato il suo popolo. Sulla via dell'uomo che soffre, Libreria Editrice Vaticana, 2012, pagg. 268, 16 euro) ... arcivescovo presidente del

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