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*The illustrations in this issue have been
provided by the review “Ecclesia” no.14/97*



SECRETARIA STATUS

Summus Pontifex

IOANNES PAULUS II

ad Sedem Episcopalem tit. Aufenensem evexit Reverendum Patrem

IOSEPHUM ALOISIUM REDRADO MARCHITE, O.H.

Secretarium Pontificii Consilii de Apostolatu pro valetudinis Administris

Id in notitiam ipsius Reverendi Patris Redrado Marchite perfertur, ut ea de re opportune certior fiat ad eiusdemque normam se gerat.

Ex Aedibus Vaticanis, die V mensis Decembris anno MCMXCVIII.

+Angelus Card. Sodano

L'Osservatore Romano, Sunday, December 6, 1998,
in the section, "Our Information", published the following news:

His Holiness has nominated
Fr. José Luis Redrado Marchite, O.H.
Secretary of the Pontifical Council for Pastoral
Assistance of Health Care Workers, as titular Bishop of Ofena.

Message of the Holy Father on the Occasion of the World Day of the Sick February 11, 1999

Dear Brothers and Sisters!

1. The next World Day of the Sick, February 11, 1999, according to a tradition that is now becoming consolidated, will have its most solemn celebration in an important Marian shrine.

The choice of the shrine of Our Lady of Harissa, on the hill overlooking Beirut, takes on many profound meanings because of the circumstances of time and place. The land that hosts this shrine is Lebanon which, as I have already had occasion to point out, “is more than a country; it is a message and a model both for the East and the West” (Rome, September 8, 1989, in *Insegnamenti di Giovanni Paolo II*, XII/2, p. 176).

From the shrine of Harissa the vigilant statue of the Blessed Virgin Mary looks at the Mediterranean coast which is so close to the land where Jesus walked “proclaiming the Good News of the kingdom and curing all kinds of diseases and sickness among the people” (*Matthew* 4:23). Not far away is the region that preserves the bodies of the martyrs, Cosmos and Damian, who accepted Christ’s mandate “to proclaim the kingdom of God and to heal” (*Luke* 9:2), and carried it out with such generosity so as to deserve the title of *holy doctors*, “*anàgyros*”; in fact, they practiced medicine without any retribution.

The year 1999, within the scope of preparation for the Great Jubilee of the year 2000, will be dedicated to the universal Church and to a more careful reflection on God the Father. In his first Letter, the Apostle John reminds us that “God is love” (4:8,16). How can reflection on this mystery not revive the theological virtue of charity in its dual aspect of love of God and love of neighbor?

2. In this perspective, the Church’s preferential choice for the poor and for those who are suffering in body and spirit will take on the character of a “journey of authentic conversion to the Gospel” as the second millennium comes to a close. This will not fail to stimulate a greater search for unity among all people in order to build up the civilization of love (cf. Apostolic Letter *Tertio Millennio Adveniente*, 50-52), in the example of the Mother of Jesus, “the perfect model of love toward both God and neighbor” (*Ibid.*, 54).

What place on earth better than Lebanon could be the symbol today of unity among Christians and of the encounter of all people in the communion of love? In addition to being a place where Catholic communities of different traditions and various Christian communities live together, Lebanese soil is also a crossroads of many religions. As such, it can truly act as a laboratory for “building a future together of conviviality and collaboration in view of the human and moral development” of peoples (Post-Synodal Apostolic Exhortation *A New Hope for Lebanon*, 93).

The World Day of the Sick, which will have its convergence point precisely in Lebanon, calls on the universal Church to ask herself about her service to the condition which, more than any other, highlights the limitations and fragility of human creatures and also asks for their mutual solidarity. The Day thus becomes a privileged moment for reference to the Father and a dutiful reminder of the primary commandment of love, about whose observance we are all called to give an account (cf. *Matthew* 25:31-46). The model which should inspire us is indicated by Jesus himself in the figure of the Good Samaritan, a key parable for full understanding of the commandment to love one’s neighbor (cf. *Luke* 10:25-37).

3. The next World Day of the Sick should therefore enter into the framework of a particular sensitivity to the duty of charity which the meeting for reflection, study and prayer will not fail to emphasize at the shrine of Our Lady of Harissa, the destination of pilgrimages by all the Christian Lebanese communities from the various Churches and also by devout Muslims. From this the need for unity will emerge more clearly through that “ecumenism of works” which, in the care of the sick, suffering, marginalized, poor and deprived, is both the most urgent and the least arduous of the ecumenical paths, as experience now shows. Along this path it will be possible not only to seek “full unity” among those who profess to be Christians, but also to open up to inter-religious dialogue in a place like Lebanon where different religious beliefs “have a certain number of indisputable human and spiritual values in common” which can lead on, even “beyond the significant divergences between the religions”, to discern first of all what unites (Post-Synodal Apostolic Exhortation, *A New Hope for Lebanon* 13-14).

4. No request rises from human hearts with such great entreaty as the request for soundness and good health. Therefore, it should not be surprising if human solidarity, on all levels, can and must be developed with priority and urgency in the area of health. Therefore, it is urgent “to carry out a serious and in-depth study on the organization of health services in institutions with the concern to make them places of ever greater witness to love for people” (*Ibid.*, 102).

In turn, the response expected from the suffering should be adapted to the condition of the receiver who wants above all the gift of sympathetic sharing, loving soli-

darity, and generous dedication, even to the point of heroism.

May contemplation on the mystery of God's fatherhood become a reason for hope for the sick and a school of careful concern for those who take care of them.

5. To the *sick*, of all ages and conditions, to the victims of infirmities of all kinds, calamities and tragedies, I extend my invitation to abandon yourselves into God's fatherly arms. We know that life has been given to us as a gift from the Father as the highest expression of his love, and that it continues to be his gift in every circumstance. All our responsible choices, whose objective may sometimes seem dark and uncertain to us because of our limitations, should be guided by this conviction. The Psalmist's invitation is based on this: "*Unload your burden on to Yahweh, and he will support you; he will never permit the virtuous to falter*" (Psalm 54:23).

In commenting on these words St. Augustine wrote: "What are you concerned about? What are you troubled about? The one who made you will take care of you. Won't the one who took care of you before you existed take care of you now when you are what he wanted you to be? Because now you are faithful, you already walk on the way of justice. Will by chance the one who makes the sun rise on the good and the evil and lets the rain fall on the just and the unjust not take care of you? Will he neglect, abandon and leave you alone, you who are just and live in the faith? On the contrary, he does good to you, helps you, gives you what you need here, and defends you from adversity. By giving you gifts, he consoles you so that you will persevere; by taking them away from you he corrects you so that you will not perish; the Lord takes care of you, don't worry. The one who made you sustains you, do not fall from the hand of your Creator; if you will fall from the hand of your maker, you will break. Good will helps you stay in the hands of the one who created you...By abandoning yourself to Him, do not believe that there is the void almost as if you were about to fall in; do not imagine a thing of this sort. He has said, 'I fill the heaven and the earth'. He will never fail you; do not fail him, do not fail yourself" (*Enarr. In Psalmos 39,26,27: CCL 38,445*).

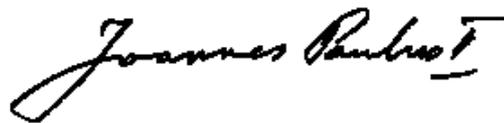
6. To the *health workers*—doctors, pharmacists, nurses, chaplains, men and women religious, administrators and volunteers—called by vocation and profession to be custodians and servers of human life, I point to Christ's example once again: after being sent by the Father as supreme proof of his infinite love (cf. *John 3:16*), he taught man "to do good with suffering and to do good for those who suffer" by revealing in depth "in this dual aspect, the meaning of suffering" (Apostolic Letter *Salvifici Doloris*, 30).

In the school of the suffering, learn to grasp through loving indulgence the profound reasons for the mystery of suffering. May the suffering to which you are witnesses be the measure of the dedicated response that is expected from you. In render-

ing this service to life, be open to the collaboration of all, for “the issue of life and its defense and promotion is not a concern of Christians alone... Life certainly has a sacred and religious value, but in no way is that value a concern only of believers” (Encyclical Letter *Evangelium Vitae*, 101). And since those who suffer ask only for help, accept help from everyone when this is expressed in a response of love.

7. To the *ecclesial community* goes my pressing invitation to make the year of the Father a year of active charity, the charity of works through the full involvement of all the ecclesial institutions. St. Ignatius of Antioch writes to the Ephesians that charity is the road to God. Faith and charity are the principle and the goal of life; faith is the principle, charity is the end (cf. *PG*, V, 651). All the virtues follow these in order to lead people to perfection. St. Augustine, on his part, teaches this: “If, therefore, you cannot read all the pages of Scripture one by one, nor can you unroll all the books that contain the Word of God, nor enter into all the mysteries of Sacred Scripture, have charity on which everything depends. In this way you will know not only what you will have learned therein, but also what you have not been able to learn there” (*Sermo* 350, 2-3: *PL* 39, 1534).

8. May the Virgin Mary, Our Lady of Harissa, with her sublime example, be near to all those who are suffering on this World Day of the Sick. May she inspire those who give witness to the Christian faith through service to the sick; may she guide everyone with her maternal hand to the House of the Father of all mercy. May she who watched over the heart-rending sufferings of the Lebanese people, arouse in the world, through the hope that is flourishing again in that land, a renewed trust in the healing power of charity and, like lost children, may she bring them all together under her mantle. May the new millennium that is about to open, inaugurate an era of renewed trust in man, the lofty creature of God’s love, who only in love will find the meaning of his life and his destiny.

A handwritten signature in black ink, reading "Johannes Paulus II". The signature is written in a cursive, flowing style with a distinct flourish at the end.

From the Vatican, December 8, 1998

Magisterium



*Address by
the Holy Father*

Offer your Suffering to God

On the evening of Saturday, 24 January, the Holy Father went to the Shrine of St Lazarus in El Rincòn, located on the outskirts of Havana, where he presided at a prayer service with the patients and staff from the nearby leprosarium. During the service the Pope gave the following address.

Dear Brothers and Sisters,

1. In visiting this noble land, I could not fail to meet with *the sick and suffering*, because *Christ is very close to all who suffer*. I greet you with the deepest affection, beloved who are sick, especially those from the nearby Hospital of Dr Guillermo Fernández-Baquero, here today in this Shrine of St Lazarus, the friend of the Lord. In greeting you, I also greet those throughout Cuba who are most afflicted, the elderly who are alone, all who are suffering in body or in spirit. In the words I speak and the affection I feel, I want to reach out to all who heed the Lord's exhortation: "I was sick and you visited me" (Mt 25:34). You are

accompanied by the tender love of the Pope, the solidarity of the Church and the fraternal warmth of all men and women of goodwill.

I greet the *Daughters of Charity of St Vincent de Paul*, who work in this centre and in them I greet the other consecrated religious, belonging to various religious institutes, who work lovingly in other parts of this beautiful island to alleviate the sufferings of whoever is in need. The community of the Church is very grateful to you because this is your way of contributing to the concrete mission stemming from your particular charism—that "the Gospel come to life through charity, which is the glory of the Church and the sign of her fidelity to the Lord" (*Vita consecrata*, n. 82).

I wish to greet also the *doctors, nurses and other assistants*, who with such competence and dedication use the resources of science to alleviate suffering and pain. The Church values your work because, stirred by the spirit of service and solidarity with your neighbour, it recalls the work of Jesus who "*cured the sick*" (Mt 8:16). I am aware of the great efforts being made in Cuba in the field of health care, despite the economic constraints which the country is enduring.

2. I come as a pilgrim of truth and hope to this Shrine of St Lazarus, as one who experiences in his own flesh the meaning and value which suffering can have when it is accepted by drawing near in trust to God who is "rich in mercy". This place is sacred to Cubans, because here grace is experienced by those who go in faith to Christ with the assurance we find in St Paul: "I can do all things through him who strengthens me" (Phil 4:13). At this point, we can repeat the words with which Martha, the sister of Lazarus, expressed her confidence to Jesus and so obtained the miracle of the raising of her brother: "*I know that God will give you whatever you ask of him*" (Jn 11:22) and the profession she then made: "*Yes, Lord, I believe that you are the Messiah, the Son of God, the one coming into the world*" (Jn 11:27).

Follow Jesus on the way of the Cross

3. Dear brothers and sisters, in one form or



another all human beings experience pain and suffering in their lives and this cannot but lead them to pose a question. *Pain is a mystery*, often inscrutable to reason. *It forms part of the mystery of the human person*, which alone comes clear in Jesus Christ who reveals to man man's true identity. Christ alone enables us to know the meaning of all that is human.

"Suffering", as I wrote in the Apostolic Letter *Salvifici doloris*, "can be transformed and changed with a grace which is not exterior but interior... yet this interior process does not always develop in the same way... Christ responds neither directly nor abstractly to human questioning about the meaning of suffering. Human beings come to know his saving response in so far as they share in the sufferings of Christ. The response which comes from this sharing is before all else a call. It is a vocation. Christ does not explain in some abstract way the reasons for suffering, but says first of all: 'Follow me', 'Come' *with your suffering share in this work of salvation of the world*, which is realized through my suffering, by means of my Cross" (n. 26).

This is the true meaning and value of suffering, of the pain which is physical, moral and spiritual. This is the Good News which I wish to pass on to you. To our human questioning, the Lord responds with a call, with a special vocation which is grounded in love. Christ comes to us not with explanations and reasons which might either anaesthetize or alienate us. Instead, he comes to us saying: "Come with me. Follow me on the way of the Cross. The Cross is suffering". "*Whoever wants to be a follower of mine, let him deny himself, take up his cross and follow me*" (Lk 9:29). Jesus Christ has taken the lead on the way of the Cross. He has suffered first. He does not drive us towards suffering but shares it with us, wanting us to have life and to have it in abundance (cf. Jn 10:10).

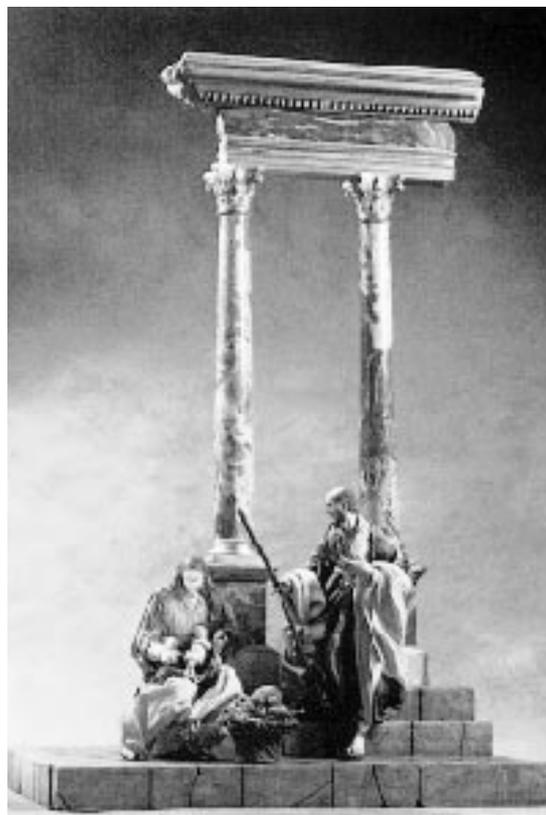
Suffering is transformed when we experience in ourselves the closeness and solidarity of the living God: "*I know that my Redeemer lives, and at the last... I shall see God my Saviour*" (Jb 19:25-26). With this assurance comes inner peace, and from this a spiritual joy, quiet and deep, springing from the "Gospel of suffering" which understands the grandeur and dignity of human beings who suffer with a generous spirit and offer their pain "*as a living sacrifice, holy and acceptable to God*" (Rom 12:1). This is why those who suffer are no burden to others, but with their suffering contribute to the salvation of all.

Suffering is not only physical. There is also suffering of the soul, such as we see in those

who are isolated, persecuted, imprisoned for various offences or for reasons of conscience, for ideas which though dissident are nonetheless peaceful. These prisoners of conscience suffer an isolation and a penalty for something for which their own conscience does not condemn them. What they want is to participate actively in life with the opportunity to speak their mind with respect and tolerance. I encourage efforts to reinsert prisoners into society. This is a gesture of high humanity and a seed of reconciliation, a gesture which honours the authority promoting it and strengthens social harmony in the country. To all of you who are detained, to your families who suffer the pain of separation and long for your return, I send my heartfelt greeting, urging you not to succumb to pessimism or discouragement.

Dear brothers and sisters, Cubans need this interior strength, the deep peace and joy which spring from the "Gospel of suffering". Let this be your generous offering so that Cuba "may see God face to face", that Cuba may walk in the light of his face towards the eternal and universal kingdom, that all Cubans, from the very depths of their being, may say: "*I know that my Redeemer lives*" (Jb 19:25-26). This Redeemer is none other than Jesus Christ our Lord.

4. The Christian dimension of suffering reaches beyond its deeper meaning and its redemptive character. Pain is a call to love,



which means that it ought to engender solidarity, self-giving, generosity in those who suffer and in those called to accompany and aid them in their distress. The parable of the Good Samaritan (cf. Lk 10:29ff.), which puts before us the Gospel of solidarity with our suffering neighbour, “has become one of the essential elements of moral culture and of universally human civilization” (*Salvifici doloris*, n. 29). In effect, Jesus in this parable teaches us that *our neighbour is anyone we meet on our way who is wounded and in need of help*. He must be helped in an appropriate way in the evil that has be-fallen him, and we must care for him until he is fully recovered. Families, schools and other educational institutions, even if only for humanitarian motives, need to work perseveringly to awaken and refine this sensitivity to the suffering neighbour, whom the Samaritan of the Gospel symbolizes. The eloquence of the parable of the Good Samaritan, as of the entire Gospel, is in real terms this: human beings must feel personally called to *witness to love in the midst of suffering*. “Institutions are very important, indeed indispensable; but no institution can of itself substitute for the human heart, human understanding, human love, human initiative, when it is a question of going to meet the suffering of another” (ibid., n. 29).

No pain is without significance

This is true of physical suffering, but it is even more true of the many kinds of moral suffering, and when it is primarily the soul that is suffering. This is why when persons suffer in their soul, or when the soul of a nation suffers, the pain must be a summons to solidarity, to justice, to the building of a civilization of truth and love. An eloquent sign of this will to love in the face of pain and death, in the face of imprisonment or isolation, in the face of enforced family separations or the emigration which divides families, would be for each so-

cial agency, each public institution, as well as every person who holds responsibility in the field of health care and care for the needy and the re-education of prisoners, to respect and ensure respect for the rights of the infirm, the marginalized, the detained and their families, indeed the rights of all who suffer. To this end, *pastoral work in the field of health care and prison ministry* must be given the opportunity to perform its mission of service to the infirm, the imprisoned and their families.

Indifference in the face of human suffering, passivity before the causes of pain in the world, cosmetic remedies which lead to no deep healing of persons and peoples: these are grave sins of omission, in the face of which every person of goodwill must be converted and listen to the cry of those who suffer.

5. Beloved brothers and sisters, in the anguished moments of our personal, family or social life, the words of Jesus help us in our trials: “*My Father, if it is possible, let this cup pass from me; yet not what I want but what you want*” (Mt 26:39). In faith, the poor who suffer encounter the strength of Christ who says to them through the mouth of St Paul: “*Your grace is enough for me*” (2 Cor 12:9). No suffering is lost, no pain is without significance. God takes it all to himself, just as he accepted the sacrifice of his Son, our Lord Jesus Christ.

At the foot of the Cross, her arms cast wide and her heart pierced through, there stands our Mother, the Virgin Mary, Our Lady of Sorrows and of Hope, who welcomes us in her motherly embrace, spreading grace and compassion. She is the sure way to Christ, who is our peace, our life, our resurrection. Mary, Mother of all who suffer, mercy for the dying, warming embrace for all who are disheartened: look upon your Cuban children who are passing through the difficult test of pain and show them Jesus, the blessed fruit of your womb! Amen.



No State Can Justify Killing the Innocent

THE HOLY FATHER ON FRIDAY, 22 MAY, GAVE THIS ADDRESS TO 8,000 MEMBERS OF THE ITALIAN PRO-LIFE MOVEMENT

1. Welcome, dear Brothers and Sisters, members of the *Pro-Life Movement*. You have come to Rome from various Italian cities once again to renew your “yes” to the fundamental value of life and to give a voice to the many innocents whose right to be born is jeopardized. I affectionately greet Bishop Elio Sgreccia, Vice-President of the Pontifical Academy for Life, and the movement’s President, Mr Carlo Casini, whom I thank for his strong, beautiful words to me on behalf of you all. I also greet all who in these years have actively worked to defend and promote human life.

As I recalled in the Encyclical *Evangelium vitae*: “Humanity today offers us a truly alarming spectacle, if we consider not only how extensively attacks on life are spreading but also their unheard-of numerical proportion, and the fact that they receive widespread and powerful support from a broad consensus on the part of society, from widespread legal approval and the involvement of certain sectors of health-care personnel” (n. 17).

With profound sorrow we must observe that these serious phenomena also occur in Italy, where in the last 20 years no less than three and a half million babies have been killed with the approval of the law, in addition to those destroyed illegally. However, in view of these disturbing figures, your presence, in large numbers and with great conviction, is an encouraging sign which nourishes the hope that truth will triumph over the false justifications given for abortion. The truth is that every human being has a right to life from his conception until his natural end. For the faithful the hope that this truth will prevail finds its basis in Christ, who died and rose again, and who sends his Spirit into the world to instil courage and to raise up tireless defenders and witnesses of truth and life.

Your commitment has had a positive influence

2. Encouraging signs also come today from those who observe the failure of permissive

abortion laws at the political level. Not only have they failed to eliminate illegal abortion, but, on the contrary, they have contributed to the growing decline in the birth rate and, not infrequently, to the degeneration of public morality. These data highlight the urgent need for a commitment to the promotion and defence of the family institution, the first resource of human society, especially with regard to the gift of children and the affirmation of women’s dignity. In fact, there are many who, in consideration of the dignity of woman as a person, wife and mother, see permissive abortion laws as a defeat and humiliation for woman and her dignity.

Another encouraging sign is your work, dear members of the Pro-Life Movement: as a result of the widespread and timely commitment of the *Aid Centres* you sponsor, it has been possible to save over 40,000 babies and to assist an equal number of women.

This promising result demonstrates that where concrete support is offered, despite problems and influences which are sometimes critical, women are able to make the sense of love, life and motherhood triumph within them.

Your praiseworthy commitment has had a positive influence on the consciences of individuals, where often “the eclipse of the sense of God and of man, with all its various and deadly consequences for life, is taking place” (*Evangelium vitae*, 24) and on the “moral conscience of society”, which “is responsible, not only because it tolerates or fosters behaviour contrary to life, but also because it encourages the culture of death, creating and consolidating actual structures of sin which go against life” (ibid.).

The network of concern for unborn life, which your Movement has been able to construct, attracting the attention of political institutions and broad levels of society, allows us to think that if the action of so many volunteers, supported with more explicit solidarity, were allowed in public health structures, it would achieve even greater results for many innocent lives.

I hope that parishes and Dioceses will treasure your experience in order to set up organized structures for aiding the life not only of

unborn children, but also of adolescents, the elderly and people who are alone and abandoned.

3. Concrete help and widespread educational activity, which involve the entire ecclesial community, must be accompanied by political efforts for the full recognition of the dignity and rights of the unborn child and for the revision of laws that legalize its suppression. No human authority, not even the State, can morally justify the killing of the innocent. This tragic transformation of a crime into a right (cf. *Evangelium vitae*, n. 11) is a sign of the disturbing decadence of a society.

Indeed, in addition to striking at the law impressed by the Creator on the heart of every man, permissive abortion laws express an incorrect form of democracy, present a reductive concept of society and reveal a lack of commitment by the State to the promotion of values.

Effective action in this area must, therefore, aim at reconstructing a horizon of values, which translates into a clear affirmation of the “right to life” in international charters and national laws.

Respect for life is the essential social issue today

4. On the other hand, economic and social progress cannot have a sure foundation and concrete hope if there is a basic refusal to acknowledge the right to life. There is no future for a society that is incapable of duly appreciating the wealth represented by a newborn

child and of valuing a woman’s vocation to motherhood.

As I recalled in the Encyclical *Evangelium vitae*, in the modern world there is “a surprising contradiction. Precisely in an age when the inviolable rights of the person are solemnly proclaimed and the value of life is publicly affirmed, the same right to life is being denied or trampled upon, especially at the more significant moments of existence: the moment of birth and the moment of death” (n. 18).

In view of such ambiguous positions, I wish to stress that respect for life from its conception until natural death is the essential issue in the modern social question. The lack of such respect in developed societies has serious consequences in developing countries, where pernicious anti-birth campaigns are still promoted, and it is especially apparent in the area of artificial human procreation and the euthanasia debate.

5. Dear brothers and sisters of the *Pro-Life Movement*, persevere in your courageous efforts! Every sacrifice and every hardship will be compensated by the smile of the many children who, thanks to you, can enjoy the priceless gift of life. I warmly encourage you to make every effort so that everyone’s right to life will be recognized and an authentic democracy, inspired by the values of the civilization of love, will be built.

I entrust each of you and all your good projects to Mary, “Mother of the living”, and, as I assure you of a daily prayer, I gladly impart to you and your endeavours my Apostolic Blessing.



Dying is Also Part of Life

On Saturday afternoon, 21 June, the Holy Father visited the Rennweg Hospice in Vienna. After praying briefly in the hospice chapel, the Pope gave the staff and residents of the hospice a Message.

To my beloved brothers and sisters of the Rennweg Hospice of *Caritas Socialis* and to all who live and work in the world of pain and suffering.

1. In the name of our Lord Jesus Christ, who has “borne our griefs and carried our sorrows” (Is 53:4), I greet you with great affection. My Pastoral Visit to Austria would have missed an important stop if I did not have the opportunity of meeting you, the sick and the suffering. In addressing this Message to you, I take the opportunity to express to all who work full or part-time in hospitals, clinics, homes for the elderly and hospices my deep appreciation of their devotion to this self-sacrificing service. May my presence and my words support them in their commitment and their witness. Today, when I have the opportunity to visit the *Caritas Socialis* Hospice, I would like to confirm that the meeting with human pain contains good news. In fact, the “Gospel of suffering” (Apostolic Letter *Salvifici doloris*, n. 25), is not only written in Sacred Scripture, but in places like this it is rewritten day after day.

Dying means living before death

2. We are living in a society which seeks to remove pain, suffering, illness and death from personal and public awareness. But at the same time, the subject is being increasingly discussed in the press, on television and at conferences. The avoidance of death is also evident in the fact that many sick people die in hospitals or other structures, that is, outside their customary surroundings.

Actually, most people would like to close their eyes to this world in their own home, among their relatives and trusted friends, but a great many families feel neither psychologically nor physically able to satisfy this desire. In addition, there are many people living alone

who have no one to be close to them at the end of their life. Even if they die in a home, their heart is “homeless”.

To meet this need in past years, various ecclesial, municipal and private initiatives were undertaken to improve home, hospital and medical care, as well as to provide better pastoral care for the dying and competent help for their relatives. One of these important initiatives is the hospice movement, which has done exemplary work at the *Caritas Socialis* home in Rennweg. In it the sisters are inspired by the concern of their foundress, Hildegard Burjan, who wanted to be present at the focal points of human suffering as the “charismatic messenger of social love”.

No one who visits this hospice goes home disappointed. On the contrary, the visit is more than a tour. It becomes an encounter. By their mere presence, the sick, suffering and terminally ill patients invite the visitor who meets them not to hide the reality of suffering and death from himself. He is encouraged to be aware of the limits of his own life and to face them openly. The hospice makes one understand that dying means living before death, because even the last phase of earthly life can be lived consciously and organized individually. Far from being a “home for the dying”, this place becomes a threshold of hope which leads beyond suffering and death.

3. Most sick people, after learning the results of the medical tests and the diagnosis of a terminal illness, live in fear of the progress of their disease. In addition to the suffering of the moment comes the fear of further deterioration and the feeling that their lives are meaningless. They are afraid of facing a path possibly marked by suffering. An anguish-filled future casts a shadow over the still bearable present. Perhaps those who have had a long and fulfilled life can wait for death with a certain tranquillity and accept their dying “full of years” (Gn 25:8). But for the majority death comes too soon. Many of our contemporaries, even the very elderly, hope for a quick, painless death; others ask for a little more time to take their leave. But fears, questions, doubts and desires are always present in this last phase of life. Even Christians are not spared

the fear of death, which is the last enemy, as Sacred Scripture says (cf. 1 Cor 15:26); Rv 20:14).

4. The end of life raises profound questions for man: What will death be like? Will I be alone or surrounded by my loved ones? What awaits me after death? Will I be welcomed by God's mercy?

To face these questions with gentleness and sensitivity—this is the task of those who work in hospitals and hospices. It is important to speak of suffering and death in a way that dispels fear. Indeed, dying is also part of life. In our time there is an urgent need for people who can revive this awareness. While in the Middle Ages “the art of dying” was known, today even Christians hesitate to talk to each other about death and to prepare for it. They prefer to be immersed in the present, seeking to distract themselves with work, professional recognition and amusement. Despite or perhaps because of today's consumer-, achievement- and experience-oriented society, there is an increasing thirst for transcendence among our contemporaries. Even if concrete concepts of life after death seem very vague, fewer and fewer believe that everything ends with death.

Knowledge of being loved lessens fear of death

5. Death conceals even from the Christian the direct vision of what is to come, but the believer can trust in the Lord's promise: “Because I live, you will live also” (Jn 14:19). Jesus' words and the testimony of the Apostles reflect the new world of the resurrection for us in evocative language that expresses the hope: “We shall always be with the Lord” (1 Thes 4:17). To make the acceptance of this message easier for the critically ill and dying, it is necessary that all who approach them show by their own conduct that they take the words of the Gospel seriously. Therefore care and concern for people close to death is one of the most important signs of ecclesial credibility. Those who in the last phase of life feel supported by sincere Christians can more easily trust that Christ truly awaits them in the new life after death. Thus the pain and suffering of the present can be illumined by the joyful message: “So faith, hope, love abide, these three; but the greatest of these is love!” (1 Cr 13:13). And love is stronger than death (cf. Song 8:6).

6. Just as the knowledge of being loved lessens the fear of suffering, so respect for the sick person's dignity helps him in this critical

and difficult phase of life to discover something that fosters his human and Christian maturation. In the past, man knew that suffering was part of life and accepted it. Today he strives instead to avoid suffering in every way, as is shown by the wide range of pain-killing medicines for sale. Without detracting from their usefulness in many cases, it must still be pointed out that the overhasty elimination of suffering can prevent a person from facing it and acquiring greater human maturity through it. However, in this growth process, he needs competent people who can really accompany him. Giving practical help to another requires respect for his particular suffering and recognition of the dignity he still has despite the decline that suffering brings with it.

7. Hospice work arose from this conviction. Its goal is to respect the dignity of the elderly, sick and dying by helping them understand their own suffering as a process of growth and fulfilment in their life. Thus what I expressed as the leitmotiv of the Encyclical *Redemptor hominis*, that man is the way of the Church (cf. n. 14), is put into practice in the hospice. Its focus is not sophisticated, high-technology medicine, but man in his inalienable dignity.

Willingness to accept the limits imposed by birth and death, learning to say “yes” to the basic passivity of our life, does not lead to alienation. It is rather the acceptance of one's own humanity in its full truth with the riches that belong to every phase of earthly life. Even in the frailty of the last hour, human life is never “meaningless” or “useless”. A fundamental lesson for our society, tempted by modern myths such as the zest for life, achievement and consumerism, can be learned precisely from patients who are seriously ill and dying. They remind us that no one can determine the value or the non-value of another person's life, not even his own. As a gift of God, life is a good for which he alone can make the decisions.

We discover the face of God in Jesus of Nazareth

8. From this standpoint, the decision actively to kill a human being is always an arbitrary act, even when it is meant as an expression of solidarity and compassion. The sick person expects his neighbour to help him live his life to the very last and to end it, when God wills, with dignity. Both the artificial extension of human life and the hastening of death, although they stem from different principles, conceal the same assumption: the conviction

that life and death are realities entrusted to human beings to be disposed of at will. This false vision must be overcome. It must be made clear again that life is a gift to be responsibly led in God's sight. Hence the commitment to the human and Christian support of the dying which the hospice attempts to put into practice. From their different stand-points, doctors, nurses, pastors, sisters, relatives and friends strive to enable the sick and the dying personally to organize the last phase of their life, as far as their physical and psychological strength allows. This commitment has great human and Christian value. It aims to reveal God as One who "loves the living" (Wis 11:26) and to perceive, beyond pain and death, the glad tidings: "I came that they may have life, and have it abundantly" (Jn 10:10).

9. We discover the face of God, who is a friend of life and of man, above all in Jesus of Nazareth. One of the most vivid illustrations of this Gospel is the parable of the Good Samaritan. The injured man lying by the wayside arouses the compassion of the Samaritan, who "came to where he was... and went to him and bound up his wounds, pouring on oil and wine; then he set him on his own beast and brought him to an inn, and took care of him" (Lk 10:33ff.). In the Good Samaritan's inn lies one of the roots of the Christian hospice idea. Precisely along the Medieval pilgrim routes, hospices used to offer travelers refreshment and rest. For the weary and the exhausted, they offered first aid and relief, for the ill and the dying they became places of physical and spiritual assistance.

Down to our day, hospice work has been committed to this legacy. Just as the Good Samaritan stopped beside the suffering man, so those who accompany the dying are advised to pause, to be sensitive to the patients' wishes, needs and concerns. Many spiritual actions can spring from this sensitivity, such as listening to the word of God and praying together, and human ones, such as conversation,

a silent but affectionate presence, the countless services which make the warmth of love tangible. Just as the Good Samaritan poured oil and wine on the wounds of the suffering man, the Church must not withhold the sacrament of the Anointing of the Sick from those who wish it. Offering this enduring sign of God's love is one of the duties of true pastoral care. This palliative care needs a spiritual element that will give the dying person the feeling of a "pallium", that is, a "mantle" for shelter at the moment of death.

Just as the wounded man's suffering aroused the compassion of the Samaritan, so encountering the world of suffering in the hospice can make a community of suffering out of all those who accompany a patient in the last phase of his life. Feelings of closeness and sympathy can grow from this, as an expression of true Christian love. Only those who weep themselves can dry the tears of this world. A special role is played in this house by the sisters of *Caritas Socialis*, to whom the foundress wrote: "In the sick we can always care for our suffering Saviour and thus unite ourselves to him" (Hildegard Burian, *Letters*, 31). Here is an echo of the Good News: "As you did it to one of the least of these my brethren, you did it to me" (Mt 25:40).

10. My deepest appreciation goes to all who are tirelessly involved in the hospice movement, including all who serve in hospitals and clinics, as well as those who care for their seriously ill or dying relatives. I am particularly grateful to the sick and dying, who teach us how better to understand the Gospel of suffering. *Credo in vitam*. I believe in life. Sister life and brother death take us in their midst when our hearts feel anxious before the last challenge we must face on this earth: "Let not your hearts be troubled... In my Father's house are many rooms" (Jn 14:1f).

I bless you with all my heart.

Vienna, 21 June 1998



The Humanisation of Medicine is the Soul of a Science Attentive to the Hopes of Man

ADDRESS OF THE HOLY FATHER TO THE PARTICIPANTS
AT THE CONGRESS OF THE ITALIAN SOCIETY OF SURGERY,
THURSDAY 15 OCTOBER 1998

Illustrious ladies and gentlemen!

1. A cordial greeting to all of you, participants at the hundredth congress of the prestigious Italian Society of Surgery. Thank you for your visit! Your presence is especially significant for me, not only because of the qualified professional activity you are engaged in but also because of the fundamental ethical values with which you seek to inspire your daily work.

I give a cordial greeting to your president, Professor Giorgio Ribotta, and I thank him for the courteous words that he has addressed to me in the name of you all. With him I greet those responsible for the Societies of Surgery of the nations which belong to the European Community and for other sister national societies, and the presidents of the Surgical Societies which have come into being as an expression of general surgery.

2. During your congress you have explored the complex tasks of surgery. You have also analysed the prospects opened up by the extraordinary advances which have greatly increased the therapeutic possibilities of surgery, such as those achieved in the area of the deconstruction and reconstruction of the body or in the vast sphere of transplants.

Your overriding concern is the defence of the health of the patient and respect for his physical, mental and spiritual integrity. In expressing my keenly-felt happiness at this noble intention, I hope that it will be the constant concern of every medical doctor and surgeon. The humanisation of medicine is not a secondary dimension but rather the soul of a practice of medical science which is able to ensure that the hopes of the human being do not remain unheard and disappointed.

With your profession you intend to be in the vanguard in the defence of life whose lapses and limits you experience because of illness, without, however, abandoning the fight against such lapses and limits, and this in order to overcome them or, at least, in order to hinder their most painful consequences. In the performance of this irremissible vocation the Church is at your side because "The Church today lives a fundamental aspect of her mission in lovingly and generously accepting

every human being, especially those who are weak and sick. This is made all the more necessary as a "culture of death" threatens to take control" (*Christifideles Laici*, 38).

I also on several occasions during these years have shared the condition of patients, visiting them or having myself to be admitted to hospital. In this way I have been able to experience your professional skill which has always been accompanied by concerned and feeling humanity. I am happy to express to you today all the feelings of my appreciation and my gratitude for what you have done for those who suffer. At this moment I feel that it is incumbent upon me to direct a special and grateful thought to the memory of Professor Francesco Crucitti who passed away only recently. He knew how to embody these very high qualities in a generous and exemplary fashion.

3. Illustrious ladies and gentlemen! I express the hope that your congress will help to open the field of surgery to ever more promising prospects in the field of prevention, diagnosis, therapy, and rehabilitation. Your activity as surgeons is an incomparable gift to society.

May God help you to be always faithful to the spirit of your profession and to serve with love those who experience the trials of illness and suffering. Let Him give you the strength to always practise your profession with great enthusiasm and the spirit of service.

Make yourselves the teachers of young surgeons not only from a professional but also from a human point of view so that learning from your school they may be the stewards of health and life, placing at the summit of their commitment that ethical dimension which alone fully guarantees authentic service to the person.

I entrust to Mary, Health of the Infirm, the results of your congress and I assure you of my prayers to the Lord, Physician and Saviour of souls and bodies, to ask him to sustain your activity.

With these feelings I implore upon you, upon your families and upon your collaborators, an abundance of celestial favours, in pledge of which I willingly bestow upon you my Apostolic Blessing.

Topics



*Biblical and Pastoral
Itineraries
in the Accompanying
of the Sick Person*

*A Health Care Project
in the Field of Euthanasia*

Ethics and the Placebo

*“Matercare International”
A practical initiative
for the Millennium*

Biblical and Pastoral Itineraries in the Accompanying of the Sick Person

During his ministry Jesus paid special attention to the sick and in his approach to them he never separated physical illness from spiritual illness—he was a physician of both bodies and souls.

Care for the sick person, therefore, is not confined to the physical sphere but also involves his psychological and spiritual needs.

Care for the inner world of the person who suffers is not a task which is entrusted only to pastoral workers—it is a dimension which nurses and all other kinds of health care workers can integrate into the service they provide.

Holy Scripture is at the heart of the Christian tradition—it is the *Magna Carta* which has guided the journey of the Church and which continues to inspire all those today who internalise its spirit and express that spirit in the way that they themselves live and work.

Three biblical journeys which began in Jerusalem are chosen from Holy Scripture for the purposes of this paper. They illustrate those features of the relationship of help which can make the encounter with the sick person a moment which is more suffused with meaning, humanity and spirituality.

The three itineraries chosen for discussion in this paper are as follows:

– the journey from Jerusalem to Jericho (Lk 10: 30-37), which presents the experience of pain and compassion;

– the journey from Jerusalem to Emmaus (Lk 24: 13-35), which symbolises the disappearance and return of hope;

– the journey from Jerusalem to Gaza (Acts 8: 26-39), which represents the search for, and then the achievement of, inner healing.

First Itinerary: From Jerusalem to Jericho - the Path of Compassion (Lk 10: 30-37).

Two-thousand years away in time, this parable nonetheless maintains its present-day relevance and its power to inspire people. Let us follow the relationship of help implemented by the Good Samaritan by observing the six steps he took. Such steps can be used as practical reference points for the carrying out of pastoral action.

– *First step:* awareness, “he saw him”.

“A man who was on his way down from Jerusalem to Jericho fell in with robbers, who stripped him and beat him, and went off leaving him half dead. And a priest, who chanced to be going down by the same road, saw him there and passed by on the other side. And a Levite who came there saw him, and passed by on the other side. But a certain Samaritan, who was on his travels, saw him...”

All three of the protagonists of the episode “see” the unfortunate man but each one of them looks at him with different eyes and hearts. The priest and the Levite—who are influenced by their religious role and by a vertical conception of their relationship with God, by the injunctions of the law, and by cultural assumptions—“pass by on the other side”. On the other hand, the Samaritan, guided by the impulses and instincts of his own heart, stops.

Responsibility begins with awareness—the individual is responsible for what he sees and what he knows about and not for things he is ignorant about. For everybody the sick person is an unrepeatable document of suffering, an open book about the truths of life in front of which each person chooses to stop or to pass by on the other side.

– *Second step:* compassion, “he took pity at the sight”.

The Samaritan links the external awareness of his seeing the wounded man with an interior response. He is moved by compassion and is involved in what he sees. Compassion—from the Latin “cum passione” (to suffer with)—is composed neither of pity nor of superiority: it involves being moved by the wounds of another person.

The relationship of effective help is based upon the development of such inner capacities as compassion, sensitivity and a motivation which inspires and directs behaviour.

– *Third step:* drawing near, “he went up to him”.

It is not enough to feel one’s heart moved by images which trouble us and make an appeal to us. Without external action interior sensitivity is sterile and damaged.

To draw near to somebody means to break down geographical or cultural barriers and to become that person’s neighbour. To draw near is especially important in situations where there are people who have pathologies which at times cause discomfort or rejection on the part of health care workers—drug-addicts, the mentally ill, the sieropositive or those afflicted by AIDS, and those who are dying.

– *Fourth Step:* treatment, “he went up to him and bound his wounds, pouring oil and wine into them”.

The Samaritan does not appear on the scene with his hands empty but brings with him those resources which prudence and common sense have suggested.

Today the binding of wounds means offering a welcome to those who are in pain through kindness and gestures which embody good will. The pouring of the oil of hope and the wine of consolation symbolises the treat-

ment of the physical and moral wounds of the suffering.

– *Fifth step*: accompanying, “and so mounted him upon his own beast and brought him to an inn, where he took care of him”.

After breaking off his journey to come to the aid of the unfortunate man, the Samaritan takes responsibility for this situation of emergency, accompanies him to an inn, and looks after him during the night.

To accompany means to go down a stretch of road with those who feel alone and disheartened, with those who are tempted to surrender because they are tired and strained. It means taking on board the message: “do not walk in front of me, I could not follow you; do not walk behind me, I could not see you; walk beside me and be my friend.”

– *Sixth step*: co-operation, “And next day he took out two silver pieces, which he gave to the inn-keeper, and said, Take care of him, and on my way home I will give thee whatever else is owing to thee for thy pains.”

After paying personally for the expenses which have been incurred, he does not seek to do everything on his own but involves the inn-keeper in the project of help and care. This is the vital element in the pastoral work which is carried out today. Twenty centuries away in times this is the aspect of the parable which has undergone the most growth and development. The inn has been substituted by a myriad of health care structures—hospitals, first aid and rehabilitation centres, homes for the elderly, and so forth. The inn-keeper, for his part, has been replaced by surgeons, radiologists, anaesthetists, cardiologists, nurses, technicians, and auxiliary staff, and each of these categories have their own specific skills and tasks.

The tragedy of the unfortunate man is presented again today in the form of thousands of different episodes, and the capacities of the Good Samaritan find expression in the actions of those who treat those who suffer as their neighbours. Let us listen to an encounter which on the one hand illustrates the feelings and the worries of an elderly lady who has been admitted to hospital because of a major injury, and on

the other describes the contribution of a voluntary worker who offers comfort by being near to this elderly lady.

Dialogue

E: Elsa (the voluntary worker)

R: Rita (the patient)

A visit takes place to a lady who is about seventy-five—a widow who was knocked over by a car while she was crossing the road. She was told that after knocking her over the driver fled in a panic. The elderly lady’s femur is broken, she has a number of bruises on the right side of her face and on her arm, and she is very upset. The encounter takes place the morning after she has been admitted to hospital.

E.1: Good morning. My name is Elsa and I am a voluntary worker in this ward. I have come to say hello to you and to hope that they are taking good care of you. What is your name?

R.1: Teresa (after a moment’s pause). I haven’t slept a wink all night. Even the smallest movement caused me pain (she gives a sigh)...and each time I called the nurses I had to wait a long time before they came (she closes her eyes). I really didn’t expect that this too would happen to me! (She gives an expression of regret). What a horrible world this is. I just can’t go on anymore!

E.2: It seems to me that what has happened has upset you a great deal and that you are very bitter about everything that is happening to you.

R.2: Yes! The more time passes the more difficult it is to live. Eight years ago my husband died and I was left on my own...we couldn’t have children and now my only companions are my cats. I’m worried because there is nobody at home who can give them something to eat. (After a brief pause)...Damn that driver! That wretch, I will never forgive him! How could anyone knock down and leave on the road an old lady like me? People like that should be shut up in prison.

E.3: Teresa, your resentment towards the person who has caused you so much pain is understandable and one certainly can’t forgive when the wounds are so new...

R.3: Forgive... but are you joking? People like that make you want to kill them. For as long as I have left to live I will have to bear the consequences of this accident (she moves a little and

shakes with pain). Oh God! Oh God!...(she sighs). It feels as though I have got thorns in my side. (Then, trying to relax)...my poor cats...!

E.4: I can see that you are worried about your cats, but isn’t there anybody who can look after them while you are here in hospital?

R.4: I live in an apartment block and I hardly ever see my neighbours. Each person lives in their own little world and looks after their own affairs...we only say hello in passing. There is also one person who made clear that they found my cats a nuisance. The only person I am slightly friends with is another widow on the floor below me. Every now and then we meet and have a chat, that is to say when she is not with her children or her grandchildren.

E.5: Well if you think it is a good idea and you have her telephone number I could try to reach her and tell her about what has happened. Perhaps she could give the cats something to eat and perhaps bring you something you need from your home...

R.5: Yes, perhaps that is a good idea...If you could be so kind as to come back later because first I would like to talk to the doctor and try to find out how long I have got to stay here so that I can sort out what I have got to do.

E.6: OK. In a little while the doctors will come to examine you and assess your condition. I will come back later so that you can tell me whether you want me to get into contact with your neighbour.

R.6: OK young lady, thank you very much for your kindness.

E.7: Not at all. See you again soon.

A Short Analysis

Like the unfortunate man of Jericho, Rita has undergone an experience which involves violence and being abandoned. From this dialogue we can also perceive the grief and the bitterness caused by other losses—the death of her husband, the lack of children, and the climate of anonymity which is experienced in her apartment block.

The only company she has are her cats which to a certain extent fill the emotional void which she feels around her. Her thoughts, even during this bad event, are

directed towards them, and she wants to make sure that they do not go hungry and that in the future she will not be deprived of their valuable company. A ray of light is to be found in the relationship she has with the widow on the floor below her who is joined to her by a shared sense of loss.

The voluntary worker draws near to this human reality with sensitivity and makes some of the capacities of the Good Samaritan her own—she stops and pours the oil of understanding and empathy on the wounds of the patient by communicating to her her own nearness.

She does not judge her but enters into harmony with her feelings, especially as regards her resentment towards the person who through his lack of care has complicated her present and her future. She does not blame her for being unable to forgive but gives her the room to give free vent to her bitterness and her anger in the knowledge that forgiveness—the fruit of the grace of God and human co-operation—needs time to mature and come into existence.

In the disquiet and anxiety experienced by Rita the voluntary worker represents a human and humanising presence. This is a presence which acts as a bridge—much as was the case with the Samaritan and the innkeeper—with other communitarian resources represented by the neighbour who can reduce the worry experienced by Rita by taking care of the cats and acting as a link in a chain of solidarity.

Taken as a whole, the visit of the voluntary worker, which is marked by listening and simplicity, is experienced as a positive moment by Rita.

Second Itinerary: From Jerusalem to Emmaus - the pathway of loss (Lk 24: 13-35)

The second journey revolves around the meeting between Jesus and the disciples in Emmaus.

On the one hand, this meeting illustrates the provisional and precarious character of human certitudes expressed in the disquiet and anxiety of the disciples when faced with Jesus's death; and on the other, brings out the importance of discovering that we are not alone in suffering but

that someone is walking at our side—as long, that is, as we are not blind or deaf to that person's presence.

Let us examine the biblical story in order to bring out its pastoral relevance.

– *The initiative taken by Jesus*
“They were still conversing and debating together, when Jesus himself drew near, and began to walk beside them”.

The initiative taken by Jesus allows the story of Emmaus to enter history. If he had chosen not to appear to the unknown people nothing would have happened. However, as events turned out, his drawing near to them was transformed into an opportunity for healing.

The pastoral worker also offers his presence although it is not asked for by sick people, and he is aware that there are people who do not want or who do not need this contact just as there are people who do want it, or that there are those for whom this chance meeting means a reawakening of their faith or the resurgence of hope or of the need for reconciliation.

There is no chance of a relationship without the offering of a presence, and there is no offering of a presence without the ability to present oneself, leaving the other person the freedom to choose the approach which is to be adopted.

– *Entering the wave of history*
“And he said to them, What talk is this you exchange between you as you go along?”

Jesus must have seen the worried and troubled expressions on the faces of the travellers and sought at once to enter into the flow of the conversation by asking a question designed to bring out their inner history. The question is an instrument by which to begin a conversation, stimulate thought, and promote openness and communication.

The pastoral worker often begins his or her visits with a question: “How do you feel?”, “how are you responding to the treatment?”; or “did you manage to regain some energy during the night?”

At times there is a risk that too many questions will be asked and that the conversation will turn into a kind of interrogation or into the expression of curiosity rather than into an authentic

encounter with another person.

When the question is in harmony with the patient and tries to understand his or her inner world it becomes an opportunity for deeper listening and allows the other person to tell their own story.

– *Giving voice to pain*
“And one of them, who was called Cleophas, answered him, What, art thou the only pilgrim in Jerusalem who has not heard of what has happened there in the last few days...?”

Sadness is the feeling which prevails during this stage of the event. Cleophas explains to the unknown man the reasons for this sadness which is connected with the tragic destiny of Jesus, nailed to a cross, and to the collapse of their hopes: “We had hoped that it was he who was to liberate Israel.”

There is another feeling which accompanies the tragic epilogue—perplexity when faced with the testimony of “Some women who... had been at the tomb early in the morning and could not find his body; whereupon they came back and told us that they had seen a vision of angels, who said that he was alive.”

This section is the longest part of the account and includes the worry of the disciples, the description of the dramatic unfolding of events, the disappointment of unfulfilled hopes, and dismay in the face of developments which are difficult to decipher. To listen to them there is an unknown pilgrim who gives room to the expression of their feelings, does not interrupt their account, and allows them to give voice to the pain that they feel.

The style employed by Jesus acts as guidance for all those who draw near to the sick and invites them to overcome the various temptations to judge what the other person says or feels, to give facile advice, to minimise or banalise pain, to blame who complains by shifting attention onto those who have far greater suffering, to interrupt everytime the speaker pauses for breath, or to change the subject by turning the conversation to shallow and superficial questions.

The history of every single individual, which is woven with hopes and disappointments, aspirations and frustrated desires, has the right to be heard. Careful listening allows the helper to pro-

vide a proper perspective on the need to be at the centre of attention and to allow the other person to emerge with his history, his limits, and his potentialities.

– *The realistic encounter*

“Then he said to them, Too slow of wit, too dull of heart, to believe all those sayings of the prophets! Was it not to be expected that the Christ should undergo these sufferings, and so enter into his glory?”

Careful listening is followed by an honest reflection because the disciples of Emmaus are the interpreters of a partial vision of truth which involves the glorious waiting for the Messiah but forgets about his painful life.

The encounter has the purpose of opening minds and hearts to the truth and expanding the boundaries of a person’s horizon in order to understand the plan of God who saves man through the supreme test of complete self-giving.

Jesus does not deny that his final goal is his glory and resurrection but points out the necessary stage to achieving this, which is the cross.

The attitude of the disciples reflects that of very many sick people who were previously under the illusion of being able to live their lives in relative calm and who did not expect unpleasant surprises such as that of having to come to terms with pain.

The impact with suffering, with a terminal diagnosis or an imminent death, provokes a sense of incredulity, dismay and a feeling of having been betrayed: “But why me?”, “Why doesn’t God punish drug dealers, or prostitutes, rather than my family?”, “Why does God make innocent people suffer and not instead punish the wicked?”¹ The pastoral worker comes into contact every day with a litany of “whys” which put God in the dock. Many sick people protest because they feel that they are the victims of unfair situations, and behind their cries there are wounded and betrayed hopes. Others are disturbed at the fact that God keeps quiet, does not answer, does not intervene, and his silence provokes dismay and consternation.

To so many wounded creatures who protest, God sends us to represent Him. He does not ask us to defend Him or to be-

come involved in elaborate theological discussions as to the meaning of pain because this would not eliminate the suffering of the protagonists. What He asks us to do is to be near those who suffer in the same way as Mary was at the foot of the Cross. Mary in her silence represented the love which is present.

In every human tragedy we have before us not so much the creature who interrogates God as a situation where pain forces the suffering person to interrogate himself. The painful moments in life reveal our visions of the world, our false certainties and examples of ingenuousness. In the suffered encounter with the truths of life the pastoral worker is not there to provide answers which he does not possess but to facilitate the path of the internal trial of the protagonists.

The “why” of so many tragedies remains an inscrutable mystery. There are no clear and precise maps which help us to understand the meaning of human misadventures. Some are caused by irresponsibility, others are the fruit of human imperfection, but many occur without our being able to identify a logical thread which helps us to understand them or to justify them.

The pastoral worker accompanies sick people in such a way that this encounter gives rise to a deeper reflection on life and a renewed journey of faith. At the same time, he is aware that the season of pain needs time before it can become transformed into a season of growth and of hope, and for this reason he welcomes the journey of confusion and dismay as a necessary step towards the achievement of inner peace.

– *The Catechism*

“Then going back to Moses and the whole line of prophets, he began to interpret the words used of himself by all the scriptures”.

Jesus passed from the encounter to an illumination of history and leads the disciples to go back to Holy Scripture in order to understand more fully the identity and the mission of the Jesus in whom they had placed their faith.

The deep knowledge of Holy Scripture displayed by the mysterious companion helps the travellers to see what has hap-

pened in a new light.

The educational element is of vital importance in the internalisation of a paschal and incarnate faith. The catechism is an instrument of great value which the pastoral worker can use to promote the human and spiritual growth of those to whom he is speaking.

At times the catechism involves helping the sick person to know God and the mysteries of the Christian faith when that person has not had an authentic religious formation or training. At times it means leading him to discover the meaning of prayer and of Holy Scripture. At other times it means preparing him to receive the sacraments. And at others it involves searching together for the meaning of pain or appealing to the virtues of faith and of hope.

By its very nature, illness is a rich and fertile opportunity for reflection and thought.

Confined to his bed, the sick person is forced to look into himself and from this process of introspection ideas and intuitions expressed in the following phrases can emerge and come forth: “for the first time I have realised what fear really is”; “I no longer feel safe as I once did”; “only now have I realised how many people really love me”; “after many years I feel the need to pray and I have asked God to help me”; “from now on I will change my ways, I can no longer behave as I once did if I want to go on living”; or “these days spent in hospital have changed me, I am no longer the same person who came here ten days ago”.

For many people the experience of being admitted to hospital helps them to become more human, calls many models of life into question, enables them to distinguish between what is ephemeral and what is really important, creates solidarity with other patients, forces them to become responsible for their own illness and their own health, and makes them humble and at the same time wise.

The pastoral worker makes his presence felt during this process of introspection and through the relationship of help enlightens the experience of those he is in communication with, gives value to their insights, and encourages them to develop the conclusions they have reached.

– *The experience of communion*

“And now they were drawing near the village to which they were walking, and he made as if to go further; but they pressed him, Stay with us, they said; it is towards evening, and it is far on in the day. So he went in to stay with them.”

The fact that Jesus listened to their tale, and his capacity to penetrate their minds and their hearts through his teaching, created within the disciples a thread of trust and of warm feeling towards the unknown person.

Jesus is no longer a stranger but a friend. He has entered their hearts, he has broken down their defences, and his healing presence has transformed them.

The initial contact began with Jesus but now the wish to take things further begins with the disciples of Emmaus. What we have here is a gradual growth of intimacy where there is a move from a chance encounter to authentic communion.

Sick people, too, often feel the need for a healing presence near them, especially when night has fallen and their lives have become evening, as is the case when they are waiting for an operation, during moments of loneliness, or during the actual process of dying.

To be with someone becomes a presence marked more by silence than by words, by expressions of affection or by a prayer which generates peace. The more difficult the journey, the greater the need for communion.

The person who is immersed in Good Friday does not so much need somebody who tells him about the resurrection as someone who is prepared to stay at his side during his pain. The person who is able to keep going during his Good Friday is a symbol of resurrection.

– *Revelation*

“And then, when he sat down at table with them, he took bread, and blessed, and broke it, and offered it to them; whereupon their eyes were opened, and they recognized him; and with that, he disappeared from their sight. And they said to one another, Were not our hearts burning within us when he spoke to us on the road, and when he made the scriptures plain to us?”

Jesus achieves the complete transformation of the disciples

through the rite of the breaking of bread. The symbolic language has a power which rises above mere verbal language.

For the disciples, the eucharistic action of breaking bread and the blessing echoes another meal and brings out the real identity of the guest. The pieces of the mosaic are now clear—concern at the death of Jesus is transformed into joy at his resurrection and sadness is changed into joy. There is no longer any need for the physical presence of the Resurrected One because their eyes have been opened and their hearts have been transformed.

Each encounter of the pastoral worker involves entering into the sacred space of revelation. The sick person reveals himself through the symbols which surround him—a paper or a book on the desk refer to his cultural interests, a bunch of flowers or a photograph speak about his near ones, and a book of prayers or a rosary describe his religious sentiments.

The sick person also reveals himself through oral communication—the messages he transmits, the feelings he experiences, and the hopes which are in him, all reveal his interior world.

The pastoral worker can use these “pointers” to enter into the hearts of people and thereby understand their true identity.

— *Witness*

“Rising up there and then, they went back to Jerusalem where they found the eleven apostles and their companions gathered together... And they told their story of their encounter in the road, and how they recognised him when he broke bread”.

Peter reminds us that we must pay heed to the hope that is in us (1 Pt: 3, 15). The disciples of Emmaus pay heed to their hope and become the bearers of hope and the announcers of the resurrection.

Sick people who experience physical, psychological or spiritual healing are also called to bear witness to hope. The suffering which they have experienced makes them credible evangelisers; illuminated by the Spirit they transform their wounds into compassion and place their wisdom at the service of the healthy.

Every day there is a repetition of the miracle of the pain which releases love when people with damaged hearts, drug-addicts,

those suffering from cancer, people who undergo dialysis, widows and so forth, rather than closing themselves up within themselves open up to others, create groups of mutual help, and promote initiatives designed to radiate hope.

The pastoral worker has the privilege of touching these changed existences and where possible he works to ensure that the witness of these people reaches those who are healthy and acts to help to improve society.

Third Itinerary: From Jerusalem to Gaza - the Path of Searching (Acts 8: 26-39)

A third biblical journey is described in the Acts of the Apostles.

Along the road to Gaza we encounter the two key figures of this tale—Philip, who could symbolise every one of us, and the Ethiopian, who represents the individual who is searching for God and His truth.

Philip expresses the missionary impulse of the Church which is not limited to Jerusalem but—moved by the Holy Spirit—opens to the world to preach the Gospel.

The Ethiopian reminds us of the contemporary world with its variety of cultures, traditions, and religious faiths.

Let us read about this episode closely and extrapolate from it elements which could be useful to us in approaching the relationship of help with the sick person.

– *Going forth*

“Meanwhile Philip was commanded by an angel of the Lord, Rise up, and go south to meet the road which leads from Jerusalem to Gaza, out in the desert. So he rose up and went”.

One of the instructive images used by Vatican Council II to define the Church was that of a “people going forth”. Each day each one of us follows different paths and is probably guided by an angel of the Lord.

The route which the angel proposes to Philip is empty—empty perhaps because frequented by a few travellers or burnt by the sun or full of dangers.

This empty street could for us symbolise the hospital which is a symbolic place for human suffering.

“In the same room you can find a teacher and a homeless person, young people and the elderly, the religious and an atheist, those who have lost a child or those who want to have an abortion, those who live by memories alone and those who live in a world of plans, those who bear witness to hope and those who bear witness to despair, those who want everything from other people and those who do not dare to ask for anything at all, those who feel surrounded by love and care and those who are in the deepest loneliness.

The hospital is a complex kaleidoscope of humanity and an ambiguous symbol of the greatness and the weakness of people. For all those who work in this world, the real challenge is that of being able to transform the hospital - which is a city inhabited by pain - into a city inhabited by love and by compassion”.²

– *Looking for hidden treasure*

“So he rose up and went; and found there an Ethiopian. This man was a eunuch, a courtier of Candace, queen of Ethiopia, and had charge of all her wealth; he had been up to worship at Jerusalem, and was now on his way home, driving along in his chariot and reading the prophet Isaias.”

And here we come to the second person of the tale—the Ethiopian who had gone to Jerusalem to worship and who on returning home is trying to understand a passage from the prophet Isaias.

The tale leads us to apply certain of its salient features to our modern day situation. Given that we have an Ethiopian, the call is to develop tolerance and a sense of hospitality towards those who come from different cultures and traditions and not to be influenced by prejudices.

Peter said to the first Christian community: “I see clearly enough... that God makes no distinction between man and man; he welcomes anybody, whatever his race, who fears him and does what piety demands” (Acts 10: 34-35).

The Acts of the Apostles describes the Ethiopian as a eunuch, a high court official, and the supervisor of all the royal treasure.

These elements make us aware of the fact that when somebody crosses the door of a

hospital he brings with him his past, his history, and his personal, professional and family roles.

The risk we run is to focus our attention upon the problem in hand and to neglect the person we have before us. Dehumanisation takes place when we transform a mother into number 27, a white collar worker into a malign tumour case, or a young university student into a paranoia case.

The Ethiopian symbolises the individuality and peculiarity which characterises us all. In those days to be a eunuch meant to have taken a choice to be fully at the service of the king—today this condition could be seen as calling our attention to the different sexual tendencies which we can encounter in our neighbour.

Nobody is so poor as to lack a dignity which must be defended. We do not have to be “high court officials” to be cared for and treated with care and attention. Independently of our own impressions or assessments, each of us is the guardian of small or great treasures.

In each of us is to be found not only a sick, weak and insecure person, but a physician as well who is characterised by the resources and the values which he possesses.

In some of us these gifts are more of a physical nature and express themselves in an ability to act and react, to face up to difficult therapies, to take care of oneself and one’s own body. In others the treasures to be drawn upon are more of a mental character and express themselves in a positive attitude towards the future, in trust towards health care workers, in the development of cultural interests which are of help in the process of waiting, and in a wish to widen horizons of knowledge. For yet others the resources are psychological in nature and are bound up with character, a positive self-image, the ability to manage moods in a creative way, an openness towards others, and a balanced assessment of reality. For others, finally, personal treasures find expression in a spiritual patrimony which is marked by a healthy relationship with God, serene integration with the past, ethical behaviour which is based upon the Gospel values, and the living out of a communitarian experience.

Dialogue with sick people allows us to identify and to bring

out the resources of individuals so that they can be placed at the service of health and hope.

– *Evangelisation*

“The Spirit said to Philip, Go up to that chariot and keep close by it. And Philip, as he ran up, heard him reading the prophet Isaias, and asked, Canst thou understand what thou art reading? How could I, said he, without someone to guide me? And he entreated Philip to come up and sit beside him. The passage of scripture which he was reading was this; He was led away like a sheep to be slaughtered; like a lamb that is dumb before its shearer, he would not open his mouth... And the eunuch turned to Philip, and said, Tell me about whom does the prophet say this? Himself or some other man? Then Philip began speaking, and preached to him about Jesus, taking this passage as his theme.”

Here we encounter the central part of the tale—the Ethiopian is engaged in reading and thinking and evokes the experience of sick people who experience their time in hospital as a time of withdrawal, an opportunity for reflection and introspection.

Philip is the pastoral instrument who is enlightened by the Holy Spirit and reaches the Ethiopian, observes what he is doing, and involves him in a dialogue which enables him to understand what until that moment had not been clear to him.

Basing ourselves on Philip’s action we are able to identify three component elements in pastoral action:

1. *To become companions on a journey*

At the entrance of an ancient hospital in Rome there is inscribed the following sentence;

*“Come to be healed,
if not healed at least treated,
and if not treated at least consoled”*

To heal, to treat and to console are three key verbs in the vocabulary of compassion.

The ministry of consolation belongs in a very special way to the health care worker—his aim is not so much that of solving the problems of his neighbour but to be a companion on his journey. His solidarity-inspired presence does not remove the pain and the loneliness of the suffering person but can reduce them.

2. *The development of the art of non-oral communication*

Philip observes that the Ethiopian is engaged in reading and draws close to him. Communication is based to a great extent on observation and in order to develop this it is necessary to bear in mind the anatomical map of the human face with its two eyes, two ears and a single mouth, and to follow its direction by doubling the time dedicated to observation and listening and halving the time devoted to speaking.

Unfortunately, in the dialogue with the sick person anatomy is often inverted and people behave as though they have only one eye, half an ear and two mouths. This is because people are too intent on talking and giving advice rather than on observing and listening with care.

The invitation given by the Ethiopian to Philip to sit next to him is a call to spend time with people so as to create a relationship of trust. Nowadays spending time is one of the rarest of things and one of the most necessary.

It cannot be denied that timetables and practical needs impose limits and restraints—there is no time to stop because there are too many sick people to visit or too many tasks to perform. What matters, however, is not so much the quantity of time invested in the relationship as the actual quality which is involved.

Sometimes ten minutes can be heavy but a moment well spent can often leave happy memories.

To spend time, today more than ever before, is to offer health.

3. *To give answers to those who ask us questions*

To the question of the Ethiopian who asks him: "Tell me, about whom does the prophet say this?", Philip answers by enlightening him on the meaning of the biblical passage and making him aware of Jesus.

In the same way the pastoral worker can become a spiritual guide for those people who are searching for explanations to their questions. In this case the pastoral worker takes on the catechetical role performed by Jesus in the tale about Emmaus. There are instruments which the pastoral worker can employ to respond more effectively to the needs of modern man and they

are the reading of Holy Scripture and thinking about it, the reading of books, and taking part in refresher courses which make him a more careful, real and wise pastor.

The constant challenge which he has before him is to see Christ in the sick person. Pastoral action begins with a recognition of the likeness of our Saviour in the sick person: "I was sick and you visited me" (Mt 25: 26) and becomes fully expressed in adopting his approach: "I have been setting you an example, which will teach you in your turn to do what I have done for you" (Jn 13:15).

– The sacramental dimension

"As they went on their way, they came to a piece of water, and the eunuch said, See, there is water here; why may I not be baptised?...So he had the chariot stopped, and both of them, Philip and the eunuch, went down into the water, and Philip baptised him there. But when they came up from the water, Philip was carried off by the Spirit of the Lord, and the eunuch did not see him any longer; he went on his way rejoicing."

The encounter between the Ethiopian and Philip culminates in a sacramental act, in the wish of the Ethiopian to receive baptism.

The preceding stages of the relationship of help, the encounter and the evangelisation, prepared the terrain for his conversion to Christ in baptism, a sacrament through which the Christian dies in relation to himself and his past and is reborn to a new life.

The sign of grace which is received is expressed in the joy of the Ethiopian when he returns to his journey. He no longer needs Philip because the grace of God now guides him on his journey towards the future.

The episode refers to the sacramental opportunities which should be positively appreciated in the performance of the pastoral ministry.

Some sacraments are more typical of the time of illness—the eucharist, reconciliation, and the anointing of the sick.

The eucharist joins people more deeply to Christ, who said: "Come to me all you that labour and are burdened; I will give you rest" (Mt 11:28).

Reconciliation opens up to forgiveness and to divine com-

passion, and offers the gift of peace. Anointing is the sacrament of healing understood in an overall sense and not limited merely to the body.

Pastoral action must be suitably aware of the importance of the sacramental dimension through which the salvation of Christ takes place in believers.

In the past the great risk of pastoral work has been an excessive utilisation of the sacraments to the neglect of an effective relationship of help and of a constructive journey of evangelisation with the sick. Today the danger could be the opposite in the sense that emphasis is placed on the human dimension but insufficient importance is given to the preaching of the Word and the celebration of the sacraments seen as moments which permit a deeper union with Christ and the Church.

Conclusion

The content of the three biblical paths have been analysed in order to derive from them examples for pastoral action.

The first point is that we are all pilgrims in life and the itinerary followed by the unfortunate man, the disciples of Emmaus, and by the Ethiopian could one day become our paths.

Secondly, the routes which go from Jerusalem to Jericho, to Emmaus, and to Gaza retain their contemporary relevance. The names of the protagonists or the geographical references may change, but the questions, the feelings, and the hopes which bind the pilgrims of today with those of yesterday remain similar.

Thirdly, the three itineraries presented embody important truths about life and reveal innovative horizons and outline practical and creative methodologies by which to bear witness to the Gospel of compassion and hope at the side of those who suffer.

P. ARNALDO PANGRAZZI

Notes

¹ See ARNALDO PANGRAZZI, *Perché Proprio a Me?* (Paoline, Milan, 1995).

² See A. PANGRAZZI, *Perché Proprio a Me?*

A Health Care Project in the Field of Euthanasia

In its *Dichiarazione sull'Euthanasia*¹ the CDF makes clear that in the case of the terminally ill person the right to life involves a "right to die in full serenity, with human and Christian dignity". It should be pointed out immediately—and this to avoid any kind of misunderstanding because we are increasingly running the risk that a certain kind of "technologism" will abuse its power—that this right does not bestow the right to obtain death or obtain death through another person or to take refuge in death at any cost.²

I believe it is not only interesting but above all else important to discuss the work issued by the Federal Chamber of Doctors (*Bundesärztekammer: Bäk*) on the subject of "accompanying the dying and the limits to suitable treatment" ("*zur ärztlichen Sterbebegleitung und den Grenzen zumutbarer Behandlung*"). This is a very complex subject which requires detailed investigation by the health care world, and especially that part of this world which is of a Catholic and Christian inspiration. What I discuss here is intended as an initial evaluative reflection. In order to help to the utmost in the reading of this article I have divided it into a prologue which outlines the reasons behind the project, a preamble which discusses its meaning, certain essential guidelines, certain highly sensitive points which should be debated, and a concluding assessment of the whole question under consideration.

The Prologue: the Reasons behind the Project

In order to understand the intention and the concerns of the project in question it is without doubt useful to place it within

the framework of the reasons which lie behind it, as indeed has been done by Prof. Med Egert Beletes.

The reasons behind the new guidelines are bound up with the rapid growth and development of science and technology in the field of medicine. Indeed, this growth and development does not only bear upon forms of life and their various relationships but also upon the basic elements in the conception that man has of himself. Obviously enough, all this concerns human responsibility because of the simple fact that in this specific field moral, ethical and legal uncertainties are on the increase.

On the one hand, advance in the area of therapeutic overkill, and on the other, developments as regards the possibility of manipulating the whole process of death, are both becoming sources of fear of "too much" when it comes to the progress of not leaving people to die, and of apprehension concerning "not enough" as regards the opportunities for medical care and treatment.

These fears—and it is important to stress the fact—also spring from a political mentality directed towards achieving excessive savings in the medical and health care field. Furthermore, legislation concerning euthanasia (in Holland, Australia and the USA) are exercising strong pressures in this area, elements which are further reinforced by certain "free thinking" American philosophers, namely Ronald Dworkin, Thomas Nagel and John Rawls.³

At least two things follow from this. The first is that the subject has now become a part of public debate; the second—bound up with the first—is that we are face to face with ever greater difficulty in finding general agreement within the context of our contemporary pluralistic culture. As a result, the pro-

ject must address itself to the questions connected with ethical norms and juridical canons in addition to the needs of medical science and the "autonomous" aspirations of patients. All this remains true even if there is a categorical exclusion of every form of recourse to "active euthanasia", as is the case in this project.

Preamble: the Meaning of the Project

After a prologue the document proceeds to a meaningful and enlightening preamble. It is the duty of the medical doctor to maintain and protect life, to re-establish the health of the patient, to reduce pain, and to help the dying until the moment of death. However, this duty is increasingly conditioned by the right to autonomy of both the patient and the dying person. Furthermore, the limitations on the duty of the medical doctor do not come only from the will of the patient or the dying person but also—and this is very important—from the limits imposed by medical science itself. This is why the guidelines of the project place medical activity on the boundary between life and death.

To summarise: the project is concerned with the limits to the *incumbent* treatment on the part of the medical doctor on the one hand, and the therapeutic and curative *expectations* of the patient and the dying on the other. As a result, the guidelines aim first and foremost at the establishment, in some way, of the limits to medical—let us say therapeutic—intervention in the case of terminally ill patients. Here, too, the project goes out of its way to stress that there should be a categorical exclusion of any recourse to "active euthanasia".

1. The Essential Guidelines

The project is made up of four sub-sections. The first deals with the duties of the medical doctor towards the dying person; the second examines the limits to therapeutic treatment; the third discusses the right of the patient to take independent decisions when he is in a situation of being between life and death; and the fourth deals with the opinions of the patient in questions relating to death.

1.1. *The Duties of the Medical Doctor Towards the Dying Person*

The duty of the medical doctor lies in helping the dying person until death through treatment, assistance and care directed towards maintaining and prolonging life. However, when the patient enters the stage when he is about to die then curative and analgesic measures come into play in order to help him to die with dignity.

It should be made clear that by the explicit or presumed wish of the dying person the measures taken to prolong his life can be omitted or abandoned but on the condition that these merely delay death and have no influence on irreversible death. In cases where the reduction of pain inevitably shortens life the medical doctor should not worry, as long, that is, as there is no euthanistic intent. That is to say that it remains clear that every intentional—or rather euthanistic—shortening of life is not only unacceptable but is also punishable. The co-operation of the medical doctor where the dying person asks him to help in his suicide is in contradiction with his professional code of ethics and therefore should quite rightly be punished.

1.2. *The Refusal of Treatment which can not be Requested (Unzumutbare)*

The question of the refusal of treatment and care in the case of “very serious” patients who, however, it is made clear, are not yet in a dying situation, is rather complex in character. Above all, it would be fitting for the medical doctor to change the treatment as long as he has taken the right to independent decisions of the patient into ac-

count, and provided the previous treatment—which would prolong life—does not help the patient in any way, indeed would only aggravate his life condition in an irresponsible way. With the goal of excluding every question of economics, there is a definite request for necessary basic help which consists of human warmth, physical care, the reduction of pain, the opening of the respiratory systems, hydration, and **natural (sic!) alimention.**

In order not to leave any doubts there is a “nominatim” reference to the people referred to—people in a state of “awake coma” (*Wachkoma*) and newly born children with very serious congenital handicaps or perinatal injuries.

In the first case it is possible to interrupt the therapeutic treatment which prolongs life whenever this corresponds to the explicit or presumed wish of the patient.

In the case of very serious malformations (*mit schwersten kongenitalen Fehlbildungen*) which afflict newly born children who can be kept alive solely through the constant use of extraordinary technical instruments, the medical doctor can—after a discussion with the parents—not only interrupt the use of these instruments but also not even initiate their employment in treatment.

1.3. *The Right of the Patient to Take Independent Decisions*

The medical doctor is obliged to respect the wishes of the patient even when he is called upon to interrupt treatment which has already begun. In the case of “unconscious” patients reference must be made to their presumed wishes, especially if a previous decision made by them exists. Furthermore, it is necessary to pay attention to the patient’s religious beliefs, to his general attitude and approach towards life, his life expectations, the risks being run of a permanent handicap, and even the pain of the patient who is being treated. If a person trusted by the patient is nominated *ad hoc* then reference must be made to that person’s wishes. When it is not possible to ascertain what the presumed wishes of the patient might be the

views of a guardian are not enough—the consent of the tutelary office is required (& 1904 BGB).

1.4. *The Arrangements of the Patient before his Death (Vorfeld)*

Here we are dealing with arrangements involving a guardian, the will of the patient, or provisions which can not only help the medical doctor in the performance of his responsibilities but which can also be an important element in the conscientious evaluation of the presumed wishes of the patient. However, the medical doctor must not forget that certain wishes of *healthy* people can change *when they fall ill*, and it should also be pointed out that hope often grows when desperate situations are present.

2. Highly Sensitive Points to be Discussed

The reactions of the newspapers have on the whole been rather critical. Here are some of the headlines on the subject: “a sensible document or an absurdity?”, “the demi-gods at their limits”, “no to active euthanasia but more space for the halting of treatment in cases of very serious cancer”, “for medical doctors as well the distinction between “good and evil” becomes difficult”, “unconsciousness: prolong treatment or let die?”, “fracture of the barrier of help to the dying”, “medical doctors display a lack of resolution”, “between the reduction of pain and the prolonging of life”, “euthanasia and ethics”, “the federation of Marburg favourable to the guidelines”, “we reject active help to die”, “the Evangelical Church in Germany (*Die Evangelische Kirche in Deutschland*: EKD) praises the document of the medical doctors”.

Going into greater detail I would like to point out that attention is uniformly paid to the readiness to interrupt medical treatment in cases of awake-coma (*Wachkoma*) and the congenital malformations of newly born children where there is an explicit or presumed wish to do so on the part of those concerned. Reference is made, above all else, to the questions

and issues relating to the interruption of artificial alimantation in the case of seriously ill people who have not yet begun the process whereby they are about to die.

Another point to be considered is that of the limits to *what is possible* in the medical field because such limits are constantly being pushed backwards, especially when one is dealing with the boundary between life and death. For this reason, these limits are increasingly becoming ethical questions, or rather questions regarding the legitimacy or otherwise of medical *action*. Another point concerns the cases of certain people who are judged to be still “alive” (that is to say not dying)—here the question arises as to whether basic help is enough. It is sufficient in such cases to establish that every form of active euthanasia should be excluded but otherwise there is a dilemma—should the therapeutic treatment be continued or should the patient be allowed to die? To resolve this dilemma is it really sufficient to refer to the explicit or presumed wishes of the patient or to those of the people who act on his behalf? Is not the adoption of such a position a clear breaking of the barrier and thus an opening up to passive euthanasia asked for by the patient or by those who act for him? But can then one still affirm: *salus aegroti suprema lex esto*? Or rather, and this question is even more impelling, what determining ethical value does the commandment of God “thou shalt not kill” actually have here? And above all else, what remains of the dignity of the human person “created in the image and likeness of God”? From all this it is clear that many highly sensitive issues have come to the fore.

This fact is relevant first and foremost because it is in contrast with the praise expressed by Hermann Barth, the vice-president of the Evangelical Church in Germany (EKD). It is also in contrast with the judgement of Prof. Reiter who, although he raises certain questions concerning passive euthanasia, the interruption of therapeutic treatment, and the independence of the patient, concludes by asserting that the

guidelines of the project, taken as a whole, are to be judged as being ethically acceptable.⁴

3. A Propositive Evaluation

I believe that the project under consideration is an attempt to offer certain guidelines—from an ethical point of view as well—in a health care field which is very complex and sensitive in character. The emphasis on the specific and proper duty of the medical doctor in favour of the life of the patient is correct. “The activity of health care workers has the high value of *service to life*. It is the expression of a deeply human and Christian commitment, borne and performed as an activity which is not only technical but also involves dedication and love towards one’s neighbour”.⁵

The repeated exclusion in categorical fashion of the legitimacy in any form whatsoever of active euthanasia as a deontological consequence of this duty is certainly the expression of a great sense of the responsibility of the art of medicine. What the Charter has to say here on the question is very valid: “The compassion provoked by pain and suffering towards the terminally ill, abnormal children, the mentally ill, the elderly, and people afflicted by incurable illnesses, does not authorise any form of active euthanasia...This is not a matter of help being given to a sick person but of the intentional killing of a man”.⁶

Also sound is the statement that the use of palliatives for atrocious pain, although this might have the effect of a possible shortening of life, is not illegitimate. This is because in the long term pain impedes the achievement of higher goods and interests; it can provoke effects which damage the psychophysical integrity of the person; and suffering which is too intense can diminish or impede an individual’s control over his own spirit. For this reason it is legitimate, and beyond certain levels of tolerance it is also incumbent, for the health care worker to prevent, reduce and eliminate pain.⁷

Thus it is that “amongst the forms of treatment to be given to the terminally ill are to be in-

cluded those of an analgesic character. These favour a less dramatic development and act in favour of the humanisation and acceptance of dying”.⁸ When proportionate motives require such a course of action it is also permissible to use certain narcotics which alleviate suffering in a moderate way, even if they lead to a more rapid death.⁹ In this case “death is not wanted or sought for in any way although the risk of death is run for a reasonable cause—the aim is simply to reduce pain in an effective way using to this end the analgesics which medicine has available”.¹⁰

In the same way, the increased attention paid towards the independence of the patient or rather towards the free and responsible decision of his will whether explicit or presumed, or to a third party acting in his name, corresponds to the dignity of the person. The fact that one is dealing here once again with a project subjected to very wide debate is admirable because this means that improving corrections of the situation are now envisaged.

After saying this in favour of the project it is incumbent upon me to stress the breaking of the barrier raised in favour of the “unconditional” defence of the life of the newly born child, of the seriously ill, or of the dying person. One should introduce here with great force the “principle of proportionality of treatment” and this in order to judge from an ethical point of view the question of the basic help which is required by the dignity of the person of the seriously ill or the dying person after the interruption of therapeutic treatment has actually taken place.

According to the principle of the “proportionality of treatment” it is legitimate in all conscience to take the decision to abandon treatment which would only lead to a precarious and painful prolonging of life. It should be observed—and this is a very important point—that here we are in the presence of an imminent inevitable death notwithstanding the instruments and techniques which are employed. However, even here it is not possible to interrupt the normal forms of treatment which should be given to the patient. Now, and this point should be

stressed, alimention and hydration, even when *administered artificially*, are part of the normal treatment which is due to the sick person when they are not actually injurious to him—thus their inappropriate suspension could amount to a real and authentic example of euthanasia.¹¹

I would like to observe, to avoid all misunderstanding, that here we are considering sick people who are about to face an inevitable death. Now, and this is a point I would like to emphasise greatly, in the project in question we are dealing with sick people who are “still living” (that is to say that they are not in an imminent state of death). As a result, for these people, whether they are adults or newly born children, of imperative importance is the ethical and deontological obligation not to interrupt artificial alimention and hydration. If, however, this is carried out we specifically encounter the intentional killing of a human being which when called by its real name is actually passive direct euthanasia.

I would like to add, in order to justify the “ministerial” respect for life until natural death, that it should be stressed that nobody—neither the medical doctor nor the patient nor a third party acting on his behalf—is the lord of life or the conqueror of death, but simply and solely, and above all else in the case of the health care worker, “the guarantor” of life and “the com-

panion” of a dignified death. Furthermore, the patient is the “steward” of life until his natural death.

It is on the basis of this principle of proportionality that the patient has the right to refuse so-called therapeutic overkill, but it should also be clear that he never has the right to take an independent decision as regards his own death. Death was, and remains, always a natural process entrusted to, and thus to be placed in, the hands of the Giver of life—God. From this point of view the title of the project is fitting: **no longer help but accompanying in death**. No health care worker should ever help a person to die, whether that person is an elderly person or a newly born child, but should, rather, accompany a terminally ill person to live out the process of death.

For this reason, it is to be hoped that the debate will manage first and foremost to introduce into the project the barrier of the categorical exclusion of every form of passive direct euthanasia.

Furthermore, it is to be hoped that the “deliberating” will of the patient and the dying person or of the person who acts on the latter’s behalf will be clearly relativised. I hope that this propositive evaluation of mine attains its goal—to correct and improve the project so that this corresponds more effectively to the health care professional code of ethics, and this in line with the right of the terminally

ill person to die in all serenity with human and Christian dignity.

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Notes

¹ SACRA CONGREGAZIONE PER LA DOTTRINA DELLA FEDE, *Dichiarazione sull’Eutanasia*, 5 May 1980, in *Acta Apostolicae Sedis*, 72 (1980), p. 549, hereafter in this paper I will refer to CDF, *Dichiarazione*, in AAS, p.

² Cf PONTIFICIO CONSIGLIO DELLA PASTORALE PER GLI OPERATORI SANITARI, *Carta degli Operatori Sanitari* (Vatican City, 1995), n. 119, hereafter in this paper I will refer to *Carta*, n.

³ Cf JOHANNES REITER, *Sterbebegleitung: Entwurf der Bundersärztekammer... “Herderkorrespondenz”*, 1997, 7, p. 336.

⁴ Cf “Herderkorrespondenz”, 1997, 7, p. 338. See also Reiter, “Zwischen AErtepflicht und Patientenautonomie” which will appear in a forthcoming issue of *Medizinrecht*. I would like to observe that in the main this is the same article as appeared in the already cited “Herderkorrespondenz”.

⁵ *Carta*, n. 1.

⁶ *Carta*, n. 147.

⁷ *Carta*, n. 70.

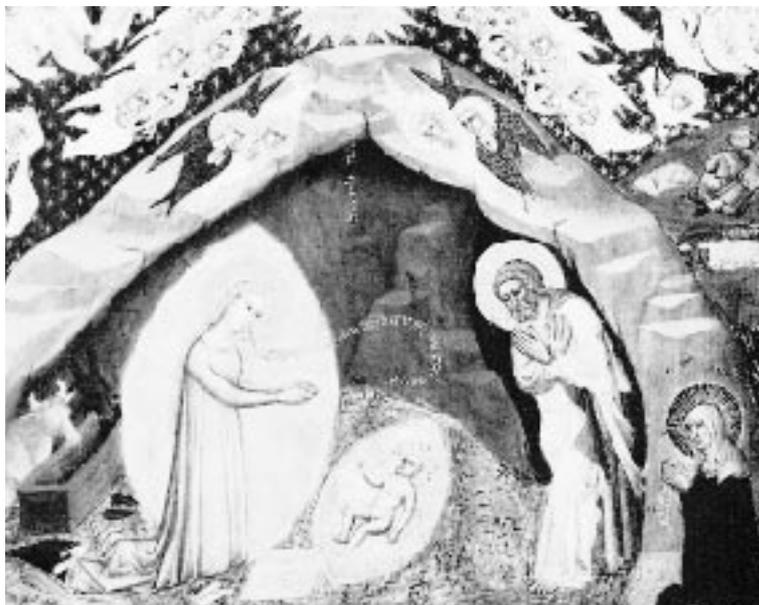
⁸ *Carta*, n. 122.

⁹ Cf PIUS XI, “Ai Partecipanti a un Congresso di Neuropsicofarmacologia, 9 Sett. 1958”, in AAS 50 (1958), p. 694.

¹⁰ SACRA CONGREGAZIONE DELLA DOTTRINA DELLA FEDE (CDF), *Dichiarazione sull’Eutanasia*, 5 May 1980, in AAS 72 (1980), p. 548.

¹¹ *Carta*, n. 120, the bold type is mine.

* Translator’s note: the translations into English from the *Carta degli Operatori Sanitari* are those of the translator.



Ethics and the Placebo

The number of books and articles on the placebo have multiplied over recent years. The progress of what is termed "psychosomatics" is a development which is not unconnected with this renewed interest in the subject. Some people praise the benefits of the placebo while others talk about deception and lies. In order to understand this whole question more deeply it is necessary first and foremost to make clear what the words employed in the debate actually mean.

Definitions

A medicine which is totally without objective effectiveness is termed by us a "placebo". It is also to be observed that this is a substance which contains no active principles at all. Dr. P. Lemoine is opposed to an exaggerated use of psychotropic medicines and declares that in the opinion of Mr. Jourdain "Western medicine practises the placebo without being aware of the fact" and adds "or rather without wanting to be aware of the fact".¹

Historians have it that the word "placebo" became a medical term roundabout the year 1785. The aim at that time was to entice clients. The Latin term means "pleasure to the Lord" and Psalm 114 in its liturgy for the deceased also employs the word—"Domino in regione vivorum". In the Vulgate this was translated with the phrase "it will please the Lord in the land of the living". In present day translations the version is different and reads: "I will walk in the presence of the Lord in the land of the living".

Later the word "placebo" took on a connotation connected with being an intriguer, a flatterer or an opportunist. At the end of the Medieval period this word meant a flatterer or a braggart. During the Renais-

sance the placebo "took its first philosophy lessons".² Montaigne provides various examples which bring out the influence that trust and the role of the imagination have in the process of healing. Amongst various cases this authority provided one which was especially instructive and supportive of his case:

"A woman thought that she had swallowed a pin while eating bread. She wept and tormented herself as though she had an unbearable pain in her throat where she thought she could feel the pin. But because there was no swelling and no change could be seen from outside an intelligent fellow—after coming to the conclusion that he was dealing with a simple case of imagination - took a number of pieces of bread and made her eat them, he made her vomit, and then three a pin into what she had regurgitated. The woman believed that things had been put right and suddenly felt "the pain pass".³

During the eighteenth century—thanks largely to scientific research which was carried out in England—the term "placebo" came to find a place in medical dictionaries, and during the nineteenth century it later became a scientific medical term. During our age we speak about "placebothrapy" when we refer to the administration of "a product which by its nature is ineffective but which has the form, the appearance and the character of an active medicine".

An Ethical Problem

During the history of this medical concept phrases like "pathetic lie" or "deception" and so forth have often been heard. It is certainly true that the circumstances which lie behind the prescription of a placebo can lead one to think in such terms. Certain medical doctors

when writing about the action of a placebo have observed: "waiting in the surgery of a doctor or in the waiting room of a hospital, the imposing terminology which is employed, and the mythology of the all powerful doctor who prescribes a remedy—all these factors join together to make the patient have faith in the remedies which are prescribed and to give him the impression that the treatment which is prescribed contains the necessary elements to improve his condition of health" (Lachaux-Lemoine, p. 86).

It is certainly the case that the elements in hand do not come within the parameters of a conventional therapeutic situation but the term "lie" does not seem to be appropriate. The criticisms levelled against the use of the placebo are many in number. It is said that today everybody seeks to obtain the clear consent of the sick person in line with his rights and his independence when experiments are being conducted and this is something which appears to be rather incompatible with the employment of the placebo.

Furthermore, it would be a very serious thing for the medical doctor to lessen his supervision of a patient who had reacted favourably to the placebo. Indeed, the medical doctor would run the risk of losing an opportunity to heal the sick person through the use of a suitable remedy. Thus it is that a pharmacologist writes: "A placebo can even become a 'nocebo'—it can cause harm".⁴ It is possible to use this kind of language for other ways of "treating the soul". Dr. J. Vigne has observed that "meditation understood as superficial relaxation can have a 'Valium effect' and can conceal the real problems of the case, thereby giving the patient the impression that he is better but without actually bringing about a real improvement in his condition".⁵

However, the researchers who are interested in these ethical questions rightly assert that the placebo can be prescribed as a medicine and “as a stage in the therapeutic pathway decided upon in the most objective way possible and restored to its place in the overall medical relationship”. From this departure point the moralist goes back to definitions. Every modern dictionary which is used today declares that a medicine is a substance used to treat illnesses and wounds or injuries. At the same time a lie is defined as being an act or a statement which is contrary to the truth.

Thomas Aquinas wrote that a liar is somebody who seeks to express something that is false with the intention of deceiving (Sum. Th. II/II 11o, 1). But the same authority, when discussing simulation, teaches that; “one lies when one says something that is not true but not when one keeps quiet about the way things are” (111, 1, ad4). Here we encounter the problem which is at the heart of the employment of the placebo.

Basing himself on the thought of Aristotle and St. Augustine, the angelic Doctor describes certain so-called acceptable lies and refers to the good which is aimed at; “to be useful to somebody for his own good”, “prevent him undergoing material damage”, “saving his life”, or “impeding him from a fault which stains his body and his soul”. These “lies” are outlined in a list of decreasing seriousness (11o, 2). These gradations are full of teaching and it should be observed, as one moral authority has observed, that for Thomas Aquinas “to conceal or to represent the truth in a certain way does not necessarily always mean to betray it or to falsify it”.

The fact that certain people referred to mental reservation, and thought that one was dealing with an equivocal idea, gave rise to discussion and debate on the subject by Pascal and the Jesuits.

P.H.Jone, a Capuchin and German theologian of our time, drew up a compendium of moral thought which was later published in ten editions. In this work he declares that: “Reservation in a broad sense is allowed, and at times is even

obligatory, as long as there is sufficient good cause and when the other person does not have the right to know the truth. A good cause exists when one is dealing with things which are good for the soul and the body or when one is dealing with ridding oneself of inopportune and unjustified questions”.⁶ This text does not propose a shortcut but is in reality a lesson in common sense. The idea of “good cause” seems useful in the case of therapeutic treatment involving a placebo.

In these discussions it is interesting to listen to a modern philosopher who does not speak in the name of God but in the name of moral values which are necessary to each one of us. When referring to good faith, the philosopher A. Comte-Sponville affirms that this virtue involves first and foremost loyalty to what is true and love for the truth. He goes on to ask: “Is a lie a bad thing?”. Certainly. But the aridity of hearts is even worse. Is veracity a duty? Yes. But helping a person in danger is another, and is more compelling.⁷ The author loves to refer to Montaigne and the latter affirms in his *Essais* that truth “is the first and fundamental part of virtue” and that “it is necessary to love it for its own sake” (II, 7). From a Christian point of view, rigour is clearly opportune because truth does not depend first of all on the warmth or aridity of hearts.

There is, therefore, a moral problem of responsibility for the medical doctor and “rigorous ethics are indispensable”. This is the opinion of Prof. J. Bernard who goes on to declare: “in no case must these comparative studies lead to prejudice towards the sick person”. On the other hand, it should be recognised that one is referring here to therapeutic action. In a work which gave rise to great controversy in 1979, its author Norman Cousins stressed the real nature of the attitude of many researchers towards the use of the placebo: “They do not see it solely as a psychological aid used by doctors in the treatment of such patients but as an authentic therapeutic agent which changes the chemistry of the body and helps to mobilise its defences in order to combat disorders or illness”.⁸ The placebo,

therefore, does not only have the appearance of a medicine but really acts as a medicine. Medical doctors affirm that it would be an error to see its use as a way of getting rid of an intrusive patient through the prescription of any kind of preparation whatsoever which in reality has no impact at all.

On the contrary, one is dealing here with a psychosomatic therapeutic strategy and this must also guide moral judgements about taking such a step. What is important in this field is to maintain a healthy evaluation of the goals and aims in view and the circumstances which are present. Today certain philosophers ascribe the whole of the value of an act to the motivations which lie behind it. Others, however, look to the consequences of that act in making such an assessment.

What is clear is that great objectivity must be applied if one does not want to lapse into relativity or into being merely concerned with effectiveness.

Body and Spirit

Researchers nowadays lay emphasis on a more scientific knowledge about the relationship between the spirit and the body. In various studies we encounter references to a work by a Californian doctor, Dr. E.L. Rossi, who has dedicated himself to the psychobiology of healing. He describes the case of a sick person, a certain Mr. Wright, whose life history in a surprising way illustrates the action of a placebo:

“Wright was afflicted by cancer of the lymphatic glands (a lymphosarcoma) which was in an advanced state. He ended up by being resistant to every form of palliative treatment... Despite this fact Mr. Wright had not given up hope even though his doctors had done so. He placed all his hopes in a new medicine which he was waiting for and which he thought would save him. The newspapers had talked about it—it was ‘Krebiozene’ (which was later shown to be an inert drug without any effects whatsoever).⁹ The patient wrote to the Association of Doctors which was engaged in tests on this drug—the treatment in-

volved repeated injections three times a week.

From the beginning of the treatment Mr. Wright, who was ill and fever-struck, amazed his doctor because very soon he was passing down the corridors and speaking happily to the nurses. But the other patients who received the same treatment did not notice any change at all in their condition. "Only Mr. Wright made notable progress. His cancer growths dissolved like snow in the sun and within only a few days had been halved in size". The injections were continued and "within ten days Mr. Wright could leave his 'death bed' and walk away. Every sign of the illness had practically disappeared over this period of time".

Two months later the Press declared that experiments with Krebiozene had revealed a lack of positive results and this worried the sick man a great deal. "As the results became gradually more negative his faith declined, and after two months of almost perfect health he fell back into his previous state and returned to his sad and dark state of mind". Given that the patient had given way to despair the doctor decided to engage in a dangerous stratagem. He assured Wright that a new version of the medicine was about to arrive which was "pure and super-active". There was a new beginning and the hopes of the sick man reached their peak.

"The healing which took place in this second state—which was practically terminal in character—was even more amazing than the first. The cancerous growths dissolved, the fluid which had filled the lungs disappeared, and he could once again be treated in the mobile clinic". The injections of water continued...

But the newspapers published an announcement of the Academy of Medicine which stated that "the tests carried out all over the country demonstrate that Krebiozene has no effect in the treatment of cancer". A few days after this announcement Wright was once again admitted to hospital in a desperate condition. "This time he no longer believed, all his hopes had gone, and he died within two days".

One well understands that a

case such as this is of interest to all those who are concerned with the question of the use of the placebo. In humble terms Dr. Rossi has written: "we still do not understand all the important factors of a given individual situation and we have only a vague idea of the way in which in certain fashion one could facilitate the healing of the body through thought" (p.24). The doctors simply observed that the experience of Wright shows that to believe blindly in the effectiveness of a medicine—which in actual fact has no value whatsoever—activates the placebo effect. This process activates all the chief systems of communication between the spirit and the body—we may refer here to the autonomous, endocrinal and immunity systems.

We should not forget the advice of Plato in *The Charmides* who wrote: "good doctors, when a sick person goes to see them because their eyes hurt them, declare that not only the eyes should be treated, the head should be treated to heal the eyes and at the same time to want to heal the head alone, without reference to the body, is an absurdity" (156ss). The philosopher adds that it is by treating everything that one should direct oneself to healing the sick part.

In contrary fashion it would be ridiculous to conceal the complexity of the mechanisms which are in play. A specialist of the scientific study of the emotions tells us that "when it comes to psychosomatic illnesses we find ourselves in a world of uncertainties".¹⁰

Patient and Doctor

The most recent works on the subject never tire of stressing the importance—when it comes to the question of the placebo—of the sick person's trust in his own medical doctor. The patient's expectations with regard to the treatment are of fundamental relevance but the same may be said of the personality of the doctor and his level of being convincing. Dr.J.J.Aulas writes that "a rigorous study demonstrates that the most important motor of the placebo effect is the medical doctor himself".¹¹

For his part, Cousins affirms that the best placebo is the medical doctor himself, and refers also to the independent capacity to achieve a recovery that the will of every sick person must develop. On the basis of his experience the author has been able to observe that "the human body is itself its own best chemist and the best prescriptions are those which the organism itself wants to receive" (*op. cit.* p. 50). The same statement returns: "every sick person bears his own medical doctor within himself" (p. 62).

Various authors deal with the role of the prescriber in the use of the placebo. There are significant differences between the results even though the same pills are being administered and the doctors are different. The personality of the person supplying the treatment leads to different kinds of service in that not every doctor has the same ability to communicate, to reassure and to be compassionate. We can say exactly the same about spiritual advisers and confessors—not everybody engaged in such activity has the same ability to place a discouraged or sinful soul back on the right lines.¹²

Modesty is required for all those whose mission is to help other people in moments of crisis and Dr. P.Lemoine is right when he writes "No medical doctor will ever manage to be equally good with all sick people and in treating all illnesses" (*op. cit.* p. 75). It is also said that no man of the Church is always able to perfectly understand the hidden faults which are at the origins of the guilty conduct of a penitent or of any other kind of individual.

It cannot be doubted, in addition, that psychological disturbances often spring from a religious or cultural context. Often they are connected to disturbances of the body and thus one comes to disorders of a psychosomatic character. This is what makes a specialist declare that in such a situation "faith in the doctor and the wish to get better play a role of vital importance". If the research is extended one comes to the conclusion reached by Prof. E.Zarifian after analysing the problems and issues of psychopharmacology: "an anti-depressive on its own

never heals a depressive. There is also a need for a healing relationship to be established where the medicine which is administered is a necessary element but not in itself sufficient".

The "healing relationship" and "the psychological work of accompanying" are classical subjects in medicine. The techniques of Dr. Balint have always revealed that the medical doctor cannot fail to be involved in the therapeutic relationship. Much has been said about the language of the organs as an instrument of expression—a physical disturbance can be the channel through which a sick person expresses his psychic difficulties. In such a case it is very important to recognise that every patient is unique in the broad sense of biology, genetics and haematology. This individuality of the patient should not be forgotten when the question of the placebo is discussed. In the same way spiritual advisers are useful when they provide their help in line with the notion that "every soul is a diocese", a special world all of its own which God loves in a particular way.

When Prof. J.M. Charcot in 1892 wrote a small work entitled "The Faith which Heals" he stressed that the essential goal of medicine is the healing of sick people "without any distinctions being made in the curative process which is implemented".¹⁵ This book appeared in a collection called the "diabolical library"! It is clear that the curative process is not of no importance and today one thinks of all the problems of abortion, euthanasia and bioethics. Charcot's work was also called into question by believers because of its rationalist tones and the critical attitude of the author towards so-called miracles. Charlot referred to "the clearly influenced spirit" of those who go to a sanctuary and laid emphasis first and foremost on the presence of hysterical phenomena. However, he himself sent some of his patients to these holy places in the name, it appears, of therapeutic action.

Prof. de la Salpêtrière posed a question which now makes us reflect somewhat: "Why place so many challenges in the way of science which ends up by having the last word in every-

thing!" (p. 8). At the end of the twentieth century it is not possible to have the same trust or the same optimism.

Certain ideas of Charcot could undoubtedly have been applied to the studies which have been carried out into the placebo. Indeed, today specialists admit that "suggestion seems to be a valid explanation for the action of the placebo". This action may thus be above all else "the materialisation of the suggestion of the medical doctor who administers it". One is dealing here with an affective influence exercised on the mind and the body of the patient.¹⁶

Over fifty years ago a Swiss doctor wrote the following words: "Man is not a two-floored house but a complete living being made up of a soul and a body which are intimately fused".¹⁷ Spiritual advisers have always known this and it is in this perspective that the question of the placebo—"the medicine which searches for the truth"—should be approached at a medical and moral level. The phrase here is that used by two psychiatrists who have come to a conclusion which well summarises the debate¹⁸: "the placebo is the purest of the psychotropes but it is also the most difficult to prescribe. It is however certain that the placebo is a medicine. Its active principle is understanding. The quality of the relationship, its dosage".

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⁸ NORMAN COUSINS, *La Volonté de Guérir* (Paris, Seuil, 1980), p. 45. See my article 'Psychopharmacologie et Morale' in *La Vie Médicale au Canada Français*, vol. 4, January 1975, pp. 56-63.

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¹⁰ ROBERT DENTZER, *L'Illusion Psychosomatique* (Paris, Editions Odile Jacob, 1996), p. 46. Cf J.P.Schaller, *Morale et Psychosomatique*, Préface de Jean Hamburger (Paris, Beauchesne, 1982).

¹¹ DR. J.JACQUES AULAS, *op. cit.*, p. 232. After questioning certain medical doctors François Laplantine wrote down an observation made by one of them: "What we learn from lengthy consultations is the fact that if most patients have organic symptoms all of them want, consciously or unconsciously, to tell us about other things": *Anthropologie de la Maladie* (Paris, Payot, 1992), p. 316.

¹² See my article 'Direction d'âme et Ministère Médical' in *La Vie Médicale au Canada Français*, vol. 3, July 1974, pp. 682-691 where the placebo is discussed. In the same review (vol. 36, January 1965, pp. 95-103) I examine the phrase employed by Montaigne: "*L'étrière couture de l'esprit et du corps s'entrecommuniquant leurs fortunes*" (*Les Essais*, t.I, bk. 1, chap.20).

¹³ PHILIPPE LABURTHE-TOLRA and J.PIERRE WARNIER, *Ethnologie - Anthropologie* (Paris, PUF, 1992, second edition), p. 281.

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¹⁵ J.M.CHARCOT, *La Foi qui Guérit* (Paris, Alcan, Bibliothèque Diabolique, 1987), p. 1. Monique Hebrard has also published a work with the title "La Foi qui Guérit" but this book is an expression of the charismatic movements: (Paris, Desclée de Brouwer, 1988).

¹⁶ In 1952 American doctors wrote: "The doctor who prescribes a placebo in whatever form is sincere in his wish to help the sick person. He knows that his patient wants remedies, he is aware of his resistance to the idea that his symptoms are the outcome of an emotional conflict, and he knows about the happy effects of suggestion": E.Weiss and O.Spurgeon English, *Médecine Psychosomatique* (Neuchâtel, Switzerland, Dalachaux et Niestlé, 1952), p. 176.

¹⁷ DR. A. STOCKER, *Etudes sur la Psychologie de la Personne* (Saint-Maurice, Switzerland, Editions Saint-Augustin, 1942), p. 264.

¹⁸ BERNARD LACHAUX and PATRICK LEMOINE, *op. cit.*, p. 123. See also my article 'Les "Affections Tristes" de l'âme. Ethique Médicale', in *Bulletin des Médecins Suisses* (Schweizerische Arztezeitung), Band 61, 1980, Heft 4, pp. 175-180.

Matercare International

A practical initiative for the millennium

1.00 A vision

An international group of Catholic obstetricians/gynaecologists and midwives met in October 1995, having a concern for the poor state of maternal health throughout the world and the unacceptable solutions being offered to improve the situation. Having been inspired by the message of the Encyclical, *Evangelium Vitae*, and conscious of the fact that the Catholic Church must maintain its faith centred mission of serving those in need and are most vulnerable, through its health care ministry, they resolved to develop a new professional initiative for the care of mothers.

2.00 The rationale

2.10 *The most neglected tragedy of our times*

Mothers and their unborn children suffer considerable discrimination in our times. This is the conclusion that one must draw from an examination of current rates of abortion, and maternal mortality and birth injury (maternal morbidity), especially in the developing world.

In poor parts of the world, mothers, are experiencing "unimaginable suffering." It is estimated that 600,000, die annually during pregnancy and labour. The risk of a mother dying as a direct cause of pregnancy and labour in Africa is 1:13, compared to, 1:7,300 for example in Canada. The executive director of UNICEF commented in a June 1996 report, "the Progress of Nations," "It is no exaggeration to say that this is one of the most neglected tragedies of our times, when 1600 mothers—some in their teens—die every day."

The UNICEF report howev-

er, failed to mention, the unimaginable suffering of millions of unborn children, killed in their mothers womb and suffering of millions of mothers who resort to abortion as a solution to their poverty; over 50 million annually, worldwide. Most of these maternal deaths and injury and all of the abortions are readily preventable. UNICEF points to the basic reasons for the lack of improvement in maternal death rates in the developing world as "a conspiracy of silence" and a "lack of imagination" to which should be added, a "lack of love and compassionate services" to explain the abortion deaths.

Maternal deaths do not take place in a visible and concentrated way, but occur among very young mothers, in small villages, and a few at a time. Most die in terror from haemorrhage or in agony from obstructed labour as their pelvises are too small. Not only are the lives of these mothers abruptly terminated but the chances of survival of their new-borns and the two or more children that they already have and leave behind, decreases dramatically. It is also very likely that their families disintegrate in the aftermath of their death.

Sadly, these deaths only represent the tip of the iceberg. It is estimated that for every mother that dies, 30 more suffer long-term damage to their health, most frequently from obstetric fistulae. These arise in very young mothers, aged between 14 and 20 years, as a consequence of unrelieved obstructed labour, and frequently also from cultural practices e.g. female circumcision. The result is that the baby dies and because of damage to the bladder, rectum and vagina, the mother becomes incontinent of urine and/or faeces (obstetric

fistulae). She thus becomes a complete outcast and is treated worse than a leper by her husband, family and society, simply because she is wet, filthy and foul-smelling. They suffer pain, humiliation, and lifelong debility if not treated. There are estimated to be 500,000 - 1 million women, mostly in sub-Saharan Africa who are suffering the consequences of a fistula.

These high rates of mortality, morbidity and abortion indicate neglect. Mothers in the developing world do not have access to safe, clean, dignified places to have their babies or access to expert medical services to look after them and while obstetric fistulae can be treated surgically, at present there are insufficient trained doctors, nurses or adequate facilities for that purpose. Unfortunately, the international safe motherhood initiative has accepted the current culture of death prevalent in obstetrics and gynaecology, as abortion is included as the solution to maternal health problems. All of this points to a real poverty—the lack of love and compassion.

The 1987 Safe Motherhood Conference in Nairobi first drew attention to the tragedy experienced by mothers in the developing world and issued a "call to action." However the response was not good enough and there have been repeated calls since without much response. The UNICEF report points to the basic reasons for lack of improvement in these deaths rates as "a conspiracy of silence" and a "lack of imagination."

2.20 *The role of the Catholic Church in maternal health care*

The Christian Church has deep religious and long historical associations with the deliv-

ery of health care. It has been, until now, one of the largest providers of health care for mothers, throughout the world.

The Church's teaching concerning the dignity of all human life has been made clear over the last 30 years, most recently in *Evangelium Vitae*. This teaching reiterates that the deliberate and direct taking of innocent human life is an abominable crime to be condemned. However, perhaps we are too quick to condemn and forget that we too may have some share in the responsibility, through the sin of omission. There is nothing theoretical about having a baby, or dying in childbirth, or sustaining an obstetric fistula, or having an abortion and thus argument even in defence of life, is not enough.

The Church's continued involvement in maternal health care is now threatened, and this should be of serious concern to all members of the church. While there are over 2000 institutions providing care for the sick throughout the world, many with departments of obstetrics and gynaecology are being closed frequently because of their ethical positions. Few Catholic specialists obstetricians/gynaecologists remain in practice and few are entering specialist training programmes. Many government agencies, specialist associations and international health agencies have the opinion that Catholics can no longer be relevant in maternal health care because of their moral and ethical opinions.

It has become increasingly clear that there is a widening gap between knowing WHY we Catholics value motherhood and human life so highly, and knowing HOW we are going to serve them.

2.30 An Appeal to Health Care Professionals

In his Encyclical *Evangelium Vitae* Pope John-Paul II has issued an urgent appeal to all but in a special way to Catholics;

"To the people of life for life," "to offer this world of ours new signs of hope, and

work to ensure that a new culture of human life will be affirmed for the building of an authentic civilisation of truth and love" (E.V. No 6).

"To all health care personnel who have a unique responsibility to be guardians and servants of human life" (E.V. 89).

A specific contribution must come from "Catholic universities, Centres, Institutes and Committees of Bioethics and places of scientific and technological research." (E.V. 98).

Obstetricians and midwives share a unique and privileged vocation in the service of life. They assist in bringing into the



world new life and are frequently called upon to use their skills to help save the lives of mothers and their unborn children, when seriously threatened by disease or complications during pregnancy and delivery. This proposal is a practical response to the Holy Father's call to action to all those engaged in the care of human life. It is a new initiative that could provide health professionals wherever they may be, the opportunity to:

"allow their talents and activities to be nourished by the living force of the Gospel... and to place themselves at the service of a new culture of life offering serious and well documented contributions, capable of commanding general respect and interest by reason of merit" (E.V. 98).

3.00 The millennium a golden opportunity

Pope John Paul II, in his Apostolic Letter, *Tertio Millennio Adveniente*, has reminded the world that it will celebrate not only the most important birth in history but also the most important event for all mankind, which in obstetrical terms likely took place 266 days previously—the Incarnation. "The Son of God became man, taking a body and a soul in the womb of the Virgin, precisely for this reason: to become the perfect redeeming sacrifice."

The letter points out that jubilees are usually connected with the dates of births and therefore are a time of joy, a time to rejoice, and to hope. Equally, this most significant of jubilees should be, as were those for the people of Israel, a time to be reconciled, and a "time to restore equality to all its children."

The Holy Father has talked of the next three years as a time "to be lived as a new advent". During this time he has asked us all to "discern what the Spirit is suggesting to the Church, to different communities, from the smallest ones, such as the family, to the largest, such as nations and international organisations, taking into account cultures, societies and sound traditions." All are called to be involved in the celebration of the great millennium. What better way for health professionals to celebrate than through a new initiative dedicated to the care of mothers?

4.00 Matercare international a project for the millennium

4.10 Mission Statement

Matercare International is an international organisation of health professionals, dedicated to the care of mothers and babies from the moment of conception which has the sole objective of improving the lives and health of mothers, wherever they may be, by contributing to the reduction of maternal mortality and morbidity rates by 75% in the next ten

years and to the elimination of abortion, through new initiatives of maternal service, training, and research, in accordance with the teaching of the Encyclical, *Evangelium Vitae* (the Gospel of Life).

4.20 Specific Objectives

To provide a permanent, professional, interdisciplinary co-ordinating centre for Catholic health professionals, who are committed to its general objectives, for the provision of service, training and research programmes into maternal health care.

To provide on a continuing basis, through research of the highest scientific and ethical standards, information to assist Catholic health care decision makers in setting appropriate priorities required to uphold Church teaching.

To collect information on existing programmes relating to the general objectives, to evaluate, and adapt them where necessary in order to provide new approaches.

To publish, textbooks and articles in learned professional journals etc. explaining the knowledge and experience of the Catholic contribution to maternal health care.

To provide educational assistance through such activities as an international residency training programme in obstetrics and Gynaecology, a consultation service in project development, and specialist courses and workshops.

4.30 Planned Activities

4.31 A West African Maternal Health and Obstetric Fistula Project

The project will provide programmes designed to reduce maternal deaths and birth injury in rural areas. An obstetric fistula treatment and rehabilitation centre, will also be established, with the important objective of training local physicians and nurses in the surgery and management of fistula patients. A basic research programme is also planned to develop a new method of managing life threatening obstetrical complications in rural areas, for example; postpartum haem-

orrhage. In addition an advocacy programme will be developed to inform the public about the plight of mothers with obstetric fistulae.

4.32 An international specialist training programme

This international programme will provide training for physicians specialising in obstetrics and gynaecology but who wish to follow their consciences and the teaching contained in *Evangelium Vitae*.

4.33 Clinical bioethics courses

These courses for students,



physicians and nurses, given by clinicians and bioethicists, will be based on respect for all human life.

4.34 An Alarm (African Labour And Risk Management) course

Based on a similar course developed for specialists, GPs and midwives in Canada will provide health professionals in for example rural areas of Africa with a systematic approach to risk management in pregnancy and labour...

4.35 An internet Web Page

Will provide information on the policies and activities of Matercare International.

4.36 Publications

Through publications of for example: an international journal presenting an alternative

view on maternal child health practice, or a textbook on the "Scientific Foundations of Natural Family Planning" or an educational video highlighting the tragedy of obstetric fistula or a training programme for physicians and nurses in the surgery and management of obstetric fistula.

5.00 Structure

Matercare International (MCI) will have a revolutionary structure for the 21st century i.e. no large buildings, but a small central core agency linked to flexible reference centres distributed throughout the world where required, through modern communication technology and using modern concepts of distance learning.

5.10 MCI Core Agency

The Centre will provide the support for reference centres which will provide the basis for implementing particular programmes and services, have access to data bases, libraries, and appropriate university research centres etc. The centre will not have to be large. It will reflect the unique, international, interdisciplinary, diverse vocational character and experience of our Church, and will include an administrator, medical and nursing directors, theologian/ethicist, health educator, communications expert, and support staff. An international bank of experienced and mobile consultants will be formed, who will provide: long or short courses in basic sciences, clinical obstetrics and gynaecology and courses in medical ethics, help in developing research and grant projects through the preparation and evaluation of proposals.

5.20 MCI Reference centres

These reference centres will be established, where necessary and according to local needs, and where there is interest. They will be the initiators of local activities and will gather information, implement services and educational programmes, conduct research

and also provide consultants for the bank of specialists.

6.00 Financing

Funding will be sought through MCI support groups in different countries from for example: the private sector, including, corporate sponsors, foundations, service clubs, church groups and individuals. Matching funds will be sought from national and international development agencies.

7.00 Final plea

The millennium jubilee is also a celebration of a motherhood which began in Nazareth. In a small way all mothers

share in a special and intimate way in the Incarnation through their own birthing experiences and also sadly in many circumstances, through death and injury, they share intimately in His suffering and death on the cross, and also share His mother's suffering at the foot of the cross, when they suffer the loss of a child.

"The Father chose a woman for a unique mission in the history of salvation: that of being the Mother of the long awaited Saviour. The Virgin Mother responded with complete openness." "The motherhood of Our Lady will be felt during the jubilee year as a loving and urgent invitation addressed to us all when we hear her say, "Do whatever Christ tells you."

Everyone is asked to do as much as possible to ensure that the challenge of the Year 2000 is not overlooked, for this challenge certainly involves "the special grace of the Lord, for the Church and for the whole of humanity." It is proposed to mark the millennium by establishing this international organisation dedicated to the work of life, as a gift to mothers throughout the world and to the Church, to aid in its fight for life.

Respectfully submitted

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*Professor of Obstetrics
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Matercare International*

September 4th 1997



Testimony



*Spain: plan of action
for the quadrennial 1997-2000*

*Mexico:
programme for 1998-2000*

*Cuba: Pastoral Work
in the Health Care field*

*Chile: Pastoral Work
and Health Care*

*Catholic Health Care
Professionals (PROSACs)*

*Pastoral Care
in psychiatric hospitals*

The Spanish Episcopal Conference Department for Pastoral Care in Health Plan of Action for the Quadrennial 1997-2000

Presentation

The Church is moving towards the celebration of the Great Jubilee of the Incarnation, an appointment of the spirit which unites us around the mystery of Christ in which we live and achieve our fullness. Pastoral care in health, in all its aspects and contexts, is joined to the whole of the Church and within the Church it seeks to seize the opportunities and meet the challenges which this great event presents for its evangelising action.

Pastoral care in health finds one of its most productive reasons for being in the mystery of the Incarnation. In taking on the human condition, Christ expressed in culminating fashion the love of God for mankind, and this was done so that every man, having regained his dignity and having become healed deeply, could become transformed into a new creature and at the same time into an effective instrument of solidarity and healing for other people.

As we draw near to the Jubilee which will mark the beginning of a new stage in the history of the Church, it is fitting to remember the path taken by pastoral care in health in Spain over the last twenty-five years. The plan of action for the quadrennial 1997-2000 is the point of arrival for an itinerary of renewal which has experienced moments of great meaning, such as, for example, the national congress on "Church and Health." The triennial plans of action have also played an important role in the path which has been taken and have regularly brought out the character of the direction and the details of pastoral care in health as it has been practised and implemented at different levels.

We should draw great satis-

faction from the fact that pastoral care in health—thanks to the breath of the Holy Spirit and the efforts made by very many people—has increasingly drawn together an ever greater number of people involved in the difficult and at the same time thrilling evangelising action of the world of health and illness. For this reason this brief paper discusses not only the plan of action but also the organisational structure of the family of pastoral care in health, that is to say the National Group, the committees, and the delegates from the dioceses.

This plan of action has been drawn up with great care. All those who have taken part in its preparation are people who are directly or indirectly involved in its subject matter and practical implications. The objectives, the guidelines and the initiatives which it proposes are honestly ambitious. We hope, therefore, with the support of everyone, that this plan will be an effective instrument by which to promote and support the evangelising mission of the Church.

May the Lord Jesus, Good Samaritan, through the intercession of Mary, *salus infirmorum*, help us to embody in the world of health and illness the salvation offered to us by him in the form of health, and to be credible witnesses to his compassionate love.

+ JAVIER OSÉS
Bishop Responsible for
Pastoral Care in Health

General Objectives

To develop and promote the evangelical dimension of the presence of the Church in the world of health and health care, to help the Church to become aware of the healing di-

mension of all of her forms of pastoral action, and to encourage a new culture of health within society which is based on, and inspired by, the Gospel.

Priorities of the Plan

1. During these four year to stress the evangelising dimension of pastoral care in health and achieve a revision of its approach and activity in these terms.

2. To stimulate and foster the participation of the lay faithful.

3. To intensify the overall training of the agents of evangelising action of the Church within the world of health and health care.

4. To promote the greater integration of pastoral care in health into the general evangelising action of the Church.

5. To foster and stimulate the active participation of all sick people at all levels and in particular with regard to evangelising action.

Objectives, Guidelines and Action

Objective 1

In a spirit of ecclesial communion to integrate pastoral care in health into the path of the Church towards the Jubilee of the Incarnation, meet the challenges of the new evangelisation, and strive to renew and revise the approaches and the activity of such pastoral activity.

1. Action

To prepare for the World Day of the Sick of the year 2000 with especial care and give it greater prominence. The topic of this day will be: "the mystery of the Incarna-

tion and pastoral care in health”.

Authority The department
Period 1999/2000

2.

Action

To create a committee which will study and plan special initiatives for this year well in advance.

Authority The department
Period 1998/99

Objective 2

To evangelise the contemporary culture of health and health care by offering the values and the salvific and healing power of the lived out, preached and celebrated Gospel.

Guidelines

1. To promote and accompany theological-pastoral reflection on, and interdisciplinary dialogue about: health, quality of life and illness; present-day models of health and health care; lifestyles; attitudes and behaviour towards health, suffering and death; and so forth.

2. To promote education in favour of such values as: respect for human beings, solidarity, mutual help, support for those in need, compassion, indifference towards earthly realities, checking uncontrolled consumption, and impeding the search for objects which do not involve mere pleasure...

3. To help to heal our society whose pathologies of various kinds bear witness to the collective impact of pathogenic attitudes, customs and forms of behaviour.

4. To foster and reinforce the use of social means of communication to spread the thought of the Church on these various subjects.

1.

Action

To study the possibilities of creating within the department a committee or permanent team of experts on the mass media which could advise the department and its committees and promote initiatives in the field of communication.

Authority The national group
Period 1996/7

2.

Action

In so much as this is possible, to make greater use of means of communication and to organise a quarterly presence within them.

Authority

The committees, diocesan delegations, SIPS, PROSACs, and training bodies.

Period Quadrennial

3.

Action

To support the service offered in this field by reviews such as *Labor Hospitalaria*, *Humanizar*, *Etica y Debate*, etc.

Authority All
Period Quadrennial

4.

Action

To draw up a list of people prepared and ready to intervene in the field of the mass media (the press, TV, radio and TV)

Authority The department
Period 1996/7

Objective 3

To promote a more human and complete form of health care which respects and defends the dignity and the rights of every human being.

Guidelines

1. To offer the support of the Gospel and the rich tradition of the Church to the world of health care.

2. To cultivate solidarity-inspired responsibility in this field: the donation of organs and blood, the rational consumption of resources, care for sick people who are most in need, and so forth.

3. To identify and condemn inadequacies and failings which exist in actual health care coverage, and to give voice to the views and needs of the weakest and the most defenceless.

4. Taking the Gospel as a starting point and as an integral part of our evangelising mission, to throw light on the

human, social, ethical and moral problems which present themselves in the world of health and health care.

5. To increase the efforts made to examine and analyse the ethical problems which are present at all levels in the world of health and illness so that the evangelising mission meets the deepest hopes of man, helps in the humanisation of this world and its structures, and works to transform its culture (cf Proposal n.1, *In-forme Iglesia y Salud*, SEC).

1.

Action

To study the proposal that the department should have a permanent committee of experts on bioethics which could follow bioethical problems closely, act as a channel for thought and interdisciplinary dialogue about such problems, and act as a source of illumination.

Authority The national group
Period 1996/7

2.

Action

To spread within the Church herself, and of course within society too, its thought on those topics and publications which are produced by special days, courses, and conferences on the contemporary subjects of bioethics (Proposal n.1 SEC).

Authority

The department, the committees, diocesan delegations on pastoral care in health, PROSACs.

Period Quadrennial

3.

Action

To make people aware of the existence and the publications of existing bioethical committees of a religious character.

Authority The department
Period Quadrennial

4.

Action

To encourage the active participation of Christian health care professionals and chaplains in the creation and deliberations of bioethical committees.

Authority

Committees for hospital pastoral care, PROSACs.

Period Quadrennial

5.

Action

To offer courses and/or days of updating in ethics and bioethics to chaplains and pastoral health care workers in order to train them for, and integrate them into, bioethical committees.

Authority

The department, diocesan delegations, PROSACs, and the training committee.

Period Quadrennial

6.

Action

To offer the presence and the co-operation of pastoral care in health in the preparation and drawing up of the initiatives of the Church in the field of bioethics (Proposal n.1, SEC).

Authority The department
Period Quadrennial

7.

Action

To study, report on, condemn and express opinions about situations involving poor levels of care and conflicts which damage the rights of sick people and their families, or other problems.

Authority

The PROSAC Association, the department, FRATER.

Period Quadrennial

Objective 4

To promote the presence of sick people at all levels of pastoral care in health, to encourage them to be aware of their essential role in the evangelisation and the promotion of health, and to ensure that the paternalistic mentalities and attitudes which still at times exist within society and the Church are rendered out-of-date and inoperative.

Guidelines

1. To promote greater awareness within Christian communities of the dignity and the rights of sick people and especially sick people

who are chronically ill and are not receiving care.

2. To constantly make use of associations and movements of/for sick people.

3. To continue to deepen biblical-theological thought about the role of suffering and illness in the history of salvation within a framework which takes account of the experience which sick people undergo.

1.

Action

To ensure that sick people are present in the different bodies responsible for pastoral care in health, and in particular in the diocesan delegations.

Authority

The department, diocesan delegations, FRATER.

Period Quadrennial

2.

Action

To draw up training materials for sick people who live in their own homes or in nursing homes.

Authority

The department, the committee for pastoral care in health, parishes.

Period 1998/9

Objective 5

To promote voluntary work in the health care, social-health care and pastoral field so that it is a visible and effective sign of ecclesial communion and of the solidarity-inspired and evangelising action of the Church in the world of health and illness.

Guidelines

1. To promote the suitable training of existing groups or associations of voluntary workers.

2. To increase co-operation with institutions which are involved in the promotion and the training of voluntary work (pastoral care in health schools, FERS, Caritas, diocesan delegations working for pastoral care in health, the Centre for the Humanisation of Health, etc...).

3. To devote the 1998 World

Day of the Sick to the subject of "voluntary work and pastoral care in health."

1.

Action

To create a committee made up of representatives of all the institutions which promote voluntary work and of representatives of voluntary workers in order to study this subject.

Authority The department
Period 1996/7

2.

Action

To present the national group with the project of celebration of the World Day of the Sick: how the subject should be approached, objectives to pursue, possible initiatives, etc.

Authority The department
Period 1996/7

3.

Action

To study the feasibility of creating within the department a specific committee for pastoral voluntary work in the world of health.

Authority The national group
Period 1997

Objective 6

To help towards ensuring—starting from the various levels of pastoral care in health—that "the socio-health care centres of the Church are characterised by their unconditional service to life, their complete care for the sick person, preferential concern for those who are most afflicted by poverty, ethical concern with the problems and issues connected with health and illness, and care for the staff who work in such centres" (proposal n. 8, SEC).

Guidelines

1. To recognise and support health care and social-health care institutions of the Church—and above all else those which belong to religious congregations—in their role as qualified points of reference for the action of the Church in the world of health,

illness and the third age, and as an "integral part of the pastoral work carried out by the dioceses (cf proposal n. 7 SEC).

2. To strengthen co-operation and mutual help between the diocesan delegations and the institutions which have a direct relationship with the above mentioned centres (religious communities, FERS, FERS delegations).

3. To foster mutual participation in timely and opportune initiatives such as the campaign and the celebration of the World Day of the Sick, the training of voluntary workers, and the activities of groups which are engaged in pastoral care in hospitals.

1.

Action

To work to ensure that all the diocesan delegations engaged in pastoral care in health have a FERS representative.

Authority

The diocesan delegations.

Period

Quadrennial

2.

Action

To offer the FERS co-operation in the drawing up of a handbook of Catholic hospitals.

Authority

The department

Period

1996/1997

Objective 7

To support and help the diocesan delegations engaged in pastoral care in health to provide a more effective impetus to pastoral care in health in their dioceses, to introduce a more explicit and effective healing approach into the dynamics of diocesan pastoral work (catechism, liturgy, and pastoral work of charity and service to the marginalised), and to obtain the support which is necessary to stimulate and co-ordinate the evangelising action of the diocesan Church in the world of health through increased interaction and co-ordination between similar delegations (proposals nn. 3 and 6, Informe Iglesia y Salud, SEC).

Guidelines

1. To achieve greater communication and exchange of programmes, experiences and materials between diocesan delegations who are similar in character—archdioceses, rural dioceses, etc.

2. To develop the initiatives envisaged by the plan of mutual help of the diocesan delegations responsible for pastoral care in health.

3. To be aware of the realities and characteristics of the small diocese in the planning of activity and the production of materials.

4. To promote within each diocese relations and co-operation between these delegations and the other diocesan delegations, and with such bodies as the FERS, the associations and movements made up of, or for, sick people, and health care professionals (from the plan of action for the years 1993-1994).

5. To support and strengthen the interdiocesan secretariats of pastoral care in health (SIPS).

1.

Action

To send regular information circulars to delegates which can be an instrument of connection, exchange and enrichment for everybody. To this end delegates should be asked to inform the department about their activities.

Authority

The department

Period

Quadrennial

2.

Action

To celebrate the national meeting of the delegates as an opportunity for knowledge, support and the mutual exchange of experiences, projects and materials between all delegates.

Authority

The department and diocesan delegates.

Period

Quadrennial

Objective 8

To deepen the spirituality of workers in the field of pastoral care in health and encourage the promotion of their spiritual advance and renewal.

Guidelines

1. To promote biblical-theological-spiritual reflection about the spirituality of workers in the field of pastoral care in health.

2. To encourage workers in the field of pastoral care in health to advance and renew themselves spiritually, to accompany them in this process, and to offer them the means which are necessary to the achievement of this end.

3. To continue to study and reflect upon the subject of prayer and its relationship to the world of health and of illness.

1.

Action

To organise a course on spirituality for workers in the field of pastoral care in health.

Authority

Training committee and the department.

Period

1998/9

2.

Action

To use the World Day of the Sick 1999 (*Maria, salus infirmorum*) to reflect upon the Marian dimension to service to the sick and upon the spirituality of workers in the field of pastoral care in health.

Authority

The department, delegations, PROSACs.

Period

1999

3.

Action

To offer every year a course of spiritual exercises for pastoral workers (chaplains, religious health care workers, Christian health care professionals, patients, visitors...)

Authority

The department

Period

Every year

4.

Action

To appoint a co-ordinator responsible for the group, together with the department, to promote the project "praying during illness."

Authority

The department

Period

1997/8

Objective 9

To promote—beginning with

the various sectors of pastoral care in health—greater sensitivity towards those sick people who are least looked after and cared for in order to contribute to a culture of solidarity which is concerned with the causes of marginalisation and sensitive to the rights of marginalised people.

Guidelines

1. "To help the Church to take care of and look after those sick people who receive the least assistance and to encourage the Church to support such people and to be committed to the provision of care to them".

2. "To co-operate in the creation of a new awareness about, and new evangelical attitudes towards, those sick people who receive the least care".

3. "To intensify solidarity towards those sick people from the third and fourth worlds who are most in need" (proposal n. 6, *Informe Iglesia y Salud*, SEC).

4. To continue to discuss and examine topics related to complete care for the terminally ill, with particular reference to the psychological, ethical and pastoral dimensions/questions of this whole subject.

1.

Action

To take advantage of the celebration of the World Day of the Sick of 1997 to make society and Christian communities more aware of, and sensitive to, the problems and difficulties of the **sick elderly person**.

Authority All
Period 1996/7

2.

Action

To include concern with those who do not receive assistance in the programmes which are produced.

Authority

Every committee and sector
Period Quadrennial

3.

Action

To co-operate with institutions, organisations and associations which are linked to

the sector and to those sick people who do not receive assistance.

Authority

All

Period Quadrennial

4.

Action

To prepare a "dossier" on palliative treatments and pastoral care for the terminally ill which could be a "directory" or manual for all those who work with the terminally ill.

Authority

Pastoral committee on palliative treatment.

Period 1997/8

5.

Action

To distribute material on the ethical problems which arise in relation to the terminally ill.

Authority

Pastoral committee on palliative treatment.

Period Quadrennial

6.

Action

To spread knowledge about, and models of action concerning, care for the terminally ill.

Authority

Pastoral committee on palliative treatment.

Period Quadrennial

7.

Action

To promote the participation and the co-operation of the pastoral committee on palliative treatment and pastoral workers in the associations of palliative treatment.

Authority

Pastoral committee on palliative treatment.

Period Quadrennial

8.

Action

To continue to organise every year the days of pastoral care in mental health.

Authority

Pastoral committee on mental health.

Period Quadrennial

9.

Action

To create or strengthen interdiocesan groups dedicated to pastoral care in mental health.

Authority

Pastoral committee on mental health.

Period

Quadrennial

Objective 10

To dedicate especial attention to the complete training of workers in the field of pastoral care in health which will be a form of training which makes them suitable for the various requirements of this area (proposal n. 10, Informe Iglesia y Salud, SEC).

Guidelines

1. "To give prominence in the training plans of seminaries and in the permanent training programmes of the clergy to the theoretical and practical contents of pastoral care in the health care field."

2. "To promote the inclusion of the same elements in the other institutions of instruction and training which are the responsibility of the Church."

3. "To support the creation of schools, training centres for pastoral care in health, and other initiatives directed towards the training of pastoral workers" (proposal n. 10, *Informe Iglesia y Salud*).

4. To persevere in future years with the training activity which has already been programmed, strengthening it and opening it up to greater participation and co-operation.

1.

Action

To draw up and develop a **general training plan** as a point of reference which is as complete as possible with regard to its contents, orientations and criteria.

Authority

Training committee in co-operation with other committees.

Period 1997/8

2.

Action

To invite the episcopal commission for seminaries and universities to introduce pastoral care in health into the training courses for the seminarists.

Authority

The department and the training committee.

Period Every year

3.

Action

To organise a course every year on pastoral care in health for diocesan seminarists and newly ordained priests.

Authority

The department and the training committee.

Period Every year

4.

Action

To promote a policy of exchange between the various committee schools and centres or institutions involved in training for pastoral care in health, and to organise every year a meeting of the directors or others responsible for such institutions.

Authority

The training committee.

Period Every year

5.

Action

To give support and consultation to initiatives at a local or diocesan level in the field of training.

Authority

The department and training committee.

Period Quadrennial

6.

Action

To promote the sending of workers in the field of pastoral care in health to study at the "Camillianum".

Authority The department

Period Quadrennial

7.

Action

To exchange training programmes well in advance.

Authority

Every body involved in training.

Period Quadrennial

8.

Action

To promote and facilitate the participation of the lay faithful in the training programmes.

Authority All

Period Quadrennial

Objective II

To stimulate and provide an impulse to the sound and effective working of the "Services of Catholic Religious Assistance" (SARCH) and to foster, strengthen and co-ordinate the evangelical and evangelising presence of the Church in the world of hospitals and hospital services.

Guidelines

1. To provide human, spiritual and pastoral help and stimulation to people who form a part of the religious services in our hospitals.

2. To continue to make the SARCH aware of the need to work in a team, to programme and assess their activity, and to co-ordinate and integrate themselves with and into the other hospital services.

3. To intensify the renewal of the liturgy and the sacraments with sick people, with their community participation and experience of faith, to follow the preparation of such liturgy and sacraments, and to take advantage of their celebration as a propitious moment for the evangelisation of, and the imparting of the catechism to, those people who are only occasional participants (and thus "distant").

4. To see hospitals as a community of communities and therefore to ensure that the SARCH feel jointly responsible and complementary in relation to the whole of the diocesan Church in serving the Kingdom and in particular in serving the weakest of their brethren.

5. To promote and follow pastoral activity in relation to the sacraments and the celebration of important liturgical moments in close co-operation with the local parishes.

6. To clarify and investigate who could constitute the ideal figure and work with commitment and prudence to include him or her in the SARCH (proposal n. 5, *Informe Iglesia y Salud*, SEC).

1.

Action

To make pastoral vicars, diocesan delegations in pas-

toral care in health, delegations of the clergy, members of religious orders involved in health care, and Christian health care workers, aware of the need to help chaplains, to ask them to be close to them, to be interested in their work, to energise them and stimulate them.

Authority

The committee for hospital pastoral care.

Period Quadrennial

2.

Action

To produce a study of the present day situation of the staff of the SARCH and of the possible need for a future meeting.

Authority

The committee for hospital pastoral care.

Period 1997/98

3.

Action

To programme regular meetings between all chaplains which could act as a stimulus for evangelisation, renewal and permanent training.

Authority

The Bishop, the pastoral vicar, diocesan delegations for pastoral care in health.

Period Quadrennial

4.

Action

To facilitate and promote the training of new chaplains and the permanent training of those who work in SARCH.

Authority

The committee for hospital pastoral care and the committee on training.

Period Quadrennial

5.

Action

To continue to offer the SARCH orientations and models for programming. To include in the training courses for chaplains the subject of the programme.

Authority

The committee for hospital pastoral care.

Period Quadrennial

6.

Action

To stimulate the SARCH to produce a report every year on

the objectives, concrete actions and needs of their service for the management of their centres.

Authority

The committee for hospital pastoral care.

Period Quadrennial

7.

Action

To study the present day situation of the Church- State agreement and help to solve the possible problems arising from the non-fulfilment of its provisions.

Authority

The department, the committee for hospital pastoral care.

Period 1997/8

8.

Action

To compile and distribute materials of utility for liturgical celebrations in hospitals: Sunday broadsheets, Day of the Sick, information bulletins, experiences...

Authority

The committee for hospital pastoral care.

Period Quadrennial

9.

Action

To encourage and promote meetings of help and mutual co-operation between parishes and the SARCH to illuminate, identify, and live in a better way the choice in favour of the sick.

Authority

Diocesan delegations

Period Quadrennial

10.

Action

To strengthen voluntary work at a hospital and parish level and co-operate in the training of voluntary workers.

Authority

National delegations.

Period Quadrennial

11.

Action

To employ a common model to assess the quality of the services provided by the SACH and make the results of this survey known.

Authority

The department SIPS committee, diocesan delegations

Period

Model drawn up in 1998 and assessed in 1998/9

12.

Action

To draw up the document "Profile of the Suitable Person" and apply it in line with the Church-State agreement.

Authority

National group.

Period 1997/8

13.

Action

To present the document "Profile of the Suitable Person" for the approval of the Episcopal Committee for Pastoral Care, and send it to Bishops, diocesan delegations for pastoral care in health, FERS, religious congregations, etc.

Authority

The department

Period 1997/8

Objective 12

To give an impulse to the renewal of the evangelising action of the parishes in the field of health (proposal n. 4, Informe Iglesia y Salud).

Guidelines

1. "The parishes should be helped to discover and be more responsible for their evangelising action in the world of health and illness."

2. "There should be an ever deeper and effective co-operation between pastoral care in health and the other forms of pastoral care carried out within the community: namely that care centred on the family, young people, liturgy, catechism, charitable work..."

1.

Action

To work to ensure that the largest possible number of parishes create a group for pastoral care in health to which sick people or invalids also belong.

Authority

The committee for pastoral care in health in the parish.

Period Quadrennial

2.

Action

To use the campaign for,

and the celebration of, the "World Day of the Sick" to revitalise pastoral care in health in the parishes.

Authority

The committee for pastoral care in health in the parish.

Period Quadrennial

3.

Action

To gather and spread witness and experiences which help people to live their situations of illness and physical limitations.

Authority

The committee for pastoral care in health in the parish.

Period Quadrennial

4.

Action

To give support and consultation to initiatives taken at a local or diocesan level in the field of training.

Authority

The committee for pastoral care in health in the parish.

Period Quadrennial

5.

Action

To promote the relationship between the parish and the health centre of its area through regular meetings and mutual help.

Authority

Diocesan delegations for pastoral care in health.

Period Quadrennial

6.

Action

To draw up "Orientations for Pastoral Care in Health in the Parish".

Authority

The department and the committee for pastoral care in health in the parish

Period 1997/8

7.

Action

To draw up topics on training for the campaign for the "World day of the Sick."

Authority

The department and the committee for pastoral care in health in the parish.

Period Quadrennial

8.

Action

To work to ensure that there

is a committee in each delegation which promotes pastoral care in health in the parishes and that this committee is as representative as possible.

Authority

The committee for pastoral care in health in the parish.

Period Quadrennial

9.

Action

To ensure that there are representatives of all the SIPS in the national committee for pastoral care in health in the parishes and that they are active promoters of this pastoral care.

Authority

The committee for pastoral care in health in the parish.

Period Quadrennial

10.

Action

To organise national days of pastoral care in health in the parishes.

Authority

The department and the committee for pastoral care in health in the parish.

Period 1997/8

Objective 13

To promote the existence of a laity which is more trained for, and more committed to, the humanising and evangelising mission of the Church in the world of health and health care.

Guidelines

1. To create and develop the

pastoral role of PROSACs and to give an impulse to the Association of Catholic Health Care Professionals, a body approved by the Spanish Episcopal Conference (proposal n. 7, *Informe Iglesia y Salud*).

2. To spread and extend the initiatives and/or training programmes amongst those lay faithful who work in the world of health and illness.

3. "The Church should pay greater attention to the health care professionals and voluntary workers active in this sector whose service to the sick tires them and turns them into wounded healers in the image of the Servant of Jehovah" (proposal n. 7 *Informe Iglesia Y Salud*).

1.

Action

To spread knowledge about PROSACs and information material.

Authority

PROSACs, delegations, centres.

Period Quadrennial

2.

Action

To study the identity, mission and functions of PROSACs diocesan counsellors.

Authority

National counsellors and PROSAC committees

Period 1997/8

3.

Action

To organise national and in-

terdiocesan days of Catholic health care professionals.

Authority

The national committee, the interdiocesan committee.

Period

1999 and 2001 (national); 1998 and 2000 (interd.)

4.

Action

To promote the participation of the lay faithful in existing training programmes: special schools, the centre for the humanisation of health, reviews, etc.

Authority

The national PROSAC committee.

Period Quadrennial

5.

Action

To use the PROSAC bulletin as a means of publicising the association, and spread news and bibliographical material.

Authority

The national PROSAC committee.

Period Quadrennial

6.

Action

To organise meetings, days and courses for Christian health care professionals in the dioceses.

Authority

The diocesan committee of the PROSAC Association and diocesan delegations.

Period Quadrennial



Conference of the Mexican Episcopate The Episcopal Committee on Pastoral Assistance in the Health Care Field - Programme for 1998-2000

1. The Identity of the Committee

The Episcopal Committee on Pastoral Assistance in the Health Care Field is a practical expression of the pastoral action of the Church which promotes and fosters the overall evangelisation of the sick person and those who surround him (pastoral workers in the health care field, family relatives, medical doctors, nurses, hospital staff and personnel, etc.).

2. The Mission of the Committee

We feel that it is our duty to preach the *Gospel of Life* and we invite people to embody and express it in the human realities of suffering, illness and death, thereby transforming the culture of death into a culture of life and thereby celebrating this great gift of God starting with its many faceted pastoral dimension.

3. The Aim of the Committee

To formulate, spread and implement projects on the Gospel of Life in the huge field of health and health care, and to do this within the doctrinal framework of the preparations for the great Jubilee of the year 2000.

3.1. The Aim for 1998

To celebrate the transforming presence of the Holy Spirit, Lord and Creator of Life, who takes care of, and heals, our wounds.

3.2. The Aim for 1999

To celebrate the presence of God the Father, abundant in compassion, the creator of life, who calls us to salvation through his only Begotten Son, Jesus Christ, who died and rose again.

3.3. The Aim for the year 2000

To celebrate the presence of the One and Trine God, to im-

merse ourselves fully in the Mystery of God who wants all men to be saved and to know the truth.

4. Health Care Realities in Mexico: The Changing Reality which Requires our Action

1. Mexico has a young people who are rich in historical experience. It is a country which has strong contrasts of wealth and poverty and has to suffer the threat of dependence. There are very worrying situations—the reduction in the general growth of the population caused by a decrease in birth rates, general changes in the character of life expectancy, migratory movements, and imposed population movements brought about by violence and the search for a better standard of life.

2. The epidemiological profile of the country is mixed in character. It combines the traditional problems connected with contagious and transmittable diseases and malnutrition—which in essential terms afflict the young sections of the population and those who live in conditions of extreme poverty—with those problems associated with illnesses produced by economic development—most notably cardiovascular and degenerative illnesses and cancer.

3. The break up of the family, free unions, the phenomenon of girl mothers, premature motherhood, death in childbirth, abortion, the interference of government in the planning of children, the subjection of women which takes place in certain cultures, the woman's many responsibilities in the home and in the work place, the discrimination which is practised against women—all these are forms of aggression against the family in Mexican society.

4. Present-day acute poverty

has generated hunger, malnutrition, unemployment, ignorance, the use of drugs and the practice of alcoholism. All these phenomena, like the unfair distribution of economic, human and institutional resources, play an increasing role in the generation of illness and the reality of inadequate health care coverage.

5. The Mexican people have deeply-rooted values and beliefs which at times involve what might be described as a magical approach to faith. Both false religious beliefs and superstition and fanaticism can become obstacles to the defence and promotion of life and health.

6. The health systems are essentially concerned with illness and see it as a result of life conditions and do not concentrate on health. Many health care programmes have adopted a neo-liberal approach which limits the role of the state and subjects health care to the laws of the market. When applied to the world of health, this policy (which describes itself as democratic) favours the supposed prerogatives of a small minority, neglects and violates the rights of the majority, offloads the responsibility for health onto private enterprise, and utilises new technology which the majority of the population cannot afford to use.

7. The sums allocated by the Mexican government to health care and the inadequate distribution and administration of resources have a negative impact on the coverage and quality of the services which are provided. The population passively accepts the situation and waits for a remedy to be provided by government bodies without itself becoming directly involved in securing changes in this situation. This attitude is especially true of the people who live in the rural and marginalised areas.

8. The infrastructure of the in-

stitutions and the precarious conditions of work of the staff and personnel have created a need to join trade unions. But some of these trade unions are manipulated by political, ideological and personal interests which thereby have a negative effect on the quality of the service which is provided and act to reduce the quality of professional commitment.

5. Analysis of the Reality of Pastoral Work in the Health Care Field in Mexico

1. The charitable work of the Church in Mexico was largely born out of an impulse to engage in care when members of religious orders discerned a path by which to realise their charisms. The hospital was seen as something which was sacred and the patients were the centre of attention. Similarly, the process of secularisation within society, and even of secularism, have had a major role in leading many religious congregations to be tempted to abandon their apostolic missions of care and to dedicate themselves to missionary work or to working with the poor.

2. At the present time the Church in Mexico has a clear policy in favour of evangelisation and this enables it to draw closer to specific groups who work to defend life. One notices that amongst pastoral workers in the health care field there is a marked poverty of theological and technical grounding which would enable them to tackle, illuminate and direct social and health care issues and questions towards the search for solutions which are suited to the circumstances which prevail and which are based on the ethical and moral values upheld by the Church. Evangelisation does not get to the root of things and the Gospel is not expressed in the real, social and personal life of people. What we have to do is to intensify pastoral work and organisation at all levels—whether national, parochial, diocesan or institutional. In addition, there is a failure to recognise that pastoral work in the health care field is the responsibility of all Christians and is not just the prerogative of a committed few.

3. There are facts which call out for the presence of the Episcopal Committee on Pastoral Assistance in the Health Care field in the world of health and health care, and they are as follows:

3.1. A lack of knowledge about social issues and questions, of familiarity with the context, of motivation, of creativity and of boldness—all these are elements which we need to revitalise the health mission of the Church.

3.2. Over 50% of the members of religious orders involved in pastoral work in the health care field are over 65 years old. Young members of religious orders who dedicate themselves to this dimension of apostolic care constitute a low percentage of the whole, and this is something which has an impact on the availability of human resources and the Church's ability to provide a suitable response to the problems and needs which exist.

3.3. A commitment to self-training is rare amongst lay pastoral workers in this field. There is a lack of a propensity to study, a lack of intellectual discipline, and a lack of theological and pastoral grounding.

6. Present Day Challenges for Pastoral Work in the Health Care Field in Mexico

The changing realities of the contemporary situation (which have already been referred to in this paper), when seen in the light of what the Gospel calls upon us to do, involve certain challenges which threaten the life and the vitality of the Gospel itself.

1. If we do not react with boldness and creativity to the needs of today's world in the world of health and health care, beginning with qualified training, we will lose our dynamism and our effectiveness.

2. If we do not commit ourselves with aware, planned and rational action in the defence of life and human rights our mission will not be faithful to the Gospel.

3. If we do not act together with professionals in serving health and life according to

Christian ethical principles, our presence in the overall health of the human being will lose its evangelising dynamism.

4. We must choose in favour of organised, dynamic, bold pastoral action in the health care field which is open to change and which will revitalise our missionary presence. Otherwise, our presence in the world of health and health care will have no evangelising meaning.

7. Priorities and Strategies

7.1. The Qualified Training of Pastoral Workers

1. The promotion of a theological and pastoral grounding rooted in the Word with a human, ethical, spiritual and biblical dimension.

2. The strengthening of fraternal life—sign of communion and commitment in the performance of mission.

3. The promotion of training and the up-dating of the female members of religious orders in subjects which condition and determine health.

4. Action in favour of the culture of health of the people in our mission.

5. The evaluation and analysis of health care policies from an evangelical point of view.

7.2. The Defence of Life and Human Rights

1. A reading of the reality of health and health care in a critical way in the light of the Gospel.

2. A retrieval of human and ethical values in the provision of health care services.

3. The conversion of the prophetic Good News into a commitment in favour of health.

7.3. Quality of Life and the Participation of the Citizens

1. The promotion of, and participation in, inter-disciplinary teams which provide support for the culture of life.

2. The dedication of our mission in particular to areas where there are situations of poverty, abject poverty or social exclusion.

7.4. The Lay Faithful and Service to Life and Health

1. The rediscovery of the vocation to service and commitment to the defence and promo-

tion of life and health in the lay faithful.

2. The generation of a suitable spirituality in those lay faithful who serve the sick.

3. The recognition and upholding of the sacredness of life and the dignity of the human person.

4. Our involvement in pastoral vocations for the various charisms at the service of the sick.

7.5. *The Organisation of Pastoral Work in the Health Care Field*

1. The promotion of the spreading of the Gospel in the world of health and health care.

2. The perception of our service as pastoral workers as a deepy rooted continuity of the action and work of Jesus Christ.

3. The rediscovery of the value of mass means of communication and their employment in favour of the defence and the promotion of life.

7.6. *Organising and Energising Pastoral Work in the Health Care Field Through the Participation of the Laity*

1. At the level of parish communities and in the rural and marginalised areas, dynamic support for an educational, participatory and transforming process in the field of health and health care.

2. The expression of solidarity with those who are sick and with their family relatives both in hospital institutions and in homes.

3. The rediscovery in all pastoral workers of a new evangelising dynamism in the field of health and health care.

8. **The Project of Preparation for the Jubilee of the Year 2000 for Pastoral Workers in the Health Care Field**

8.1. *The Mission of the Lay Faithful*

Like Christ, the Church is attentive, respectful and transparent towards those who have to deal with the trials of illness. This is because of the care and concern of the chaplains in the hospitals, the male and female members of religious orders who are present in health care centres, and the committed help and assistance of the lay members of the Church who work in

those groups which are dedicated to pastoral activity in the health care field.

In his apostolic letter written to prepare us for the Jubilee of the year 2000, John Paul II invites us to promote “in the ecclesial field the most careful listening to the voice of the Spirit through welcoming the charisms and the promotion of the laity” (TMA, n. 46). The laity, whether voluntary workers or professional workers, express their commitment by taking part in this service of the Church and by taking care of their brethren who suffer. To this end they must receive a specific theological, pastoral and ecclesial training. They must be supported and guided in their mission by the group to which they make an original contribution through the help they provide, and this group must be a point of reference and a centre of reflection. They should participate in the ministry of life by following the example of priests, a category of people who have received the pastoral ministry.

8.2. *The Ministry of Life*

In 1995 the Holy See published the “Charter of Health Care Workers,” an initiative of the Pastoral Council for Pastoral Assistance to Health Care Workers and the outcome of long deliberations and multidisciplinary preparation. The document offers an organic and complete synthesis of the position of the Church in the field of health and health care on matters concerning the primary and absolute value of life in itself and of the life of every human being. It deals with the complex problems raised by the innate bond between medicine and Christian morality, outlines the proper profile of professionals who work in the health care field, and sets out their essential obligations.

In the encyclical *Evangelium Vitae* the Holy Father declares that “health care workers—medical doctors, chemists, nurses, chaplains, male and female members of religious orders, administrators and voluntary workers—have a very special responsibility entrusted to them. Their profession calls upon them to be the stewards and the servants of human life” (E.V. n. 89).

For us this Charter is an in-

strument of our work and is part of both the initial and the final training of pastoral workers: “so that their witness is a demonstration of the fact that in the defence of life the Church opens her heart and her arms to all men because the message of God is addressed to all men” (*Charter of Health Care Workers*, n. 6).

The pastoral worker must not only be competent and skilled in the scientific and professional field. There must also be a readiness to help, care and concern, understanding, participation, benevolence, patience, dialogue and Christian charity. The patient is not only a clinical case and to treat him does not only involve defending his health or treating his sick organs—it means being at the total service of his life. “No individual can confine himself to being a physician of organs or the physical apparatus, he must also be responsible for the whole of the person” (John Paul II, *Insegnamenti*, V/3, p. 673, n. 4) given that “the human person, with the dignity and the rights which belong to him, although he expresses himself in his functions is not them only. He is composed of that ontological identity, at once both spiritual and corporeal, which makes him that subject in which believers perceive the image of God” (*Dolentium Hominum*, n. 30, p. 18).

The health worker, for his part, loyal to his mission which is a real and authentic vocation, must (like the Good Samaritan) dedicate himself body and soul to his task, and this is something which requires all his humanity and total devotion. From this point of view, his activity is a continuation of the healing charity of Christ who “passed by doing good to, and healing, everyone” (Acts 10: 38) and he looks at Christ himself who appears to us in the form of a sick person: “I was sick and you cared for me” (Mt 25: 341).

Profession, vocation and mission complement each other in a Christian vision of life. The pastoral worker develops a real healing ministry—the “ministry of life.” Indeed, to serve life means to serve God through one’s neighbour. In his work he is not alone but in a state of ecclesial communion in a holy place such as a parish, or in a hospital, which is the house of

God, as is brought out with force and effectiveness by its ancient name—hotel of God.

8.3. Towards the Jubilee of the Year 2000

To begin the third millennium in the right way, the Episcopal Committee for Pastoral Assistance in the Health Care Field has sought to utilise the three years of preparation leading up to the Great Jubilee of the year 2000—as defined in the publication *Tertio Millennio Adveniente*—to promote pastoral activity in the health care field in Mexico.

Since 1997 a national congress has been planned to celebrate the World Day of the Sick, diocesan committees for pastoral work in this area have been projected, and in the future the idea is to establish regional secretariats for pastoral work in the health care field.

For 1998

Since 1998 we have realised the need to suggest that we should have a section for pastoral care in Catholic hospitals and those health care institutions belonging to the private or state sector. This section could be promoted by parishes or by the diocesan committees themselves. The second project for 1998 involves the instruction of people who can then provide training for those who carry out pastoral work in hospitals.

8.3.1. Proposals of the Episcopal Committee on Pastoral Assistance in the Health Care Field CEM - Mexico Concerning Pastoral Care for Drug-Addicts and their Families

The Bishops:

Faced with a social problem of the proportions of drug-addiction, a phenomenon promoted by drug dealers or “merchants of death,” the national community should urgently take part in a national campaign which upholds the Christian values of life and health to combat the anti-values of drug-addiction and the drug traffic.

To this end, the whole of the national community should be committed to a change in direction and deal with the problem of drug-addiction not only as a social problem or as an illness but as a factor which destabilises the family, the community and national life.

2. It is of urgent importance that the dioceses and their pastors become aware of this question, but not only to help drug-addicts in a pastoral sense. They should also unite their forces with the various programmes of civil society and the Mexican government. It is of equally urgent importance that a national campaign of prevention is set in motion addressed to families and all men and women of good will.

3. In their dioceses pastors must engage in an evangelising effort to co-ordinate and sustain the various initiatives which already exist in their dioceses promoted by civil society and many different parts of the population. Government, private and Catholic initiatives in this sphere must come together and be co-ordinated in order to support a programme of rehabilitation and reintegration of drug-addicts in their families and in the community. They must remove the abyss of non-communication which exists in this field between the Church and the Mexican government.

Young People:

4. Pastoral work with young people must motivate them in an authentic sense to the utmost so that they, as Christians and like authentic prophets, utilise their energies to oppose and condemn “the culture of death” which strives to hold them in its chains. We must energise priests who help groups of young people so that they give a mighty propulsion to this struggle against drug-addiction.

5. We must help young people to remember that in Christ there is the fullness of life and that our human existence gains in him all its dignity and splendour. Each and every young person must be a convinced promoter and a defender of life and its dignity. We must support young people in the required Christian witness of a profound conversion within the context of death which generates consumerism and hedonism whose greatest expression is drug-dealing. Only their faith united to Christ, to authentic life, and to real love, will free them from the temptations and the idols of this world.

6. We must work so that young people search for sincere dialogue with the neighbour whom Christ places in front of

them and in whom they can confide and from whom they can gain support in the midst of this “culture of death”.

7. Let us give them the opportunity to be “Good Samaritans” with their friends and companions who have been taken over by drugs so that they can learn to be their supports in their most difficult moments and be near to them always and never abandon them.

Families

8. Pastoral work with families must bring the Christian values of solidarity and nearness to the families which are going through the difficult process of educating adolescents and young people. Parents whose children have been seduced by drugs or the drug traffic must be offered guidance.

9. We argue with insistence that the (physical or spiritual) absence of one or both of the parents, negative examples (alcoholism, family irresponsibility), conflicts between the marriage partners (separation or divorce), and the lack of affection or ignorance about family education are very often the reason why a child or a young person turns to drug abuse. Parents who are aware of these dangers must take remedial action in relation to these evils within the family context. Prevention must begin when their children are between the ages of eight and ten because the statistics we have available indicate that the first experience which young people have of drugs takes place between the ages of ten and twelve.

10. Parents must promote the development of the personality of their children by encouraging their sense of responsibility through setting a good example, trust, and sincere dialogue. Just as our Heavenly Father is near to us, helps us, and protects us, so we must take care of and encourage our children within the family context.

The Educators:

11. Pastoral work in the educational field must perform the role which belongs to it by sowing Christian values in the minds of the children and young people for which it is responsible. There must be an increase in the campaigns against tobacco use, alcoholism, and the distribution of drugs in

schools. The system of “anti-doping” might perhaps be used to detect drug use early on.

Support and psychological help must be offered to children, adolescents and young people when their emotional problems begin, and in particular when low self-esteem begins to appear. This last is something which is a major factor in bringing about drug abuse.

The promotion of overall health through sport is a safe way by which to remove the temptation of idleness and the decline of adolescents and young people. It encourages, for example, their sense of individual responsibility and their capacity for self-discipline.

12. Teachers should not compensate for, or substitute, parents but must help them and support them. They must learn to act in close co-ordination and union with parents and always provide them with criteria of good and evil founded on authentic personal witness.

13. The educational community must be fully aware of the social networks which envelop them and identify the source points of drug-addiction or drug dealing so that it can promote strategies of prevention. Use must be made of suitable programmes to uproot the curse of drugs in our schools,

The Parishes:

14. Every parish community should engage in the most effective possible rejection of drug dealing and promote solidarity-inspired prevention of drug-addiction in addition to caring for, and securing the rehabilitation of, drug-addicts.

15. The diocesan community must reach deeply into the consciences of drug dealers and remind them of the Christian values of repentance and forgiveness: “Seek the Lord while he may be found, call upon him while he is near; let the wicked forsake his way, and the unrighteous man his thoughts; let him return to the Lord, that he may have mercy on him, and to our God, for he will abundantly pardon.” (Is 55: 6-7).

The Media of Social Communication

16. Those who hold power in the mass media (TV, radio, the press etc.) and decide upon the kinds of information which are

provided by them must make their contribution to liberating humanity, and in particular young people, from the chains of drugs and openly and decisively condemn the trade in death represented by the drug traffic.

17. Audio and visual images and the messages sent out by the mass media should always uphold the value and the dignity of human life. The mass media should not sell themselves by broadcasting ambivalent or subliminal ideas full of praise for drugs and by worshipping idols which young people take to be authentic but which in fact lead to death and the destruction of peace, truth, and real love.

18. We must unite together as



Mexicans to abandon the idolatry of power, of money, of pleasure and of violence. We must commit ourselves to life, to health, to reconciliation, to unity and solidarity like the brothers that we are in this land of Mexico where God has allowed us to live and to belong and where our Lady of Guadalupe has been bountiful with her presence of love and maternal care.

19. We are aware that the problem of drug-addiction in the contemporary scene of our country is connected to a problem which is even greater—that of the drug traffic. The present day situation is made worse by the geographical location of our country because it is an intersection point for the arrival and

transit of drugs which come from other countries and are then sent on to the United States. The violence and the conflict between the “cartels” have transformed Mexico into a place of death and violence which government forces cannot contain both because they have lost control of the situation and because of the complicity in the drug traffic which has corrupted many structures of control. The persecution practised by the drug dealers is another factor behind the deterioration of the situation.

For 1999 and 2000

8.3.2. The Training of Hospital Chaplains

An exemplary form of training which Mexico should imitate is that practised in many dioceses in North America and Europe. Its academic framework could be the future Institute for Pastoral Workers in Health Care. The course will last two years at the end of which a university diploma in pastoral training in health care will be conferred. A Ph.D. programme might also, perhaps, be established.

The preparatory stages: first of all the candidate must overcome the first obligatory phase - a special course of two months involving eight hospital visits. This provides an opportunity for an assessment (from both sides) of capacities, difficulties and inadequacies. If the test gives a positive result the candidate can then go on to the first year. The programme for the first year involves the following areas of study:

1. Theoretical studies: dogmatic theology (the Church and the sacraments) and morality (human life and Christian ethics). Pastoral training: the educational relationship (psychological and historical approaches); the act of catechism; cultures and Christianity.

2. Practical courses in a general hospital (two four-monthly courses) to train people in how to accompany the sick.

3. Theoretical training in pastoral care in the health care field.

4. A personal course with supervisors in pastoral care in the health care field to help in adaptation, follow progress, deal with problems, and tackle the

Pastoral Work in the Health Care Field in Cuba (Pastoral Assistance Without Hospitals)

Introduction

We are aware of the fact that the mission entrusted by Christ to preach the Gospel and to heal the sick (Mk 16:14-18) was also given to the Christians of Cuba whose socio-political conditions differ notably from those to be found in other countries of the world.

The Marxist-Leninist government nationalised health care and offered it free to the whole of the population. This is something the Church applauds even though she thereby lost the opportunity to have her own religious institutions in this sphere—the Church is now responsible for only eight nursing homes for the elderly, all of which are located in Havana. In addition, certain religious orders are present in two government-run health care centres.

The Celebration of the ENEC

During the Cuban National Ecclesial Meeting (ENEC, 1986)—which was devoted to reflecting upon the mission entrusted by Christ to evangelise the world of illness—it was decided to promote to the utmost a path which would be separate and distinct from the world of government—that of the world of voluntary work. It was decided to do this through the religious communities.

The ENEC invited us to: “make the communities aware of the evangelising meaning of the charitable action of the Church and its social significance, and to discover the redemptive value of human suffering so as to accompany in a fraternal spirit all those who suffer” (N. 1074). To achieve this it was necessary to “establish groups of visitors to sick

people within the Christian communities and to give them pastoral orientations which enrich the work that they perform” (N. 1076).

The Establishment of the Episcopal Committee on Pastoral Assistance in the Health Care Field

With the support of the ENEC, the Episcopal Conference decided in favour of organising and promoting pastoral assistance in the health care field throughout the country, and decided to begin by establishing an Episcopal Committee on Pastoral Assistance in the Health Care Field. His Excellency Mons. Mariano Vivanco, the Bishop of Matanzas, was appointed to chair this committee, and to help him in his work an executive secretary was also appointed.

Leading religious figures and activists of every diocese co-operated to establish the Episcopal Committee. During the first meetings of this body a structure was decided upon which would be able to make the whole project possible. It was therefore decided that:

– The Episcopal Committee should be made up of a chairman, an executive secretary and leading religious figures and activists from every diocese.

– The Diocesan Committee should be made up of the person in charge of pastoral assistance in the health care field, his assistant, the bishop vicars of the dioceses, and all those who for professional reasons or because of interest in this area would be able to strengthen the workings and activities of the Committee.

– That every bishop vicar should strive to create a team which would promote activity and initiatives within the areas

and the communities for which he is responsible.

This structure has rendered communication much easier—something which is very difficult to achieve in our country and something which is very important for making sure that things develop well.

The Aims of the Episcopal Committee for Pastoral Assistance in the Health Care Field

The Episcopal Committee set itself the following list of aims:

– To promote pastoral assistance in the health care field within the Christian communities.

– To train voluntary workers, to be called “visitors to the sick,” to carry out this mission.

In matters relating to the whole area of general promotion and encouragement:

– A “Hail Mary of the Sick” has been instituted—an act of devotion which involves reciting a “Hail Mary” for our sick people at 12 o’clock every day.

– In 1986 the “Day of the Sick” was first celebrated through the use of posters, celebrations, and cultural and catechistic initiatives.

– A national drawing competition for children was established on the subject chosen each year for the “Day of the Sick.” The aim here was to encourage children to be aware of the importance of solidarity.

– Periodical publications such as leaflets on the Christian life, brochures etc. have been produced with the slender funds which the Church has available.

In order to help in the training of the visitors to the sick:

– A leaflet with the title “Ten Ideas for Visiting Sick People” has been produced which offers guidance on how

to organise a pastoral meeting in this sphere, what to say to the sick person, how to say it, and so forth.

– Spiritual retreats and meetings on this subject have been organised.

– Cuban and foreign professors have been invited to hold conferences which form a part of courses organised on this subject.

– With the help of the “Cor Unum” Pontifical Council we published in 1990 a small book of prayers for these visitors to the sick. This booklet contains material for pastoral assistance to sick people.

– In 1996 the Pontifical Council for Pastoral Assistance to Health Care Workers, the Ministry of the Vatican, helped us to produce a second corrected and enlarged edition of this small book. The number of copies of this new edition was much higher and this was because we wanted to provide a copy to all visitors to the sick.

The Present Day Situation of Pastoral Assistance in the Health Care Field

This programme of promotion and formation has been kept at a constant level during the ten years in which pastoral assistance in the health care field has been organised as an episcopal level. This has meant that the number of teams has increased to the present 420 and that the number of visitors has grown to 3,761, and more importantly that a mentality has come into being with the result that every community which is well organised in pastoral terms has a team devoted to this area which ensures that sick people do not lack evangelisation and that the Church can be present in the world of pain.

The three official visits made by Cardinal Fiorenzo Angelini when he was President of the Pontifical Council for Pastoral Assistance to Health Care Workers, accompanied by the Secretary of the Pontifical Council, P. José Luis Redrado OH, together with other members of this Ministry

which has supported and promoted our work, have also contributed to the development of our initiatives in this sphere.

The First Catholic Congress on Pastoral Assistance in the Health Care Field

During the ten years of life of this Episcopal Committee and following the growing development of pastoral activity—which meant that during a single month 17,748 sick people were visited—it was realised that there was a need to organise a congress which would utilise our experience in this field to study recent doc-



trinal developments on this subject and to place our pastoral assistance in the health care field within the global pastoral plan towards the year 2000 of the Cuban Church.

Thanks to the support of our Episcopal Conference, of the Pontifical Council for Pastoral Assistance to Health Care Workers of the Vatican, and the Department for Social Pastoral Action of the CELAM, the Congress took place from 13 to 17 October 1997.

The various initiatives described by the dioceses and the very up-to-date doctrine on pastoral assistance in the field of health care outlined by Cuban and foreign experts generated enthusiasm on the pastoral front and lent conviction

to the idea that there can be “pastoral assistance in the health care field without hospitals” (that is to say hospitals that are not the property of the Church) because “Wherever there are people...afflicted by troubles and poor health...Christian charity must seek them out and find them, console them with loving care and provide them with help so that they can rise up and move forward” (AA, 8).

Once again we were able to observe that the Holy Spirit guides the Church down the centuries because in what appears to be a disastrous situation—the loss of the ownership of her medical centres—an effective apostolic instrument has flowered in the world of illness, and more specifically the practice of organising visits to people’s homes.

Perhaps this kind of apostolic action is not very developed in other countries because energies have been devoted to action in favour of health centres or to more serious questions and issues. But we devote all our energies exclusively to the spiritual and human accompanying of sick people, thereby displaying how the Gospel reaches not only patients but their families as well.

Certainly the newness of all this is not to be found in the fact that sick people are visited but rather in the reality of an apostolate which is organised and guided by the Episcopal Conference of the country. The twenty-first meeting of the Episcopal Health Committee well bears out this point.

The pastoral guidelines set out by the Pontifical Council for Pastoral Assistance to Health Care Workers have already been sent out to us and we hope to be able to go on developing our pastoral assistance in the health care field. Our aim is to do this in a way which always follows the light of the Spirit—the safest guide there is for the fulfilment of the mandate bestowed by Christ to preach the Gospel and to heal the sick, and the sick of Cuba as well.

Havana, June 1998

Pastoral Work and Health Care in Chile

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Because of the lack of time which usually characterises these important conferences I would like to send a brief summary which emphasises the most relevant aspects of what we are now doing to develop pastoral work in health care.

I would like first of all to refer to the source of inspiration and the vital and creative experience which I have been able to perceive and recognise as the means by which to become more a man and to look at others with the eyes of compassion, even when the lack of instruments or evasive and destructive behaviour - quite apart from an absence of personal consistency—have prevented me from “being more.” I am referring here to the journey which has always taught me to see every man as a “traveller,” that is to say as being on a journey towards the same destination—Christ, the instrument of authentic humanisation and the icon of man when it comes to the potentialities of all of his vocation.

This is the force which defends us against what is without meaning and which has sustained me in my failures, projecting towards eternity even the most banal and insignificant facts and generating within me that wish for a new life in the face of which the culture of modernity demonstrates itself to be incapable of creating real and good humanity or generating loyalty to the conscience.

The Journey of Care (Mk 6: 56)

As often and forcefully emerges from the pages of the Gospels, within the journey of Christ there is broad space for his “healing ministry.”

The Son of God made man cares for the sick, consoles the afflicted and banishes evil spirits, and for this reason the New Evangelisation is certainly the primary task of the Church—“her grace and proper vocation” as Paul VI declared (E.N.14). But in order to implement it would it not be a good idea to have before our eyes the healing personality of Jesus and the *healing ministry* which accompanied the whole of his life? Is not the journey of contact with sick people a privileged moment through which there passes this power which acts to heal man in his entirety?

The New Evangelisation requires a renewed kind of pastoral work in health care which is an act of obedience to Christ himself and a privileged journey of participation in his ministry of consolation and care.

Pastoral work in health care is an integral, essential, necessary and inescapable part of the salvific mission of the Church. It is not something apart, a kind of optional, or something which should be confined to the activities of an elite. It is obedience to the mandate of Christ and for this reason belongs to the life of the Church and furthermore to her deepest being.

We are certainly dealing here with a journey of vast dimensions. This is so not only because of the quantitative aspect of that journey but also because pastoral action in the health care field has become increasingly difficult, complex and sensitive in character. The reasons for this are numerous and varied. They are not only the result of a decline in the quality of the health system and its failings or because the services which are on offer are not what they

were. The primary cause, rather, is to be located in cultural factors.

Reference should be made in particular to the secularisation present within life and to the thinking which marginalises or censures pain, death and the elderly. One should also think of the implications of ethical problems—of a more serious character than ever before—which now arise in relation to the administration of health care and hospitals: abortions in the maternity wards, contraception, the desire to practice euthanasia, people afflicted by AIDS, and the presence of political and trade union conflict.

It is precisely because this journey has grown larger in such a striking way that the whole of the Church must return to paying attention to contact with sick people. It is necessary to relaunch that pastoral work in health care which is able to generate hope. And this process of generation involves ensuring that pain is not seen as being merely a problem but is perceived as a “mystery” which is illuminated by the light of the cross of Christ. It involves giving strength to those who are sick through the celebration of the sacraments and through prayer—signs which make the Christian a participant in the Easter mystery of Jesus.

It involves awakening awareness of the dignity which comes from man being a living image of God. This is a dignity which cannot be annulled and which man possesses in every condition of his life but which at the moment of apparent “uselessness”—which the context based on criteria of effectiveness so encourages to extremes—needs so clearly to be transmitted as being the

most powerful instrument there is by which to redeem pain.

Lastly, it involves creating a process by which the sick person is seen not as a mere object or receiver but as the first subject, the responsible protagonist of pastoral work in health care, as is made clear by *Christifideles Laici*: "One of the basic objectives of this renewed and intensified pastoral action, which must involve all components of the ecclesial community in a coordinated way, is an attitude which looks upon the sick person, the bearer of a handicap, or the suffering individual, not simply as an *object* of the Church's love and service, but as an *active and responsible participant in the work of evangelization and salvation*" (n. 54).

I would like to describe certain experiences of a national character which have taken place within the field of pastoral action in health care.

In the name of the local Church, "Caritas Chile" opened the first home for seropositive people, the homeless and the abandoned. The discrimination which reigns has not diminished our energy and our commitment to continuing on our journey of welcome. A second home was the object of an arson attack and violent opposition. However, these events enabled us to open up new spaces for hope.

We often visit prisons and hospitals where sick people suffer from the harshest forms of indifference.

Faced with the presence of sick people—an image of the suffering Christ—we have found the energy to build a real clinic for those AIDS victims who are in a terminal condition.

Caritas Chile has been helped by the Faculty of Medicine of the Catholic Pontifical University of Chile and together they have created a new foundation with the name of "Pro Dignitate Hominis"—the only institution of its kind in the whole of Latin America.

Today the "Family Clinic" is a reality. It has forty beds

(the number of an average sized clinic) and is run by voluntary workers supported and helped by four medical doctors from the Faculty of Medicine of the Catholic Pontifical University of Chile thanks to an agreement signed by this faculty and the foundation. We are also helped by the presence of the Religious Congregation of St. Anne and by priests belonging to the Order of the Mother of God.

In this way a climate of spirituality has been born where we also seek to *train young people* for the field of health and health care.

We hope that we will soon be able engage in (bold) alternative initiatives which will extend pastoral work in health care to all the dioceses and in particular to all the parishes in the country.

The National School of Caritas Chile (ENAC), a non-profit making educational institution based on Christian values and principles, acts within the sphere of health and health care to respond to the call of the Catholic Church and contemporary society to train future health care workers as human persons in all their dimensions, and to ensure that they render their profession a "mystic" profession at the service of sick people and thereby offer something which goes beyond their mere work functions or beyond mere effective professional service. To see the sick person in his entirety as a "person" and not only as a patient, to understand his suffering and his emotional difficulties, and to work to ensure that future health care workers have an inner propensity for sincere love for the sick person—such are the aims of this school.

The health section of the National School for Training (Caritas Chile) is continuing its effective work in favour of the training of auxiliary staff, and the qualifications issued by this school are officially recognised by the state. The following categories of such staff are trained by the school:

- Paramedical auxiliaries in nursing
- Paramedical auxiliaries in odontology
- Paramedical auxiliaries in laboratory work, radiology, and the administration of blood banks
- Paramedical auxiliaries in pharmacy

Courses are also taught in:

- The preparation of surgical instruments (here the qualification of auxiliary nurse recognised by the Ministry of Health is required)
- Caring for sick people with a specialisation in births, new born children and the elderly (for women only).

The Voluntary Work Department (DEVOL)

I would like to lay especial emphasis on the role of voluntary work in caring for sick people. Voluntary workers provide service in hospitals, institutes and clinics, as well as in the parishes of the six deaneries in Santiago. These voluntary workers also work in such dioceses as those of San Felipe, Melipilla, and Valparaíso and meet regularly to attend courses, participate in workshops, engage in debate, take part in special retreats, and so forth.

It should be observed that a large proportion of students come from the rural regions of the country or from isolated localities, and that once they have received their diplomas they go back to their home areas to practise their professions. This is something of the very greatest value given that there is a marked lack of personnel in these areas.

Our educational contribution is of fundamental importance for the development of health and health care in our country and involves giving our students the instruments by which they can break the trap of poverty which exists and work to promote and spread the values and principles which are transmitted by our institution.

Santiago, September 1999

The Evangelising Action of Prosacs

PAPER GIVEN BY THE COMMITTEE OF THE NATIONAL ASSOCIATION OF CATHOLIC HEALTH CARE PROFESSIONALS (PROSACS) TO THE CONGRESS ON "THE PASTORAL WORK OF EVANGELISATION" HELD IN MADRID, SEPTEMBER 1997

Introduction

We Catholic health care professionals (Prosacs) are a group of Christian lay faithful who work in the world of health, health care and illness. United by the same faith and vocation, we, as a Church, wish to carry out in this world the mission entrusted to us by Jesus—that is to say to be witnesses to his evangelising, healing and salvific power when we practise our professions.

This congress gives us the opportunity to describe the evangelising experience we have been responsible for during the ten years of our existence.

First of all we will describe the health care world in which Catholic health care professionals work and the challenges and the opportunities which exist when it comes to evangelising action. We will then discuss the features which define our more important and relevant forms of action and our activity. Lastly, after presenting an assessment of what we have done, we will describe our programmes for the future.

1. The World of Health: Challenges and Opportunities for the Evangelising Action of Prosacs

The world of health and health care in which we work is certainly a privileged place, full of challenges and replete with opportunities for evangelisation. In this paper we will discuss some of these challenges and opportunities.

Every day we health care professionals see and touch the most important events of human existence—birth, illness, pain, healing, dying and death. Our constant contact with these realities of life affects us, calls upon us, and offers us an opportunity to mature in human terms and in our faith, or, conversely, to become arid.

We belong to a health care ser-

vice made up of thousands of people all of whom have important and complementary tasks to perform—medical doctors, nurses, administrative staff, auxiliary personnel, social workers, psychologists, and all the rest.

Many of them are Christians but in the main they perform their tasks in this sense in worlds other than that of health care. We have to pay a price for the demonstration of our faith. The environment is very secularised and there are quite a large number of people who have moved away from the faith and distanced themselves from the Church.

The temptation to become disillusioned and demoralised blinds us and we need to make a great effort to avoid becoming victims of these tendencies and to overcome this temptation. We are witnesses to, and builders of, our medical service and our health care but at the same time, however, we experience its failures and failings—things which, indeed, cause us marked suffering.

In our daily working lives we have to face up to serious human, social and ethical problems which are much larger than we are and which reveal important omissions and inadequacies in our training.

In this world of health and health care, with its challenges and its opportunities, Prosacs must preach Jesus, offer the values of the Gospel, serve life, promote overall health, humanise care, call attention to the problems of health care, and encourage solidarity-inspired attention towards those sick people who are the most undefended.

2. The Evangelising Action of Prosacs: What it Means to be a Prosac

The evangelising activity of Prosacs, which will be described later in this paper, expresses, reflects and strengthens our “being” Prosacs. From the outset

we have devoted time and energies to forming and cultivating this “Prosac spirit” by taking this reality into account and by interpreting it first and foremost in the light of the Gospel. Its most important features are as follows:

1. The fact of being a Prosac comes from a personal encounter with Christ and is the fruit of an experience of “being visited.” This experience is a vital process of awareness which makes us aware of the gifts we have received from the Creator so that we can place them at the service of others, and makes clear that being a Christian is the fruit of a gift which is welcomed and lived. In this experience of being visited the Prosac discovers his own personal vocation—to be the living image of Christ as he passed by healing the sick.

The evangelising action of a Prosac is rooted in this experience and bears witness to, or narrates, that experience itself.

2. To be a Prosac involves maturing through a dynamic, progressive and constant process of a relationship with Jesus. This process requires pedagogics, certain points of reference, and certain moments of energising input.

The evangelising action of a Prosac is shaped by this relationship with Christ.

3. To be a Prosac involves being aware of his deep wounds and of those which come to him during the exercise of his profession, and feeling the need for overall healing. In opening up to God and in dialogue with God he experiences forgiveness and disinterested salvation.

The evangelising action of a Prosac is based upon personal dialogue with God the healer who draws near to him.

4. Being a Prosac means knowing how to be an instrument in the hands of the Father at the service of sick people and trying to show to them the face of God through professional skill, nearness and tenderness. At the same time, however, the Prosac dis-

covers the face of Christ in sick people and allows himself to be evangelised by them.

The evangelising action of a Prosac is lived from the starting point of the contemplation of Christ, and service to Christ, in the sick person.

5. Being a Prosac means feeling a special preference for those sick people who are most in need, making a choice in favour of them, and helping them.

The evangelising action of a Prosac reflects this choice in favour of those most in need.

6. Being a Prosac involves feeling that you are the Church, being co-responsible for her mission, and being responsible towards the tasks which belong to you as a member of the lay faithful, that is to say the humanisation of care and the defence of human rights.

The evangelising action of a Prosac involves the fostering of both responsibility and co-responsibility in equal measure.

3. The Evangelising Action of a Prosac: His Most Important Forms of Activity

Our evangelising action is promoted through certain distinct forms of activity. We will now outline those which we consider the most important and relevant. Some of them involve the creation of groups of Prosacs and their training; others are to do with the role Prosacs play in their work environment, in society, and in the Church.

1. The Witness Borne by each Prosac in the Practice of his Profession

This subject is discussed first of all because for us it is the most significant and valuable. Our other forms of activity seek to stimulate, support and celebrate this particular responsibility. This is not the place to describe the witness borne by each Prosac in his daily work and activity, nor would it be easy to engage in such a description. We would like, here, merely to observe that a certain number of us—according to our capacities—have taken part, and take part, in the creation and the activities of ethical committees, boards responsible for overseeing the purchase and use of equipment, hospital and other types of health care committees, etc.; co-operate in the dialogue

between faith and science in the field of biology and medical science; and strive to diffuse a culture of health based upon the values of the Gospel through public declarations, publications, policy statements and so forth.

2. National Days of Christian Health Care Professionals

These days constitute an area where Prosacs have the opportunity to meet each other, celebrate their faith, study various topics, share experiences and knowledge about professional work, and plan future actions. We began in 1987 and since that date we have celebrated ten such national days of Christian health care professionals. The topic to be studied for each such day has been the same as that chosen for the world days of the sick, and more specifically: the humanisation of care (1987), the sick who are most in need and least looked after (1988), the family of the sick person (1989), Prosacs and the community (1990), professionals and health (1991), professionals and health care (1992), professionals and the process of dying (1993), the health of professionals (1994), professionals and suffering (1995), professionals and care for sick elderly people (1997).

These days have worked to unite the Prosacs of Spain and to create and strengthen the "Prosac spirit."

At the present time these national days are celebrated every two years. Inter-diocesan days designed to support and promote care have already begun and have already met with notable success.

3. Seminars on Bioethics

Since 1989 we have held a seminar on the controversial question of bioethics. These are held either every year or every two years. The subject to be discussed at these seminars is chosen during our national days. The National Prosac Committee works with the bioethical bodies within the Church to define the aims, the contents, the methodology and the research of each seminar and informs those taking part about these aspects. The seminars take place within the dioceses and the conclusions reached are made known during the national days. The topics discussed by these seminars have been the following: euthanasia and helping people to die a good

death, professional secrecy and the right to privacy, the ethics of the quality of life, the ethical aspects of AIDS, the quality of care and the ethics of the responsibility of the professional, the ethical and pastoral aspects of suffering, the ethics of the distribution of limited resources in health care, and informing the patient and informed consent.

These seminars have been an excellent way by which to create new awareness, sensitivity and concern in the field of bioethics, to stimulate and promote our training, and to open forums for study and dialogue on these topics. They have also enabled Prosacs to make their own specific contribution to this controversial area.

The conclusions reached by these seminars on the subject of euthanasia have formed the basis for the "plan of action on euthanasia and helping the good death" which was approved by the Spanish Episcopal Conference. This plan has involved the publication of a "testament to life" whose circulation and impact both inside and outside Spain have been very marked. More than a million copies have been distributed and the work has been translated into a number of languages.

4. The Creation of the Association of Christian Health Care Professionals

In 1983 we took an important step forwards, namely the creation of the Association of Christian Health Care Professionals whose rules and regulations were approved by the LX plenary assembly of the Spanish Episcopal Conference. This is an association made up of Christian laymen and laywomen whose chief goal is to promote the evangelisation of health care professionals. The association is inter-professional in that its membership is made up of medical doctors, nurses, clinical auxiliary workers, administrative personnel, and all the professional categories which work in the field of health care and serve the sick. The association is closely linked to pastoral assistance in the health care field, to its programmes, and to its diocesan, inter-diocesan and national organisations and associations.

5. The Diocesan Representatives of Prosacs

Once the Association had been approved we decided to help and

support the diocesan representatives of Prosacs in their mission of supporting, encouraging and co-ordinating Christian health care professionals in their dioceses. We began annual meetings with them and established a relationship with them based on circulars and periodic visits. These meetings have enabled us to clarify our identity, deepen our spirituality, and create local Prosac groups.

6. *The Prosac Bulletin*

In 1996 we began the publication of our Prosac bulletin. This was a simple way by which we could spread our experiences, explore what we are as Prosacs, share the witness of our lives, communicate our activities and projects, express our point of view on subjects and practical situations which are of interest to us, and become familiar with the books and documents which are important for our training.

7. *The Activities of Local Prosac Groups*

Local groups and the relative diocesan committees are the essential instruments for Prosacs. In these groups Christian health care professionals become aware of their identity and cultivate their spirituality, pray, celebrate their faith at the table of the Word and the eucharist, and shape, plan and revise their activity.

The following is a list of the activities of these diocesan Prosac groups all of which well bear out the vitality of these groups:

Relating to the Humanisation of Care

– The establishment and activity of the “Group for Humanisation” in the university hospital of the Virgin of Macarena organised by the Prosacs of Seville.

– The organisation of four days of humanisation in the “Architect Marcide” hospital promoted by the Prosacs of Mondoñedo-Ferrol.

– Courses of help for sick people in the hospital complex “Cristal-Piñor” organised by the Prosacs of Orense.

Involving Sick People most in Need: AIDS Patients, the Terminally Ill, Prisoners...

– A study of the attitudes of nursing students towards AIDS

victims promoted by the Prosacs of La Coruña.

– The establishment of the citizens’ anti-AIDS committee of Lleida and a centre for AIDS victims promoted by the Prosacs of Lleida and Logroño.

– The participation of Prosacs in the citizens’ anti-AIDS committee of Alicante.

– The creation and administration of a hospice on the American model in the sixth Vicariat of Madrid organised by the Prosacs of Madrid.

– The publication of books on the subject of “living with difficulty” (the Prosacs of Seville), “the terminally ill and health care professionals” (the Prosacs of Barcelona), “care at home for the terminally ill. A handbook for voluntary workers and family members” (the Prosacs of Madrid).

– An inquiry into the subject of “living death” conducted amongst 5,000 health care professionals and the drawing up of the rights of the terminally ill. Barcelona.

– Work with sick people from prisons at the “San Millán” hospital organised by the Prosacs of Logroño.

In the Field of Bioethical Questions and Problems

– An initiative promoted by the Prosacs of Madrid about the legal provisions concerning conscientious objection to abortion.

– Christian ethics and bioethics—shared and divergent features. A training programme for the mobile team of Prosacs in Madrid.

– The identification of the principal ethical dilemmas encountered in the emergency department of the Arnau hospital in Vilanova organised by the Prosacs of Lleida.

– The drawing up of a protocol of information for the parents of premature children by the Prosacs of Orense.

Involving Pastoral Assistance in the Health Care Field

– Celebration of the world day of the sick.

– The creation and promotion of parish groups dedicated to pastoral assistance in the health care field.

– Participation at both a preparatory level, and during the actual event itself, at the conference on “Church and Health” (1994).

4. **An Assessment of What has been Done and Our Plans for the Future**

We have only existed for ten years. Our journey together has brought out who we are, what our identity is, what we are and what we want to be in the future. The Prosac spirit has grown stronger and many health care professionals have discovered in that spirit a meaning to their lives and to the practice of their profession. The reading of the Gospels, beginning with our specific reality and experience, has been a source of life and inspiration for our work and activity. We now know through experience that it is possible to transform the world of health and health care from within through living out the values of the kingdom of heaven. An inter-disciplinary approach in our organisation and our activities has helped us to feel and act as a Church and has made our evangelising action more effective. We have discovered the pastoral and communitarian dimension to our faith.

At the general assembly of the association which was held in March in Tarragona the plan of action for the years 1997-2000 was approved. Our activities will involve the following set of goals:

1. To strengthen the association as a means by which to live and preach the Good News of Christ—that is to say health and salvation for the whole of mankind—in the world of health and health care.

2. To promote and facilitate the integral and integrating training of Prosacs through a plan of general training which looks to the personal growth of individual members and to that of the group as a whole.

3. To strengthen and develop our commitment to those sick people who are most in need.

Three pilgrimages will help us to celebrate the Jubilee of the year 2000—the pilgrimage to the Holy Land (1998), the pilgrimage to Santiago (1999) where we will celebrate the eleventh national day, and the pilgrimage to Rome (2000) where we will take part in the World Congress of Catholic Doctors.

We hope that these and other initiatives will act as a strong stimulus to us to be witnesses to Christ in the world of health, health care and illness.

Pastoral care in the “Aita Menni” Psychiatric Hospital of Mondragon, Spain, 1992-1995

1. Introduction

The aim of this paper is to inform you briefly about the experience of pastoral work carried out by us in our psychiatric hospital through our programme of “Pastoral Assistance in Health Care and Humanisation” (PSU).

The “Aita Menni” psychiatric hospital is a private non-profit making organisation which belongs to the Congregation of the Hospital Sisters of the Sacred Heart of Jesus and works with the Basque “Salud-Osakidetza” service.

The number of patients who have been admitted to this hospital is 513 and they have been admitted according to the clinical areas to which they belong—psychogeriatrics, long stay, mental retardation, medium stay, and patients belonging to the reintegration programme.

The psychiatric hospital also has a day hospital with 25 rooms, a cerebrolesis unit with 17 beds, and six residences within the community where 21 people have their homes.

The existence of a PSU service in our hospital is based upon:

1. A religious-humanistic culture which comes from its own traditions.
2. An attempt to offer overall care and assistance to its patients.
3. The right of patients to religious care and guidance.

2. The Aims and Organisation of the Service of Pastoral Care and Humanisation

The PSU service came into being in the third quarter of 1989 in order to promote a series of programmes and initiatives with two directions:

1. To develop and intensify

the work of humanisation of therapeutic and hospital care in order to bring about a greater dignity and quality of life for the mentally ill.

2. To promote pastoral work aimed at the development of, and concern for, the religious experience of patients, and to strengthen the contents of the Christian humanistic ethics of our hospital culture throughout the life of our centre.

Before that date (October 1989) the chaplain and the catechism sister, with the help of voluntary workers, were responsible for the spiritual life of the patients and the liturgical life of the hospital, even though this activity was neither organised nor built into the structure and programming of the hospital.

The activity of this service during subsequent years was strengthened by the incorporation in 1991-1995 of various kinds of workers, who, together with the chaplain, dedicated a part or the whole of their working hours to aspects of pastoral work and humanisation.

One element greatly changed the character of this service in terms of its working and its role within the hospital—the analysis of the pastoral situation which was carried out at the end of 1991 after 32 workers from various areas had been interviewed. This analysis helped us to decide the criteria which would lie behind the first planning of activity—something which took place in January 1992. These criteria referred both to the organisation of the service in the life of the hospital and to its implementation and its expressions in the various clinical areas, and in doing this the special features of the patients were taken into account.

Since 1992 the organisation of this service in the hospital

has involved the following:

- The service is directly supervised by the management of the hospital.

- The management of the service is in the hands of the pastoral health care and humanisation group which sees itself as an apostolic brotherhood of believers who share faith and a mission. The group is presently made up of six people—the director of the service, the chaplain of the hospital, the superior of the community of nuns and three pastoral workers. The functions of this group are as follows:

1. To programme every year the group’s objectives and policies of action.
2. To direct, foster and supervise the various activities of the service.
3. To distribute the functions and the performance of tasks amongst the pastoral workers.
4. To assess and revise the work which is carried out both periodically and at the end of the year.

The preparation and implementation of activity is in the hands of the six pastoral workers of the service. The dedication of human resources to the service has been progressive and proportionate to the increase in the offer of activity which has taken place in the hospital. The increase grew by about one person every year from 1992 to 1995.

Until 1992 the service involved only one person (in addition to the chaplain) who dedicated himself exclusively to pastoral work. In 1992 the service could rely upon two people (the chaplain and a pastoral worker) working full time and another person working part time, in addition to the members of the group, who, however, were not involved directly in pastoral work. In

1994 another person was appointed part time (making 3). This person increased his workload and came to work full time in 1995 (making 3.5). In that year another pastoral worker was added (making 4.5).

– The PSU service integrates and co-ordinates its activities with the rest of the therapeutic and care activities in the hospital through participation in the therapeutic teams of the various clinical areas.

3. The Basic Assumptions and Criteria of the Pastoral Action Carried out in the “Aita Menni” Hospital

Every pastoral initiative begins from certain basic theoretical assumptions (of a theological and/or anthropological character) which define both the form and the contents of the message which is proclaimed through such activity. In our case the assumptions fall into two categories:

3.1. Assumptions Derived from the Overall Mission of the Hospital

The “Aita Menni” hospital is a centre where the mission of the Congregation of Hospital Sisters of the Sacred Heart of Jesus is activated and sees itself in an overall sense as a Samaritan service of care and concern for the mentally ill. This approach is reflected in the values which shape its character as an undertaking and which are adopted by all the services and workers of the hospital and thus also by the pastoral workers such as ourselves. These values are as follows:

1. A religious-humanistic culture which directs the action of its workers.

2. A humanised form of psychiatry at the service of the greatest quality of life for the mentally ill person.

3. A mission of service open to the socio-cultural and ecclesial community to which it belongs.

4. A commitment to improved technical and technological quality.

5. A positive appreciation of the personality of the workers in the centre accompanied by an attempt to promote their ongoing training and professional advancement.

6. A commitment to working as a group.

3.2. Assumptions of the Action Performed by the Service in Recent Years

From its inception, the pastoral group of the centre has embraced four simple basic criteria which it has tried to bear in mind in the growth and the development of its service



and in the pastoral action which it has promoted. These criteria are as follows:

1. The belief that the mentally ill, like all human beings, have a transcendent dimension which requires complete and “quality” care. To advance this care we believe that one should utilise suitable and sufficient resources which correspond to the special features of their religiosity and their personal capacities. In doing this we should make every effort to adapt the Good News of the salvation to their capacities and to their special characteristics as mentally ill people.

2. The belief that the pastoral work which is practised in a health care context must adopt the first principle of the practice of medicine—“*primum non*

nocere” (first of all, cause no harm) which in our case would be: first of all do not increase the level of pathology or of suffering of the patients. We are aware that we can cause harm when we increase their sense of guilt and anxiety if we begin from a concept of God which sees Him as suspicious and punishing, when we increase the loss of the principle of reality in our patients, or when we diminish their capacity to be independent and to take decisions through the employment of dubious moral norms.

3. An attempt to promote pastoral action which is humanising and thus “healing”, which reawakens in patients their energies by which to combat illness, and helps them to find serenity and peace through the discovery that their own human reality is greater than the illness which afflicts them. This criterion is suggested by our charism of welcome which strives to bring to people a compassionate and feeling God who welcomes unconditionally and saves by humanising.

4. With regard to the independence of our patients, it may be said that this can be great or small according to their levels of ability. However, our policy in this sphere is based on an attitude of respect for the values and the religiosity of the patients themselves. Starting from this criterion, we have striven to produce a varied offer of activities which operates at different levels—levels which are different from each other in complexity and difficulty, different religious typologies, and space-time adaptation, etc.

4. Programmes and Initiatives Carried out by the Service of Health Care Pastoral Work and Humanisation

The pastoral initiatives and activities of humanisation which the SPSU has engaged in over these years have respected the annual plans which have been produced specially for each year. These plans have

been drawn up on the basis of:

1. The analysis carried out after the assessment of the plan of the previous year.

2. The orientations suggested both by the national and local Church and by the hospital congregation concerning pastoral work in the health care field.

3. The annual management plan of the hospital.

The pastoral activity which has been organised over these years in our hospital may be classified under three major headings:

4.1. Personalised Religious Care for each Patient

4.1.1. *Individual care.* Before 1991 personalised religious care for patients was carried out almost exclusively by the chaplain and certain nuns who visited the various wards of the hospital and in particular the psychogeriatric ward. This care was based upon the sacraments of the anointing of the sick and penitence, and the accompanying of dying patients.

At the present time there is a daily timetable of individual care administered by the chaplain and relates to which concerns and his presence in the various wards and rooms of those patients who are the most afflicted. At the same time the various areas have been allocated to the pastoral workers so that they can dedicate a part of their time to being present in the daily routine of the wards. There is also a weekly timetable of individual confessions for those patients who wish to engage in this sacrament.

4.1.2. *Weekly groups*

In 1992, with the adherence to the service of a full time pastoral worker and the allocation of the members of the service to the therapeutic groups of the various areas, group activity was established with certain patients on a weekly basis. This activity sought to follow, promote and secure the experience and the expression of the religious-spiritual dimension of the patients. The aims, the contents and the methodology of each group were based upon the

characteristics, capacities and religious culture of the participating patients.

In 1992 68 patients were followed in seven weekly groups. In 1993 there were fourteen groups in which on average 99 patients took part. In 1994 127 patients took part in sixteen groups, and in 1995 there were nineteen weekly groups composed of 130 patients.

4.1.3. *Annual Holidays*

In all the clinical areas of the hospital an annual holiday takes place which involves certain celebrations and activities of a religious character.



Since 1992 both staff and patients have taken part in the preparations for this holiday and in the actual event itself.

4.1.4. *Activity in the Area of Psychogeriatrics*

In this area (which has 174 patients) a series of special activities have been promoted:

a) A monthly eucharist in the open areas of this section where the patients who cannot take part in the general masses of the hospital can participate;

b) A community anointing of the sick in groups of 15-20 patients. This takes place after the meaning of this sacrament has been explained to every group and after each patient has been asked whether he or she wants to receive it.

4.1.5. *Care for Terminally Ill Patients*

Since 1993 the service has

had a person, who, after undergoing a course of special training, proceeds to dedicate a part of his day to caring for patients who are terminally ill both in the hospital and in other health care centres where patients can be admitted because of a deterioration of their condition. This person also dedicates a part of his time to religious care for the patients, and to their family relatives when the death of the patient occurs.

4.2. *General Activity in Favour of the Patients*

Before 1990 general activity was limited essentially to the celebration of the eucharist in line with the liturgical calendar. In 1990 a liturgy group grew out of the people who worked in the pastoral group, and this former group began to plan the participation of patients in the preparations for the services. In the same way celebrations of the hospital community such as "the day of the sick" and "meetings with relatives" have also been established and promoted.

Since 1992 every year has witnessed the planning of a calendar of general activities for patients. Its fundamental objective has been to offer various forms of activity which every believer can come across in his ecclesial community of reference and which meet the need for training, deal with how to live the liturgical year, provide community experience at the level of services, and so forth. To this end the following activities have been organised:

– Two or three annual cycles of dissertations and documentaries on various religious and ethical subjects and topics.

– One training meeting of prayer each month since 1993 with an average participation of 100 patients.

– Activity suitable to each part of the liturgical year: Via Crucis and spiritual exercises during Lent, solidarity work at Christmas...

– Excursions and trips with the goal of promoting knowl-

edge about important religious locations or communities. On average four excursions and five short trips have been organised every year.

– The celebration of the sacraments independently of the general liturgical calendar—daily masses, Sunday and feast day masses, the celebration of community penitence at moments of major liturgical significance, etc.

One of the objectives of the programmes of these years has been to promote the **co-responsibility** of patients in pastoral work. The level of participation of patients in the organisation and in the run-up to these forms of activity—and above all else liturgical activity—has grown from year to year. At the present time we can affirm that in all liturgical activity (whether daily or festive) we can count on the participation of the patients. There is also a liturgy group made up of patients who engage in the preparations for certain aspects or parts of religious services in a systematic fashion.

4.3. *Religious Activities Organised for the Whole of the Hospital Community*

A clear objective of the “Aita Menni” hospital project is to develop a sense of hospital community in all those who take part in it—patients, their families, the hospital nuns and other professionals who work in the hospital. It is for this reason that the liturgical services and celebrations organised by the PSU service try to obtain the maximum participation of everyone concerned both in their preparation and in their actual expression. This is so that they can become an authentic Christian celebration of our life, our suffering, our commitment, our work, our hope, our faith and our mission.

The service organises sixteen general celebrations each year. The following deserve special mention: the day of the sick, the annual feast of the Blessed Menni, meetings with families, a New Year party, the day of the departed, the celebration of Christmas Eve, etc.

4.4. *Other Initiatives of the Service of Health Care Pastoral Work and Humanisation*

Because of a lack of time and space it is impossible to describe all the activities which the service provides in areas which are not strictly pastoral in character. We would, however, like to mention the most important:

– Participation in, and co-operation with, the pastoral activities and pastoral structures of our ecclesial community of reference, namely the local Church and the Congregation of Hospital Sisters.

– The planning of training activity for its members and their participation in various external courses.

– The organisation of voluntary work.

– Helping with courses and training programmes of the hospital workers on subjects to do with organisation and bioethics.

PEDRO FDEZ. DE LARRINOA
M. CARMEN MARTÍN
M. JESÚS GOIKOETXEA



Activity of the Pontifical Council



*Congress on Consecrated
Women in the World of Health
on the Threshold of the
Third Millennium*

•

*XIX Congress of the
International Federation
of Catholic Medical
Associations (FIAMC)*

•

*International Congress
of Catholic Nurses
(CICIAMS)*

Congress on Consecrated Women in the World of Health on the Threshold of the Third Millennium

I. Greeting of Monsignor Lozano Barragán to the Holy Father at the Audience Granted to the Religious

Most Blessed Father,
replying to the wish expressed last February by Your Holiness to the Pontifical Council for Pastoral Assistance to Health Care Workers, we are now preparing to celebrate the congress on consecrated women in the world of health on the threshold of the third millennium.

The congress has been prepared by these same female religious with the help of the Pontifical Council. We thought that we would interpret the thought of Your Holiness with greater loyalty if the participants and the protagonists of the congress were the female religious who dedicate themselves to pastoral care, and not other groups of people.

In order to make our congress effective the days will always begin with a celebration of the eucharist which will thus be the focal point of all our activity.

Always bearing in mind that the Lord is at

the centre of everything, we have organised our work in four parts: the first sets out the basic model by which the female religious should carry out pastoral care in health; the second compares this model with the actual reality of the approximately 350,000 female religious who are engaged in this ecclesial mission in the five continents; the third part illuminates this reality with the word of God to confirm options, clarify obscure points and open up new horizons; we will conclude the congress with the fourth part when the most urgent policies for action will be emphasised and especial stress will be placed upon the importance of the union of the female religious who work in hospitals as a constitutive element of their ecclesial existence.

We thank Your Holiness deeply for having had the goodness to receive us and we await your august words with joy.

II. You are the Heart and Hands of Christ. Holy Father to Nursing Sisters

Dear Sisters,

1. It is a joy for me to be able to meet you during this congress dedicated to reflecting on *"The Consecrated Woman in the World of Health on the Threshold of the Third Millennium."* I extend a special thanks to the Pontifical Council for the Pastoral Assistance to Health Care Workers, which, in response to my wish, has organized this timely initiative and included it in its programme of preparation for the forthcoming *Jubilee*. I affectionately greet all of you present here, with a special thought for the President of the Pontifical Council for Pastoral Assistance to Health Care Workers, Archbishop Javier Lozano Barragán, whom I thank for his cordial words.

In watchful expectation of the new millen-

nium, you wish to reflect deeply on your mission to serve the suffering, by focusing more intently on Christ to draw from him the inspiration, courage and ability to be totally dedicated to those who critically experience the limitations of the human condition. Indeed, you know that what you do for the suffering acquires meaning and effectiveness insofar as your work is guided by the Holy Spirit and reflects the distinctive features of the *divine Samaritan of souls and bodies*.

The Church looks with admiration and gratitude to you, consecrated women, who, by caring for the sick and the suffering, are involved in an apostolate that is more important than ever. Your service helps to prolong in time the ministry of mercy carried out by Christ who "went about doing good and healing all" (Act. 10:38). A great number of

your sisters, down the centuries, “*have given their lives* in service to victims of contagious diseases, confirming the truth that dedication to the point of heroism belongs to the prophetic nature of the consecrated life” (*Vita consecrata*, n. 83). The loving dedication which urges you to assist the Lord’s suffering members confers a nobility on your apostolate which escapes neither God’s eyes nor human consideration.

Changes in health care call for a Christian response

2. Like the sisters who have gone before you, you too are called to adapt your care of the sick to the changing conditions of the times. Today in fact, the health-care structures in which you work are confronting you with rapid changes and unprecedented challenges. If, on the one hand, the progress of science and technology and the growth of the administrative disciplines have opened up new opportunities to the practice of medicine and the distribution of care, on the other, they have not failed to create serious ethical problems concerning birth, death and relations with the suffering. From the anthropological standpoint, if progress in the concept of health and sickness has advanced positively to the point that it recognizes the spiritual dimension of these existential experiences, this does not alter the fact that a secularized concept of health and sickness is spreading in many areas, with the sad result that people are prevented from experiencing their time of suffering as an important opportunity for human and spiritual growth.

These profound changes have altered the face of the world of suffering and health and call for a new Christian response. How can we harmonize technical and ethical imperatives? How can we triumph over the tendency to indifference, the lack of compassion, respect and appreciation of life in all its phases? How can we promote health that is humanly worthy? How can we provide a Christian presence which, in collaboration with the good elements already present in society, will help spread in the world of suffering and health authentic, human values based on the Gospel, which give priority to the defence and support of the young and the poor?

These questions express as many challenges, which you and the whole Ecclesial Community are called to answer.

3. The first task of your consecrated life in the joyous and engaging experience of

Christ is to remind the People of God and the world of the Lord’s merciful face. Before the power of your charism can shine in your work and service goals, it must be resplendent in a newness of life that reproduces Jesus’ distinctive features. Is it not true that the Church needs consecrated men and women who, through their persons and their lives, manifest the fruitful motherhood that distinguishes her? Now, the Church’s fruitfulness is not dependent on the efficiency of her work, but on the authenticity of your dedication to Christ crucified.

Your entire life as consecrated women must therefore be imbued with God’s friendship, so that you can be *the heart and hands* of Christ for the sick, thus revealing that faith which enables you to recognize the Lord himself in the sick and becomes the well-spring of your spirituality.

You must be faithful and innovative in your apostolates

4. Secondly, your presence in the world of suffering and health must express the richness of your feminine nature. It is undeniable, in fact, that women’s vocation to motherhood makes you more sensitive to others’ needs and talented in giving an appropriate response. When in addition to these natural gifts there is a conscious attitude of altruism and, especially, the power of faith and Gospel love, then true miracles of dedication are performed. The most important expressions of love—sensitivity, gentleness, gratitude, sacrifice, concern and the generous gift of self to the suffering—bear witness to the love of a God who is close, merciful and ever faithful. A hero of charity to the sick, Camillus de Lellis, invited people to ask the Lord first for the grace of *motherly affection* for one’s neighbour, in order to serve the sick with that loving care which a mother devotes to her only child when sick.

5. Awareness of the mission to which you are called of serving the sick and promoting health must spur, you, dear sisters, to be faithful and innovative in exercising your apostolate of merciful love.

Far from clashing, these two attitudes—fidelity and creativity—must be harmonized through wise discernment. Just as barricading yourselves in outmoded positions would be contrary to the spirit of your founders and foundresses, so too abandoning, without necessary study, apostolates that have become difficult because of current sociocul-

tural conditions would be just as opposed to the charisms of your institutes. For this reason, dear sisters, I invite you to remain faithfully at the side of those suffering in hospitals and other health care institutions, invigorating your care of the sick with Gospel spirit.

May your decisions always give priority to care for the sick who are most neglected. May your vision and your work be generously extended to Third World countries deprived of the most basic resources for dealing with sickness and promoting health. May your participation in the new evangelization about health and sickness be expressed in a courageous proclamation of Christ, who by his Death and Resurrection enabled man to transform the experience of suffering into a moment of grace for himself and for others (cf. *Salvifici doloris*, nn. 25-27). May collab-

oration with the laity, based on an authentic sharing in your charisms, become an effective way to respond, in words and deeds inspired by the Gospel, to the old and new forms of poverty and disease which afflict the society of our time.

6. In carrying out your apostolate, may the Immaculate Virgin, revered as *Health of the Sick*, be an example to you. An image of God's tenderness, she shows herself attentive to the needs of others, loving in her response to them and rich in compassion. Looking to her, always strive to be deeply sensitive, ready to make your presence a witness of tenderness and self-giving that reflects the provident goodness of God.

With these wishes, I cordially impart my Blessing to you, and willingly extend it to all the sisters of your congregations.



III. You Must be the News of the Infinite Compassion of God

*GREETING AND INTRODUCTION BY H.E. MONS. JAVIER LOZANO BARRAGÁN,
PRESIDENT OF THE PONTIFICAL COUNCIL
FOR PASTORAL ASSISTANCE TO HEALTH CARE WORKERS*

I give a cordial greeting and welcome to all of you, religious and women consecrated to the ministry of health. May the Holy Spirit, to whom we direct this meeting during the year dedicated to Him, give us the light so that the charisms which He has given us in the field of pastoral care in health may shine with greater intensity on the work of this congress.

On 14 February of this year His Holiness John Paul II entrusted the Pontifical Council for Pastoral Assistance to Health Care Workers with the task of gathering together in his name the female religious and women consecrated to pastoral care in health in order to pray and to study together the great charism which the Spirit has bestowed upon them. The Pope affirms that it is comforting to observe that today many women are dedicated to the medical and paramedical professions, that they know how to unite with their necessary professional skill and expertise marked talents of generosity, a practical sense, intuition and tenderness, and that they often have a special talent for the most sensitive and human aspects of a mission which is very demanding. He says that in illness, when the human being is especially fragile and in need, the vocation of the woman to motherhood makes her particularly sensitive to such needs and outstanding in providing a suitable answer. This is especially the case when to such natural gifts are added an aware approach of altruism and above all the strength of faith and evangelical charity. In such a context there takes place the real and authentic miracle of the dedication of these women who have become angels of consolation for innumerable patients.

The Pope wants to thank the women who work next to children, to the suffering and to elderly people within the family, in the wards of hospitals, in the clinics of the missions, and in so many public and private institutions. In this world where there continues to be so much poverty and marginalisation—and this despite scientific and technological advance—we really need, observes the Pope, a support from the soul and in this the women consecrated to the service of the sick are to be found in the front line.¹

Such is the reason behind this congress—to express to you all the gratitude of the Pope and at the same time to make a pressing appeal to you to carry out your mission ever more effectively.

It is certain that the female religious who is engaged in nursing must today enter the social-medical world, acquire the necessary qualifications, know the laws of the profession, engage in loyal co-operation within a context of total integration and of witness to poverty, in brotherhood with all those who work in the same field, and express everything with a language of signs which is most suitable to the health care environment. She thus realises in the world her mission of health and salvation, and by eliminating suffering she evangelises and becomes an instrument by which to beat back evil, fight against sin in favour of life, and form the Kingdom of God.²

Her consecration through vows strengthens and acts to fully realise the characteristic aspect of her femininity. Through her charity, sensitivity, meekness, gratitude, sacrifice, concern and dedication towards those who suffer, the female religious in the world of health care bears witness to

the presence of an always near and loyal God who generates life, transmits it, and cares for it, beginning with an intense inner life, with an always forceful and profound prayer, with a real spirit of sacrifice and rejection of the mentality of the world, immersing her charism and loyalty in the Gospels, in the unity of hearts and the generosity of witness.

She is the witness of the virginal love which far from excluding is directed towards all men and women in situations of marked marginalisation, inequality, and poverty. She is a witness to the strength of her mission even when the danger of apparent ineffectiveness might lead her to abandon or flee from a hostile environment. She is a witness to the audacity of her mission - to be in a place which presents difficulties for other people. The female religious involved in the world of health must continue to be the image of God the compassionate Father in the world of pain. She must be the news of His infinite compassion.³

It is precisely in order to renew this valuable charism that we have organised this meeting, responding thereby to the wish expressed by the Pope. We wanted the female religious themselves to be responsible for the congress so that in being bearers of the charism of the Spirit they could be a light for their sisters which will guide them in their noble mission.

Let us begin looking upwards, towards the vocation to which the female religious is called—what is the model she should base herself upon? The raw reality which is experienced is in contrast with this model. What is the situation of the approximately 350,000 female religious and consecrated women who dedicate them-

selves to pastoral care in health in the various regions of the five continents? This will be the subject which will be discussed during the second part of the congress.

This reality must be illuminated and shaped by the Word of God—in what ways does the Word of God illuminate this situation? How should we answer the various questions which it poses? How can we clarify the less illuminated areas? How should we proceed? This will be the subject discussed in the third part of our congress, or to put it more succinctly: the encounter between the Word of God and the concrete reality that we experience.

However, this meeting will not be only of an oral character. It must express itself in facts and for this reason the fourth part of the congress will deal with the following questions: which approaches should we examine more deeply in our service, which should we correct, and which are the new routes that we should take at the beginning of the third millennium? How do

we locate ourselves within the Church which is communion? The common denominator of our future is the union of all the female religious and women who are consecrated to pastoral care in health, and therefore we pose ourselves the following question: what must we do, and how, to be more effectively united than in the past, and thereby carry out together those actions which we are called upon to perform?

The Word of God achieves its greatest force and presence in the Eucharist. We therefore will begin our sessions with the Holy Mass. It is from the sacramental force of the memory of the Christ who died and rose again that our charisms take on life and make Easter shine forth. Everything that we think and everything that we share becomes real and concrete in the Eucharist. For this reason the central point of our congress will be the eucharistic liturgy which we will rightly celebrate at the altar of the Cathedral of St. Peter's, and this will be done in order to bear witness to the primatial

apostolicity of the Word of God which has brought us together following, as has already been observed, the explicit wishes of the Holy Father.

May Mary "Salus Infirmorum" extend her protective mantle over our deliberations and draw us near to her maternal care especially when we strive to be present with Christ in those who suffer and in the least of our brethren!

+ JAVIER LOZANO
BARRAGÁN

*Archbishop-Bishop Emeritus
of Zacatecas,
President of the Pontifical Council
for Pastoral Assistance to Health
Care Workers.*

Notes

¹ Cf JOHN PAUL II, *Angelus*, 13 August 1995.

² Cf TILLARD, *El Mundo sin ser del Mundo* (Sal Terrae, Santander, 1991), p. 126.

³ Cf TERESA LOPEZ BEORLEGUI, 'Le Religiose Sanitarie e la Loro Missione del Campo della Salute', in Pontifical Council for Pastoral Assistance to Health Care Workers, *Curate Infirmos e la Vita Consacrata* (Vatican City, 1994), pp. 95-110.



IV. A Congress in the Feminine Style

From the outset it was thought that the protagonists of this congress should be the female religious, and such indeed has been the case. Together with the Pontifical Council they have prepared the contents and the dynamics of the congress; they have organised the papers which have been given and have described their experiences: what the model for their presence should be, what the reality which they are living actually is, how we should preach and evangelise today, how the charisms of care should be encouraged, how we should unite our forces—such have been the central contents. In addition, certain pastoral experiences have been described: the accompanying of the terminally ill, those afflicted by AIDS, psychiatry, the parish-es...

We have been through strong days which have been rich, intense and full of emotion. 400 female religious of the health care world from 44 nations were present from 140 religious congregations. "A small army" representative of the approximately 350,000 female religious which it is estimated work in the health care world.

We have seen the whole of this army photographed in the papers given and the experiences described, in the constant,

fluid, rich, interesting dialogue which has been full of life, and this is because the female religious in the health care world actually lives the reality of life. For this reason her contribution has been very concrete and forceful. In the phrases used and the dialogues conducted we have perceived much tenderness, much responsibility, much desire to be up-to-date, a great deal of heart, and a great deal of life. As a result, in a spontaneous fashion the meaning of life, of pain, of suffering, and of the dignity of man have been touched upon; and the same may be said of being today a sign of care and of salvation; of being the action, the word which carries on the action of Christ in a world which continues to marginalise and to ignore man; in a world in which science, technology and the economy are worshipped in an idolatrous fashion. It is in this real world that the female religious in health care must be a sign, a model of tenderness, of compassion and of love. How? This was the question which was constantly touched upon during the deliberations of the congress and to which, indeed, we have sought to provide an answer.

The Pope received the religious who took part in the congress in the Sala Clementina

and called on them strongly to "be a heart and a hand towards the sick to meet the challenges posed by the world of suffering." "The Church", the Holy Father continued, "looks to you with admiration and gratitude... you are called to adapt your service to the infirm in line with the conditions of these times of rapid changes and unprecedented challenges... the world of suffering and health need a new Christian response."

The female religious active in the health care world are sensitive to this appeal of the Supreme Pontiff, know that today's health care world has many needs, and requires a constant process of updating. How much will and how much practice the female religious apply to this field!

This congress itself has been a call to action and a call to pursue a common path—the 140 congregations will have to sow together a seed as large as a mustard seed and place a little yeast with the hope that it grows and bears fruit. This seed must grow. The Pontifical Council here encounters an important challenge—to be a bridge between these initiatives and to unite many forces in order to achieve a higher service.

F. JOSÉ L. REDRADO, O.H.



XIX Congress of the International Federation of Catholic Medical Associations (FIAMC) New York, September 10-13, 1998

I. Medical Ethics at the Threshold of the Third Millennium

LETTER OF CARDINAL SECRETARY OF STATE
TO H.E. MSGR. JAVIER LOZANO, AUGUST 8, 1998

Your Excellency,

The Holy Father was pleased to learn of the Nineteenth World Congress of the International Federation of Catholic Medical Associations taking place in New York from September 10-13, 1998, and he asks that you convey to all present his greetings in the Lord and the assurance of his prayers.

His Holiness welcomes the choice of the theme, "Medical Ethics Approaching the Third Millennium: The Love of Christ through the Spirit of Life," since it goes to the very root of the Catholic meaning of the Federation and the contribution which it is called to make to the Church's great task of serving the human family in the light of the Gospel. In society today, certain developments in medical technology are bringing marvelous benefits to people's health and well-being, while others can lead to an array of serious ethical problems. It is the task of groups such as the Federation to ensure that medical ethics looks always to the good as God has revealed it, for "only the act in conformity with good can be the way leading to life" (*Veritatis Splendor*, 72).

Christ is our supreme model. In him we see the love of God, a love offered unreservedly to heal all wounds and cast out all evil in those who came to him. It is Christ, the giver of life (cf. *Jn* 10:10), who reveals a new horizon for the ethical action of Catholic physicians: doctors and medical staff are Christ's co-workers in loving and promoting life, the life of all who entrust themselves to their pro-

fessional competence. The ethics of the Catholic physician must be anointed with affection, esteem and respect for the sick. They must be filled with the Holy Spirit so that through the service of medicine Christ himself may offer his life to those dwelling in the shadow of death. It is in this sense that "the therapeutic ministry of health workers forms part of the pastoral and evangelizing action of the Church" and that they truly become "witnesses to the Gospel of Life" (*Charter for Health Care Workers*, 5). As His Holiness noted in addressing the Plenary Assembly of the Pontifical Council for Pastoral Assistance to Health Care Workers on March 9, 1998: "Every act of care for the sick, if performed in a spirit of faith and fraternal sensitivity, truly becomes an act of religion" (*L'Osservatore Romano*, March 9-10, 1998, p. 6).

Guided by the Scripture, the Church is insistent in affirming that human life is a "fundamental good, the condition here on earth of all other goods" (*Evangelium Vitae*, 5). Therefore the sacredness of human life is the primary value and the fundamental truth upon which Catholic medical ethics are based. Whatever the psychophysical capacity of human persons, they have an inestimable value in the eyes of God. In addressing participants in the International Congress on "The Roots of Bioethics" (February 17, 1996), the Holy Father made it clear that "bioethical reflection on the ontological and anthropological roots of the norms which ought to orient options of such

decisive importance is urgent. The tree of ethical reflection, to conserve its vitality and bear fruit, must be firmly rooted in the ontological truth of the human being, created in the image and likeness of God, redeemed by Christ."

At the same time, Catholic physicians are called to work closely with medical schools and bioethics centers, and to be in the forefront of efforts to promote "the profound and interior quality of the medical profession, intimately bound up with the Gospel of life" (cf. Address to Participants in the International Congress on "Training Doctors on the Threshold of the Third Millennium: The Role of Catholic Universities," November 25, 1996, in *Dolentium Hominum*, No. 32, pp. 14-15). It is also important that there be dialogue and cooperation between all Catholic agencies and associations working in the health sector, in order to foster that general mobilization of consciences and shared effort in ethics upon which His Holiness has insisted (cf. *Evangelium Vitae*, 95).

It is the Holy Father's fervent hope that the Nineteenth World Congress will be a new point of departure for the Federation, leading it to be ever more a shining light in the world of contemporary medicine. Commending all present at the Congress to Mary, Mother of the Redeemer, His Holiness cordially imparts His Apostolic Blessing.

Sincerely yours in Christ,

Cardinal ANGELO SODANO
Secretary of State

II. Greeting of H.E. Msgr. Javier Lozano to the participants of the Congress of the International Federation of Catholic Medical Associations (FIAMC)

GREETING READ BY FR. PIERLUIGI MARCHESI, O. H. REPRESENTATIVE OF THE PONTIFICAL COUNCIL AT THE CONGRESS - NEW YORK, SEPTEMBER 10, 1998

Since, because of prior commitments, it has not been possible for me to attend your Congress, please allow me and the Pontifical Council for Pastoral Assistance to Health Care Workers to be present at your meeting by way of this greeting, with my best wishes for the fruitfulness of these sessions. Brother Luigi Marchesi, a Member of our Council, bears my greetings, and I am honored to be represented by him.

I extend a special greeting to Dr. Walter Osswald, President of the International Federation of Catholic Medical Associations. I thank him for his effective work in heading it. May the Lord reward him for all his concern and effort in this labor of mercy which he has performed for so many years in guiding this distinguished Federation. It is my prayer that the new president to be elected by this Assembly may receive the light of the Holy Spirit, in this year devoted to the Spirit Himself, in order to continue and further the meritorious work done by the Federation.

There are two challenges in particular for your future: the globalization of medicine and the special problems of bioethics. FIAMC must be a bulwark which does not permit the dehumanization of medicine for the sake of gain. Each Catholic physician and the Fed-

eration as such will be the heralds of a health ministry they exercise in the name of Christ, where they always give preference to the sick, regardless of their economic status, in both government-run health systems with public facilities or private ones under contract and essentially private systems. As for bioethical problems, Catholic physicians should excel in their passion for life, in defending and fostering life from conception until its terminal stages. Catholic physicians are apostles of life and not mercenaries of death. In the face of the death culture expanding in our midst, they raise up the banner of life, for they are followers of the Risen Christ.

May God bless you, and may Our Lady, *salus Infirmorum*, assist and protect you in your lofty mission.

+ JAVIER LOZANO
BARRAGÁN

*Archbishop-Emeritus Bishop
of Zacatecas
President of the Pontifical Council
for Pastoral Assistance
to Health Care Workers*

To the official greeting of His Excellency Monsignor Lozano, I would like to add my own personal wishes as the new Director of the International Federation of Catholic Hospitals. Approved by the Holy Father in 1990, this Ass-

ciation now comes in a renewed form, to the attention of health care institutions all over the world which are inspired by the values of Catholicism.

To the scope of relaunching the role of Catholic hospitals we would like to redefine our identity, in an explicit and transparent manner. The objectives proposed are actually: the harmonization of curses for the formation of personnel, the definition of organizational models compatible with human needs and challenges of the market, and mindful of the poor. Let us hope to specify and actualize them with the contribution of all responsible people interested.

The Federation, functioning within the Pontifical Council and constantly listening to the Magisterium of the Church, offers itself as an ecclesial service respecting local traditions and various Religious Charisms operating in the Health sector.

During this meeting, it will be useful for the future of the Catholic Hospitals, in which most of those who are present here spend their life, to gather needful suggestions and counsels in order to collaborate better in achieving the goals proper to the Association.

I thank the President for giving me the possibility to talk to you and renew my wishes for a fruitful proceeding of this Congress.



III. Medical Ethics in the Third Millenium

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The title of the 19th. World Congress of the International Federation of Catholic Medical Associations (FIAMC), recently held, together with the 67th. Annual Meeting of the Catholic Medical Association of the United States, in New York, would certainly merit the attention of all those interested in bioethics and its future impact on medical care but could appear as incomplete and not entirely fitting for a confessional Federation. In fact, some could argue, any medical or ethical institution or organization could devote to such a theme an international congress; the specificity of a Federation of Catholic doctors is not revealed by such a theme. An answer to these potential criticisms is however given by the subtitle of the Congress: "Christ's Healing Love through the Gospel of Life," making it clear that those organizing the Congress wanted to convey a message. For the Catholic doctor, medical ethics, although not essentially different from the time-honoured teachings of the Hippocratic tradition, only reaches perfection when illuminated by the Gospel of Life, since Christ is the healer and doctors the instruments He lovingly uses. Aware of this responsibility and mission, the Catholic doctor does not feel superior to his non-believing colleagues, but knows that he or she is a witness to the healing love of Christ.

Thus, the Congress gave an answer to a question which is often formulated, concerning the distinctive characteristics of a Catholic doctor. At the same time, it aimed at an overview of the main ethical challenges which doctors will face in the third millenium and tried to give a comprehensive answer to them, as based on the teaching of the Magisteri-

um and the world-wide experience of engaged Catholic scholars, doctors and researchers. The letter sent to the Program Chairman, George Isajiw, by Cardinal O'Connor (who presided to a Mass and delivered a talk to the Congress) very aptly describes as tasks of the Congress "setting forth the scientific, theological and practical aspects of those Church's teachings which are in contrast to contemporary secular medical ethics, and demonstrating that the Church's teachings not only meet the spiritual needs of the human person but result in improved health as well." The Cardinal concluded that "The service this Congress will render to the Church and to society is of inestimable value."

Second World Congress held in the United States

We must go back to 1970 in order to find another World Congress of FIAMC held in the United States. The 12th. World Congress was held in Washington and presided by Dr. Mariano Alimurong, from the Philippines, elected as President of FIAMC during the Congress held four years earlier in Manila. Bio-engineering and transplantations were the novelties discussed from a moral point of view and the new statutes of FIAMC were approved. The theme of the Congress was "The Catholic doctor and the preservation of life."

Dr. Gino Papola, then President of the American Catholic doctors association, was present and active, as he was, 28 years later, in New York; in the mean time he had been Treasurer, Secretary-General and President of FIAMC; no wonder he received a special

award, as a token of gratitude, from FIAMC on September 9, 1998.

Between these two Congresses held in America, FIAMC organized World Congresses in Barcelona (1974), Bombay (1978), Rome (1982), Buenos Aires (1986), Bonn (1990), and Porto (1994), thus respecting the 4 years intervals adopted by the General Assembly; accordingly, the next World Congress, the 20th., will be held in the year 2002, in Seoul, although an Extraordinary Congress is scheduled for Rome, as part of the Jubilee Year 2000.

The format of the Congress

World Congresses of FIAMC are jointly organized by the Executive Committee of the Federation and by the local Association of Catholic Doctors (in this case the Catholic Medical Association), which obviously has the heavier tasks of choosing the venue, being responsible for organization and funding and managing the convention. Thus, each and every Congress has a format and characteristics which are peculiar to it and concede a distinctive flavour to the event. Thus, besides 5 scientific sessions, free communications sessions and poster presentations, which are usual in all scientific meetings, the program included key note addresses and lectures delivered in connection with the Linacre Luncheon and the Banquet, an unusual feature for many a visitor from overseas.

During the three and half days of the Congress (September 10 to 13, 1998) 32 contributors to keynote Addresses and Scientific Sessions as well as 30 authors of free communications and

posters dealt with such varied subjects that an attempt at a complete, even summarized, report is obviously out of the question. From terminal care to post-rape management, from a study on the origins and healing of homosexuality to the link between abortion and breast cancer, from research concerning lactation amenorrhea to studies on natural family planning or abortion practices or deaf culture and limits to medical intervention—the program offered variety, quality and significance. In the following sections, therefore, no attempt at a complete survey will be made and only those contributions highlighted, which in a very subjective way appeared to the writer of these notes as particularly relevant for those who did not attend this important meeting. Only the publication of the Proceedings of the Congress (planned as a special issue of FIAMC's bulletin Decisions) will do justice to the many excellent contributions brought to New York.

Christian versus secular medical ethics

The question of diverging views between Christian and non-Christian ethical guidelines for the practice of medicine, already referred to by Cardinal O'Connor in his letter (see above), was the subject of analysis by Edmund Pellegrino, Professor of Medical Ethics at the Center of Clinical Bioethics at Georgetown University (Washington D.C.) and one of the foremost ethicists of our time. He delivered the Jerme Lejeune Memorial Lecture on "Doctor and Patient: Christian Medicine, Christian Patients." In his view, Christian and secular bioethics are pursuing divergent paradigms of the physician-patient relationship. He urges us to accept the Christian conception of this relationship, grounded in the two images of *Christus Medicus* and *Christus Patiens*. In the light of this conception, we should be able to restore the doctor-patient allegiance. Suf-

fering is different from pain, which may be treated pharmacologically, whereas suffering calls for compassion. Ethics precede economics and a Catholic cannot wash his hands and attribute all evils to the system or the administration. Pellegrino condensed ethical normatives in a series of aphorisms (like: profit is not sanctified, catholic hospitals are not corporations, medical care is not a commodity, nobody owns medical knowledge, etc.) and reminded us that classical principles of medical ethics are supra-rogatory: justice can not be separated from charity, which goes farther than beneficence and imposes limits on autonomy.

Dianne Irving (Washington D.C.) discussed the concepts of personhood in Christian and secular medical ethics, showing that inaccurate or philosophically inexact concepts may lead to non life respecting attitudes. Alejandro Ferrero (Buenos Aires) pointed out that consensual views about critical issues may be difficult to obtain, even within an organization of Catholic doctors, and called for tolerance, spirituality and positive thought. A. Laureano Santos and Fr. Aires Gameiro (Lisbon) proposed the medical ethic of St. John of God as a model for our time, whereas L. Maciunas (Vilnius) reported on the profound impact of Soviet dominance on the ethical notions of a former Catholic population, that of Lithuania, and on the efforts now under way to revive Catholic medical ethics.

A historical and theological analysis of the devotion to *Christus Medicus*, particularly popularized by Saint Augustine and used by the early Fathers of the Church to combat the cult of Asklepius and other pagan deities, was presented by Fr. Benedict Groeschel (New York) as a cultural contribution to the essential basis of Christian medical ethics. Fr. Groeschel interestingly enough noted that the devotion to the Sacred Heart of Jesus and to Divine Mercy is a sequel to that to *Christus Medicus*.

Sexuality, reproduction, abortion

Two outstanding specialists in the field, Drs. T. Hilgers (Nebraska) and John Haas (Boston), dealt with new reproductive techniques and especially with Na Pro technology, the new procreative science. It was pointed out that although most of the measures offered by the new industry of "assisted reproductive techniques" do violence to the dignity of marriage or even contribute to the destruction of nascent life, there are morally legitimate measures to overcome infertility, the prevalence of which has never been higher in developed countries, afflicting one in five married couples. Na Pro technology has developed in an effort to correlate the causes of gynaecologic disease and procreative abnormalities, the health sciences being used in a way which is cooperative with the woman's cycle. Na Pro technology is wholly consistent with Catholic teaching and its spectrum includes family planning, treatment of infertility and other gynaecologic conditions in ways which are safe, effective and respect the dignity of women and the integrity of marriage.

Richard Fitzgibbons tried to cover, in his talk, the origins and healing of homosexual attractions and behaviour, arguing that homosexuality, in contrast to widespread notions, is a preventable and treatable developmental disorder. Healing involves an understanding of the emotional conflicts of childhood and adolescence, cognitive and behavioural therapy and the incorporation of spirituality in recovery.

The management in a Catholic health institution of women who have been raped (Eugene Diamond, Chicago), contraception as a denial of the deeper meaning of human sexuality (Janet Smith, Dallas) and the results obtained by the Teen STAR Program (Hanna Klaus, Baltimore) are items of practical significance in which the attitude of the Catholic health professional is of para-

mount importance. Through a countercultural educational approach, Teen STAR assists with the personality developmental tasks of adolescence and aims at maintaining virginity or facilitating a return to abstinent behaviour. Statistical studies demonstrate the high efficacy of this program, which is being applied in the United States, Canada, Chile and Poland.

Other objective studies, reporting results obtained in natural family planning, were presented by Ludmila Laznikova (Brno) and Pilar Vigil (Santiago de Chile); W. Taylor and D. Taylor (Las Vegas) and Sheila Kippley (Cincinnati) analyzed breast feeding frequency, suckling behaviour, mother-baby closeness and lactational amenorrhea, stressing the benefits of "ecological" breast feeding, which include a 50% increase in the delay until the return of menstrual cycles.

An overview on the medical consequences of abortion, highlighting the effects on subsequent pregnancy (including fetal loss, premature birth, low birth weight) and marked, severe, and persistent psychological or psychiatric disturbances, was presented by Michael Jarmulowicz (London). Joel Brind (New York) showed that the meta-analysis of breast cancer cases in women who had or had not aborted evidenced induced abortion as an important (and avoidable) risk factor for breast cancer. The statistics presented by J. Lucci (Houston) revealed that in the State of Texas alone more than 90,000 abortions were done in 1996 and that the large majority (2/3) of the aborted women had none or only one previous live births, thus denying the alleged correlation between large number of pregnancies and abortion. On a different note, Paulo Campos (Luanda) spoke about his experience as an Angolan obstetrician, giving support to women who want an abortion and trying to help them to accept the pregnancy-with a 20% rate of success; the babies so born are what he affectionately calls "his other children."

The end of life

If ethical problems confront the Catholic doctor in the beginning of life, life's end raises other, perhaps even more serious, problems. The terminal patient, his dignity and rights were thus addressed by a number of speakers: terminal care in an intensive care unit (Solange Grosbuis, Versailles), dying in dignity without pain (Rudolf Giertler, Erfurt), quality care at the end of life (Thomas Fahey, New York), compassionate care (William Toffler, Portland), care of the terminal patient (Laura Vega Elias, Havana),



terminal care at home of uro-oncologic patients (Simon *et al*, Barcelona) were the themes covered in this section. The authors, coming from different medical specialties and geographically diverse regions, stressed the mandatory measures needed to improve the care of the terminal patient and to combat the prevailing secular view of legitimizing, at least in some cases, the practice of euthanasia. To enhance support for those who cannot be healed, to avoid unnecessary or futile therapies, to reject euthanasia and physician-assisted suicide as incompatible with the role of the doctor as a healer, to treat correctly pain and depression and to be available in a compassionate way until the natural end of life, are the main tasks of Catholic doctors, bearers of hope and sources of strength for their patients.

A selection of topics in the current bioethical discussion

As was to be expected, some topics which appear with frequency in the discussion maintained in meetings and journals of bioethics were the object of talks given by a number of participants.

The informed consent of incompetent patients, as exemplified by the case of deaf-mute children, was discussed by Miguel Ricou *et al* (Porto), who defend a bilingual (gestural and phonetic language) approach to deafness to ensure the best possible rehabilitation for these children. The rights of people involved as subjects in epidemiological research to see their privacy respected was stressed by Rita Montanha *et al* (Porto), who advocated an interactive relationship between researchers and ethics committees.

Living wills were discussed by John Lee (Singapore), who argued that they result in loss and not in increase of the patient's autonomy, since medical decisions are transferred to the attending doctor, in case he becomes incompetent. Moreover, the concept of living wills is inextricably linked to the "right to die" movement.

Another polemic question is that of allocation of resources to health care systems, addressed at this Congress by Rui Nunes (Porto). In his view, this difficult question must be answered in the light of distributive justice, equity and social solidarity. Johannes Stevens (Maastricht) analysed "the dream of unlimited medicine," concluding that scarcity of means imposes limits and that the answer to the challenges of practising medicine in the next millenium lies in the healing love inspired by the Gospel.

Nutrition and hydration are not free from controversy, as underlined by Msgr. William Smith (Yonkers); although it is not possible to answer antecedently all possible clinical cases, the relevant ethico-moral principles discusses and elaborated by Catholic physi-

cians and clearly defined in magisterial documents (Declaration on Euthanasia, Catechism, *Evangelium vitae*, U.S. Bishops' statement, Charter for Health Care Workers) allow us to resolve all cases of this kind.

The vexing question of telling the truth, or not, to patients in life threatening conditions was the subject of talks given by Paolo Gentilini and Alfredo Anzani (Florence and Milan) and by Marija Sostarbo and Viatka Matic (Zagreb). The latter authors dealt with a specific group of patients, suffering from amyotrophic lateral sclerosis, while the former considered all conditions diagnosed as having a lethal outcome. Nevertheless, the conclusions were very similar: the patient has a right to know, the doctor must provide as much information as wanted and asked for and avoid giving false hope but also refuse to detach from the patient, remaining compassionate, helpful and supporting till the end. In this context, relatives and caregivers may also be included in the number of those who need the doctor's assistance.

Another recurrent question is that of the distinctive characteristics of Catholic medical schools and hospitals. This often thorny question was tackled by Ralph O'Connell (Valhalla, New York) and by Kwang-ho Meng (Seoul), both deans of Catholic schools of medicine. Both were adamant about the need to communicate Catholic moral and ethical principles to students and health professionals and to achieve excellence. Teaching of Christian medical ethics and implementing them in the daily provision of health care services is mandatory and should be a hallmark of any Catholic health institution.

Medical mission work

Many Catholic doctors serve in developing and poor countries, in areas deprived by famine, war or social injustice, offering medical assistance and compassionate care, working as benevolent volun-

teers under difficult conditions, sometimes exposing their health and even life to many dangers. This activity, often anonymous and hidden, is seldom recognized as an exigence of our faith and professional abilities and, although sponsored or initiated by Catholic Medical Associations, rarely reported to the public. It is therefore noteworthy that Donald Mehan (St. Louis) and Maya El Hashem (Rome) present results obtained by American doctors in Guatemala, Haiti and Honduras and by an Italian mission in Romania. Specific needs existed in both cases (in



urological and gynaecological patients in the first case, in HIV infected children in the latter) and both authors believed in the importance of providing long-term assistance and in getting the cooperation of local health professionals, training them in order to guarantee continuity of assistance.

Many differences, one approach

As in other, prior World Congresses, one of the riches of this meeting consisted in the interchange of experiences, ideas and lines of thought of doctors coming from very diverse cultures, backgrounds, political systems. It was particularly moving to hear colleagues coming from Cuba, Angola, the Dominican Republic, Japan, the Philippines, the Ukraine,

Brazil, New Zealand, Australia, share their views and experiences, stemming from a practice of medicine under social and cultural conditions widely different from those prevailing in the so called occidental world. Because in a multicultural, multiethnic and eventually multilanguage society the exercise of medicine is subject to rules which differ from those existing in differently shaped societies, this does not mean that problems differ in their essential nature or that the approach to solve them in a Catholic way should also differ. The Catholic, i.e. universal nature of our faith, becomes clearly defined to the attentive listener and the great principles of medical ethics illuminated by shared belief in the healing love of Christ.

Congresses like this have thus a stimulating and incentivating effect; contacts are established, personal acquaintance made, often the ground for lifelong friendships laid, cooperative efforts launched; one can not overestimate the value of this type of encounter, which goes far beyond that of conventional medico-scientific meetings.

Awards and distinctions

FIAMC instituted the Award of Honour to a person of science and faith in 1994, to be attributed at the occasion of its World Congress, held with intervals of four years. In 1994, at the Congress held in Porto, the Award of Honour was attributed to Professor Jerome Lejeune for the relevance of his scientific achievements in the world of genetics and for his courageous and unremitting fight for the right to live. The second Award of Honour was given in New York to Robert Walley, Professor of Obstetrics at the University of Newfoundland, Canada, for his work as a qualified researcher and teacher in Gynaecology and Obstetrics. This led him to actively and personally interfere with major problems afflicting women in many developing countries, especially in

Africa, like the devastating effects of vesicovaginal fistulae (resulting from delayed labour and mainly affecting young women, who become socially marginalized and excluded) and the avoidable puerperal death due to uncontrolled haemorrhage. Professor Walley, with the help of his wife, Susan, launched a series of relief actions, giving assistance, teaching how to cure these women and organizing local institutions devoted to the eradication of these evils. A man of faith and of action, he recently founded Mater-Care International, an international organisation of Catholic obstetricians, general practitioners and midwives dedicated to care, training and research, with the aim of reducing the high rates of maternal morality and morbidity, as well as that of abortion, still prevailing in many parts of the world.

The John XXI Prize is an award instituted by the Portuguese Catholic Doctors' Association in order to distinguish the best entry in the competition, open every four years. The jury of the 1998 edition attributed the Prize to Dr. Kathryn Watson, from the United States, for her essay on the similarities of the human and the chimpanzee's genome and the ensuing non-deterministic nature of genetic material; this closeness argues for a soul, as the author brilliantly declares.

Of a more intimate character was the ceremony of the presentation of the Distinguished Service Award of FIAMC to its past-President Gino Papola (U.S.A.) for his lifelong support and active intervention as a dedicated, dynamic and outstanding leader. Besides the recipient were two other important contributors to the growth and implementation of FIAMC; the also Past President Thomas P. Linehan and the former Ecclesiastical Adviser Msgr. James Cassidy, who received a religious art object as a token of gratitude for invaluable services rendered to the cause of Catholic doctors.

Spirituality of a Catholic doctors' congress

One of the highlights of this Congress was the climate of intense spirituality in which it was lived. There was, of course, the daily Eucharist as a foundation for all congress activities, from the opening Mass held at the Hotel where the congress took place to the closing celebration in the magnificent atmosphere of St. Patrick's Cathedral, both presided by Archbishop Edwin O'Brien, Ecclesiastical Assistant to the Catholic Medical Association. On Friday Cardinal O'Connor was the celebrant, and on Saturday Holy Mass was celebrated in the Byzantine-Ukrainian rite by Bishop Basil Losten.

The early morning recitation of the Rosary and the consecration to the Sacred Heart of Jesus were other high moments of spirituality. It is of interest to note that at the occasion of the 3rd World Congress of Catholic Doctors (Lisbon, 1947) consecration to the Immaculate Heart of the Virgin took place in Fátima. For the first time in the already long series of World Congresses, an Adoration Chapel was installed in the venue of the Congress and perpetual, day and night adoration of the Blessed Sacrament maintained for the whole duration of the Congress. An unforgettable experience, as it was felt by all participants.

The Hierarchy of the Church was present

The presence and cooperation of the Hierarchy is a must at all World Congresses of FIAMC. In New York it was Cardinal O'Connor who had the task of presenting a keynote address and reading the Papal Message to the participants, as received from the Secretary of State, Cardinal Sodano. Archbishop Renato Martino, Papal Nuncio and Permanent Observer of the Holy See to the United Nations, opened the Inaugural Session in which, besides the introductory talks of the Presidents of FIAMC and

CMA (Walter Osswald and Paul Byrne), Br. Pierluigi Marchesi participated as delegate of the Pontifical Council for Pastoral Assistance to Health Care Workers. He read a message from H.E. Archbishop Lozano, President of the Pontifical Council, who was unable to attend but expressed his wishes for a successful outcome and great interest in fruitful cooperation, also at the level of supranational health and political organizations, like the UN and WHO.

Thus, it was clear to all participants that the organizations of Catholic doctors are expected by the Hierarchy to play an important role in the evangelization of the world of health and can count on the Holy See as provider of counsel, help and guidance.

New tasks, new faces

It was rewarding to register many young doctors and medical students in the audience. Their interested faces were a sign that medical youth is not synonymous with secular orientation in the field of medicine. The doctor of the next millennium faces new tasks and challenges, increased pressure from governments and payers of health care, lobbies and public opinion as reflected in the mass media, and these influences often will contradict the guidelines of traditional, Hippocratic medicine and offend the principles of Christian medical ethics. It is therefore of paramount importance to diffuse these principles, to show how they are adequate to the human nature of illness and suffering and how, when correctly translated into medical practice, they result in betterment of the condition of the sick, the destitute, the dying, of all those in which the doctor sees the face of *Christus Patientis*.

New faces also in the group of officers who share the responsibility of steering FIAMC into the next century. Gian Luigi Gigli (Italy) was elected President of the Federation; George Isajiw (United States), who had been the pro-

gram chairman and major organizer of the Congress, became Vice-President; François Blin (France) is the new Secretary-General and Alejandro Ferrero (Argentina) was elected as Treasurer. Fr. Vitor Feytor Pinto continues his work as Ecclesiastical Assistant.

Conclusion

This 16th. World Congress of FIAMC proved to be highly successful because it mobilized a large number of delegates from the four corners of

the world, allowed for a thorough discussion of many controversial aspects of medical ethics, fostered personal encounters and discussion, stimulated individual reflection and soul-searching and challenged the Catholic nature of the participants. It will be important to read the Proceedings of the Congress (which we hope will be available as a special issue of FIAMC's bulletin "Decisions"), to study them and to find the best solutions for the many ethical questions which technical progress constantly raises. But

more important was the fact that priests and doctors, religious and lay people could meet, discuss, share the Eucharist and pray together. In this spirit they were invited to meet again in Rome, in the Jubilee Year of 2,000, for an extraordinary Congress, and in 2002 in Seoul, Korea, for 20th. World Congress.

WALTER OSSWALD
*Emeritus Professor of the Medical
Faculty of Porto, Portugal;
Immediate Past-President of FIAMC;
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for Pastoral Assistance
to Health Care Workers*



IV. Conclusions of the 19th World Congress of FIAMC

We, Catholic doctors, as we bring to an end, in prayerful solidarity, the combined 19th World Congress of the International Federation of Catholic Medical Associations and the 67th Annual Convention of the Catholic Medical Association (USA), in New York City, September 10-13, 1998, do share with deeply held conviction the following conclusions: "Christus Medicus"—Christ, our Healer, Christ the Divine Physician—is our enduring, steadfast source of saving grace, of moral courage, of professional excellence, and of spiritual inspiration and enlightenment. As Catholic physicians, we are each called to serve, in a unique sense, as "Alter Christus," as "Another Christ." Through the mystery of the Eucharist, Christ would use our hands, our minds, and our hearts, reaching out to our patients in their moment of need. We are challenged to realize, in touching and healing the wounds—both physical and psychological—of each patient we treat, that we are privileged to touch and heal the very wounds of Christ, Our Lord.

The Magisterium of our Catholic Church, through its teachings, provides to us an ageless light, shining all the more brightly in the darkness of modern-day secular humanism. By studying, by promoting, and by incorporating into daily practice, the messages held in relevant papal documents—such as *Evangelium Vitae*, *Donum Vitae*, and *Humanae Vitae*, we, Catholic doctors, are strengthened in our calling to serve proudly and unapologetically as counter-cultural witnesses to the eternal truth of God's boundless and unconditional love.

The energetic involvement of Spirit-filled Catholic med-

ical students has been a highlight of this joint convocation. The hope for the future of Catholic medicine rests on the success of our ongoing outreach to these students. We strongly encourage the active involvement, on a local, national, and international level, on the part of physicians-in-training at the pre-medical and medical school level, as well as in residency and fellowship programs.

The active involvement of women physicians in this meeting has been another highlight. We vigorously support and encourage the continued and increased involvement of Catholic women and minorities in all of our organizations.

Historic, at our meeting, too, has been our opportunity to welcome and greet in person, for the first time in over forty years, our colleagues and brothers in Christ from the island of Cuba, and to celebrate with many other colleagues—from Lithuania, the Ukraine, the Czech Republic, Croatia and elsewhere—their newly found freedoms.

Medical mission outreach to those suffering and in need—in Roumania, in Honduras and Brazil, and throughout the world—is and must remain a foremost commitment. We welcome, with special enthusiasm, participation on the part of our Catholic colleagues from developing nations, such as the Philippines and Angola. Plans for future meetings should include goals for increasing participation on the part of our colleagues in underserved parts of the world. At the same time, we Catholic doctors, stress the need on all of our parts, on a regular basis, to support and actively participate in Catholic medical mission activities, to those in

greatest need, both abroad and within our own nations.

With the same spirit we are determined to increase our efforts to be recognized as a Non Governmental Organization by the World Health Organization, to be more effective in serving the right of developing countries and the ethical needs of modern medicine.

We, Catholic doctors, renounce the evil of artificial contraception in all its forms. Most especially, we reject those agents, which, while masquerading as contraceptives, achieve their life-destroying effect through their abortifacient properties. We denounce the contraceptive imperialism of United States and United Nations governmental agencies, which propagandize, with missionary zeal, the worldwide spread of life-destroying abortifacients, condoms and contraceptives.

Conversely, we celebrate the life-affirming vision of wholesome sexuality and parenthood, which Christ teaches us through our Catholic Church. And we practice and promote positive programs, such as Natural Family Planning, Natural Procreative Technology and Ecological Breastfeeding.

We, Catholic doctors, renounce the evils of euthanasia and physician-assisted suicide. Most especially, we would warn of the dangers and pitfalls of "Living Wills" and related documents. We renounce pressure from governmental agencies and third-party-payers, who would have us act in the interest of cost-reduction, at the expense of our own patients' best interests. Conversely, we celebrate the life-affirming vision of truly compassionate end-of-life care. We strongly encourage widespread education in pal-

liative care and effective pain management. And we support life-affirming programs, such as Hospice Care.

Impressed by the striking social differences of New York City, and by the abundance of homeless and poor in the capital of affluent world, we proclaim the right of every human being to receive at least basic health care, especially when chronic or disabling diseases affect them.

Powerfully united together in prayer at this momentous meeting, we Catholic doctors commit ourselves to pray for one another on a daily basis, for the salvation of our souls, for our families and colleagues, for our patients, for the great gift of our One, Holy, Catholic and Apostolic Church, and for the world. Consecrated here to the Sacred Heart of Jesus, we, Catholic doctors, commit our-

selves to Christ-centered practice of our professions and conduct of our lives. "Most Sacred Heart of Jesus, Thy Kingdom Come in Us."

FR. VITOR FEYTOR PINTO
Ecclesiastical Assistant of FIAMC

RICHARD A. WATSON
M.D., President of CMA-USA
Archbishop

EDWIN F. O'BRIEN
Episcopal Advisor, CMA-USA



International Congress of Catholic Nurses (CICIAMS)

Taiwan, September 9-12, 1998

I. Quality of Life and Globalisation

LETTER OF CARDINAL SECRETARY OF STATE
TO H.E. MSGR. JAVIER LOZANO, AUGUST 11, 1998

Your Excellency,

The Holy Father was pleased to learn of the Congress of the International Catholic Committee of Nurses and Medico-Social Assistants (CICIAMS), taking place in Taiwan from September 9-12, and he asks that you convey to all present his greetings in the Lord and the assurance of his prayers. As the Congress reflects upon the important and complex theme of "The Quality of Life and Globalization," His Holiness invokes upon the participants a fresh outpouring of the Holy Spirit, "the Lord and Giver of life."

The process of globalization is creating a growing interdependence of peoples, but it remains true that in many fields there are gross inequalities between peoples, even in the same country or area. The field of health care is one of these. While some have access to the powerful instruments of medical science and technology, many have no access to even the most elementary medical resources. It is not only a question of health understood as freedom from physical illness or temporary organic dysfunction, but health understood as the well-being of the whole person—physically, emotionally and spiritually. For Catholic health care, this is what it means to speak of "quality of life;" and it is this which any process of globalization based upon truly human values must seek to promote.

Guided by the Scripture, the Church sees the human being as created in the image of God and possessed therefore of a transcendent and absolute dig-

nity. This vision provides the ethical foundation for Catholic health care, leading Catholic health professionals to serve all people, without distinction of any kind. The same vision can ensure a process of globalization driven not by an exclu-



sive concern for financial gain but by a concern for the total well-being of the human person.

His Holiness has insisted that "institutions are very important and indispensable; and yet no institution can replace human love and human Catholic initiative" when it is a question of tending to people's pain (*Salvifici Doloris*, 29). In the first place, therefore, the responsibility of Catholics engaged in health care is personal: the patient is not an anonymous object but an individual calling for that love and care which is always distinctly personal. Yet this personal respon-

sibility also has a communal dimension, because the health professional has a responsibility to society as a whole. In a time of great change, Catholics in health care are called to help construct a new social order on the basis of enduring values. This implies a mission which joins to their human and professional skills the spiritual depth of faith lived in charity, a mission which is part of the Church's great work of evangelization as we move towards the Third Millennium of the Christian era. This mission of Catholics in health care requires both a shared moral vision and unified action at health facilities, all working together in the name of Christ to ensure that there is a "sharing of available resources and in this way bringing about true communion" (*Populorum Progressio*, 43).

His Holiness encourages those participating in the Congress to grow in both professional commitment and Christian holiness, living "the grace and the responsibility they receive from their Lord to announce, celebrate, and serve the Gospel of Life" (*Evangelium Vitae*, 28). Thus they will bring to bear on the personal and social dimensions of health care the love of the Most Holy Trinity from whom all life coes and to whom all life returns.

Entrusting the work of the Congress to the intercession of Mary, Mother of the Redeemer, His Holiness cordially imparts to all present his Apostolic Blessing.

Yours sincerely in Christ,

+ Cardinal ANGELO SODANO
Secretary of State

II. Inaugural Greeting

Dear friends,

Welcome to the 16th CICI-AMS World Congress. As president of the Pontifical Council for Pastoral Assistance to Health Care Workers I wish to greet all of you and give you a most warm welcome to our Congress.

We desire in this Congress to define the roles of health workers in promoting global Health, and to discuss, and disseminate information that will lead to the promotion of global health and to seek ways and means to hasten the improvement of quality of life, and all this from a Christian point of view.

So let us begin with the blessing of God: Christ send us to preach in his name and to cure the ill, may this Congress continue the ministry of the health care of Christ through the care of the Catholic nurses of the world with all the advantages of the actual science and medical techniques that we have at the present time.

Our task is to fight against the culture of the death and in favor of the culture of Life; let us strengthen our efforts in this Congress in order to achieve this goal. The ministry of nurses and midwives is very important in this field, they are always in direct con-

tact with the problems of life, let us pray for their mission; we always support them in their important task. The globalization of medicine is ambivalent: it can be positive or negative for quality of life and thus for the ministry of health-care; let us direct this Congress in the right and positive direction, so that globalization can give positive fruits for the well-being of mankind.

Let me greet you once more and give my best wishes for the success of our Congress. Hearty welcome!

+ JAVIER LOZANO
BARRAGÁN

Taipei, September 9 of 1998

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III. CICIAMS: an appropriate analysis

After the congress held at Louvain we began to think about how to prepare for this sixteenth world congress of the CICIAMS which the General Council decided by vote to hold in Taiwan. At Louvain and the various regional seminars which followed that congress (in Holland, Japan, Bangkok...) we discussed the profound changes which have taken place in the world and which have produced rapid alterations and upheavals.

As health care professionals we know by direct experience that these upheavals and changes which have taken place in our societies have also had a strong impact on our services and our way of doing things. During our deliberations as a group the contributions made by the regions allowed us to share our various practical experiences with reference to these changes.

I will not discuss this subject here with this congress which is being held in Taipei. Every participant has been able to listen to, and appreciate, the very rich contributions made by our eminent conference members. What I want to do is:

- on the one hand to dwell upon certain flashes or chief ideas which have emerged here and there; and

- on the other to suggest certain solutions and remedies which we might adopt together at the end of this congress.

Let us remember above all else the goals and aims which we have in mind:

1. To explore the effects of globalisation, its impact on people and populations and on the quality of life of their personal and social lives;

2. to emphasise the challenges which health care professionals must meet, and stress their responsibilities as Catholic protagonists of health.

The programme has allowed us to reflect upon these objec-

tives from the perspective of the third millennium which is now just around the corner.

The speeches of welcome have above all else introduced us to the context of Asia and in particular of Taiwan where we have been able to appreciate the cordiality of an open and warm people who seek to fuse tradition with modernity. This cordiality has been expressed throughout the congress both at Chien Tan and during the professional visits or the parties in the evenings. Thank you very much!

Globalisation? We are dealing here with an irreversible situation and process which we have to face up to and whose negative aspects and positive and progressive consequences we must emphasise. The members of the conference—Mons. Barragán, P. Aldrich and P. Joblin—have illuminated the character of these situations of so-called crisis which are marked by contradictions where death and life intertwine.

We may cite by way of example the constrictions which the power of money places on economic and financial programmes which are linked to public powers; the technological, biological and genetic research directed towards increasing effectiveness and remunerativeness and its consequences for human beings; and the psychological and moral influence of the mass media (newspapers, films and all the rest...). All this requires that we do the following:

- struggle unceasingly to reintroduce the human dimension into our activities and our choices; and

- develop justice, love and truth for the common good of mankind.

In his analysis of the development of cultures and ethics, or to put it better of different forms of ethics, P. Aldrich pointed out from a moral and

theological point of view that the events of history are the result in part of free human will which has been a source of progress if based upon justice and good law. As nurses, obstetricians and health care professionals, he said, we are the stewards of life, of the culture of life to employ the phrase coined by John Paul II.

What is needed, therefore, is the exercise of real moral judgement and human and spiritual perception on the one hand to identify the contradictions and illusions which are present, and on the other to grasp what can strengthen our faith and our hope with a view to constructing a better life for everybody.

But when faced with the challenge of globalisation as nurses and obstetricians what can we do to improve the quality of life?

Mrs Marianne Arndt has provided us with certain key approaches which we will pursue in our countries, on our own and with other people, in our teams and in our associations.

With reference to three real life histories, Mrs Arndt observed: “our actions form the person, we are what we do, the world is the world we build.”

In reply to the question “Why have you come to Taipei?,” her answer will certainly spring to mind: “I am a Catholic nurse.” This question and this answer involve three separate perspectives of an ontological (self-identity), spiritual and religious, and professional character, and these lead each one of us to give a new meaning to health care services and through what we do to improve the quality of life of healers, patients, and those who surround them either in an immediate or a more remote sense.

This relevant and thought-provoking analysis is the work

of Shirley Dooling. After surveying the important technological advances which have had a major impact on our health care professions, Mrs Dooling observed that the third millennium will not be technological in character but the beginner of meaning for the human being, the meaning that Christians locate in the values of the Gospel and which unite ethics and justice.

She invited us to be increasingly well qualified not only at the level of technology but in an overall sense and in particular in spiritual terms in order to take part with others in the humanisation of the health system.

P.Joblin, for his part, helped us to look in the face of this world which is moving from the second to the third millennium (a symbol), this world which is increasingly marked by a pluralism of cultures and religions...he called upon us to write our vision of faith and hope into the facts, into our acts.

This vision requires us to help each other, and the CICIAMS offers us:

- a place in which it is possible to reflect together upon our profession, and upon the challenges of today's world;
- a place of friendship, of solidarity and also of prayer where we can draw upon the transcendent meaning of God present in our lives.

However, the CICIAMS is not isolated and as Mrs An Verlinde observed, it is a non-governmental organisation linked to other non-governmental organisations and official bodies.

Furthermore, the CICIAMS is a NGO partner of other international Church organisations which, acting within the Church, participate in the evangelisation of the world in their respective fields of activity, and this is especially true of the international Church organisations which are involved in the promotion of health and social action. These last, and therefore also the CICIAMS, take part in the mission of the Church and her ministry of compassion for the sick and people afflicted by handicaps, for the poor, for children, and for the elderly. Should we not be ever more aware of our personal and collective vocation in these terms?

A congress does not have a single end but is prolonged at a local and practical level. It must provoke and bring about a renewed commitment at the level of the work and activities of the association. What tasks should we commit ourselves to as CICIAMS, as national Catholic associations and as health care professionals?

The following resolutions emerged from our deliberations:

At the end of the sixteenth world congress the delegates from the various countries:

1. Undertake to achieve the general objectives outlined by the general council of the CICIAMS for the next four years, aware that each member is responsible for their being reached, and this with a view to improving the quality of life for everyone and the whole world;
2. undertake to improve

their use of the mass media, not only to be or to appear to be modern but also in order to:

- promote authentic inter-relations between themselves;
- create or recreate union and communion with full respect for differences; and
- build a solidarity-inspired network of health care professionals who take Jesus Christ and his Gospel as their point of reference.

3. And ask:

- that the CICIAMS reflects upon the kind of responsibility that it must have towards its political, economic, social, cultural and religious environment, and strives to discover the best steps to take in this direction;

- that the CICIAMS, as a NGO and international Church organisation, studies the obstacles which exist in the way of the full participation of Catholic nurses and obstetricians in the health care policies of their respective countries and the role which they should perform in order to remove such obstacles.

In the name of you all I ask the Lord to bless our deliberations and to help us to fulfill these resolutions, drawing inspiration from the Book of Wisdom of the Bible.

Lord, You who want intelligence to penetrate the secrets of nature; You who want the earth to be inhabitable for all: let Your Word illuminate us so that we work for justice and science at the service of Life for the splendour of Your Glory!

CICIAMS
Council of Administration



IV. The Globalisation of Medicine: The Mission and Responsibility of Catholic Nurses and Medico-Social Assistants

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I thank the *International Catholic Committee of Nurses and Medico-Social Assistants* for having kindly invited the Pontifical Council for Pastoral Assistance to Health Care Workers to take part in this major event. The relations between the Pontifical Council I am honored to head and this Committee have always been excellent. We have been warmly welcomed and place ourselves at your service in this assignment which the Holy Father, John Paul II, has entrusted to us as a sign of his great benevolence towards you, Catholic nurses and medico-social assistants, as he manifested in the letter of greeting which he wished to send you and which I have had the opportunity to present to you.

Our subject—"Medicine and Globalisation: The Mission and Responsibility of Nurses and Medico-Social Assistants"—holds notable current interest and is pressing, in view of the new circumstances in today's world. I shall now set forth some aspects of the nursing profession at present. These reflections may also be valid for other health professions.

Certain events lead society to reassess the ethical assumptions which have guided it. Globalisation is one of these events. It is making itself felt worldwide and affects all professional environments. The reason is that its spread is accompanied by a new social anthropology.

A New Social Anthropology

Capitalism has continued to expand its dominion over society since the beginning of this century. Regardless of political systems, a new culture is slowly replacing the

humanistic cultures which different civilizations have developed over the centuries. Instead of making man the center of social philosophy and justifying his economic obligations from this standpoint, capitalism, in the form in which it has unfolded, places man at the service of the economy. It turns competition and the accumulation of power into values determining the survival of individuals and society. It imposes an ethic of efficiency and relegates those not contributing to the success of its system to a state of poverty. This ideology has penetrated into the domain of health care in the same way.

Society imposes its Moral Criteria

The economic crises affecting peoples today are rarely due to the circumstance of a poor harvest or a natural catastrophe, since international solidarity can remedy almost everything. They are instead due to a stagnation of the economic or financial machine which sinks a whole country into recession. Abundant, easy credit created the illusion of endless prosperity. Entire populations lived by this myth, and no Cassandra was authorized to criticise it. This evolution also had an effect on health services.

This new mentality affects workers in the health sector. The first health services arose from a desire to come to the aid of the sick to relieve their sufferings. They are now conceived of as a vast organisation whose administrators establish operative norms in accordance with the economic and financial exigencies they perceive. Health personnel is expected to make the system function, whatever their per-

sonal convictions may be. Technical obligations threaten to push into the background the human concerns which for a long time were the characteristic of health professionals.

The problem is posed as to how Catholic nurses—and all those aware of the dignity of patients in a setting where the practice of their profession is subject to coercion—should behave. We affirm that they must fight to introduce the human dimension into their professional activities once again—a struggle which must be undertaken by believing professionals in other work environments as well.

In current events we must learn to distinguish between what offers renewal, so as to support it, and what is contrary to renewal, so as to reject it; and, in those areas which are ambiguous, between what ought to be retained and what ought to be left aside.

1. How does the Globalisation Process Affect Nurses and other Health Professionals?

The effects of globalisation on health professionals are felt in three spheres, above all: the organisation of health services, the beneficiaries of health services, and the working conditions of health personnel.

a) *The Organisation of Health Services*

The key lies here. The primacy of efficiency in the policy of globalisation is pervading health services and tending to obscure the human relations which ought to reign.

Those responsible for health policies want to offer people

the most sophisticated care, thinking that they will thereby guarantee the reputation and competitiveness of their facilities; to this end, when considering available resources they devote a big portion to research and the introduction of new techniques at their hospitals, whereas a large part of the population still remains deprived of elementary services as regards water, food, housing, and everything falling under the heading of primary care in general.

Hospital administrators' desire to get the latest equipment introduces an element of inequality into access to health care. In fact, there ensues a rise in the costs of investment and management which imposes limits on the number of up-to-date installations and tends to restrict access to those who can pay for them. While sophisticated care is made available to some patients, whole populations are deprived of a basic possibility for health care.

Financial pressures subject health services increasingly to administrative action which, for the sake of cost control and good management, tends to intervene in establishing working conditions for personnel and determining whether some kinds of technological innovation are necessary. This dominion of administration is encountered once again when it comes to deciding about the geography of health care—certain regions are neglected because of the administrative norms which have been promulgated. The diverting of national resources towards investments which are said to be productive is detrimental to the weak, women, the disabled, the marginalised, and the organisation of primary health care among populations living in underprivileged areas.

b) The Beneficiaries of Health Services

Beneficiaries may contribute to reinforcing the dominance of administrative over medical services, including nurses and other health

professionals; indeed, they demand that the best treatments be available to the largest number of people, if not to all. Their demands exceed possibilities; they thus require administrative services to do the utmost to respond to their hopes and to allocate resources in accordance with their wishes, imposing their decisions on health personnel.

A new way of conceiving health is appearing at present. Previously, a whole religious context surrounded illness and offered an explanation



which gave it meaning. This spiritual dimension is not accepted by society now. Health is perceived as a right and illness as an attempt upon this right, a kind of accident which society is obliged to remedy.

There is spreading a new attitude to life, which is increasingly viewed as a subjective right to well-being, in whatever way the individual conceives of it. This conception, associated with a refusal to attach a positive meaning to suffering, has led to acceptance of abortion and euthanasia by a large part of public opinion in countries which have adopted the contemporary outlook.

The urbanisation of peoples accentuates the lack of humanity frequently encountered in health care—the sick are isolated beings. Family members and friends often run into major difficulties regarding visits; many of them, subjected to strict schedules at work, are far away from the hospital, sometimes living in distant regions.

Globalisation contributes to increasing the number of migrants and refugees; both of these groups see a transformation of their lives to which they must adapt; a number of psychological or other problems thereby originate, and nurses and other health professionals must be attentive to them.

The transformation of life entails the disappearance of the customary support structures for the weak or disabled, making it necessary to offer them special assistance.

New scourges appear, such as drugs and AIDS, alongside the former ones, like alcoholism, which nurses must deal with.

The increase in forms of inequality and of unemployment and underemployment, together with the ensuing decline in earnings, creates psychological and social problems to which Catholic nurses must respond.

c) Health Professionals

Professionals are imprisoned by their environment. Administrators and patients expect miracles from them, regardless of their physical condition (stress, excessively burdensome work schedules, and so on). Human contact with patients and their families is often neglected.

Catholic nurses have to be on the front line among those struggling against the depersonalisation of their profession, against the tendency for technical aspects of care to prevail. There thus arises a lack of attention to other aspects which comes to affect the right to life of the newborn and the as yet unborn.

The transformations we have analysed have brought us to take a new look at health in today's society, which no longer views it as the absence of illness, but as maximum prevention of possible illnesses. This conception has become a moral exigency justifying in the eyes of the general public the adoption of an unreservedly positive attitude to the progress of medicine and scientific research. Whereas new techniques for

medical care were traditionally appraised in terms of objective moral criteria based on the nature of man, contemporary societies follow other, subjective, criteria based on individual personal judgment and recognising only one limit: the actions performed must not harm third parties. This development increases the moral responsibility of Catholic nurses.

The notion of "harm to third parties" enables us to understand the current situation. Whereas in the traditional position this was evaluated in terms of an anthropology which took into account man's future—and, as we Christians say, man's "supernatural destiny"—contemporary civilisation tends to erase from people's minds all historical dimensions and focus man's attention exclusively on the present. This evil is already considerable in Western countries and is now threatening the peoples striving to enter modern life. What the West proposes unites people in the struggle to obtain the greatest efficiency in the present moment.

Progress in surgery, the use of pharmaceuticals, and techniques for intervening on the human body have in the end given rise to a desire to control life on the part of politicians (demography) and scientists in exploring the human body and the causal links among its components so as to reproduce them in the laboratory. Catholic nurses and other health professionals are faced with questions like genetic examinations and the discovery of genetic anomalies in the unborn, genetic therapy, and attempts to replace the natural process of procreation.

All of these questions, which are at once technical and moral, present themselves to nurses in a climate of the erosion of traditional values, especially in the family. They are thus called to rebuild society by bringing these new medical practices back into a moral context and by showing that they assess them in terms of a conception

of man as a being who is in formation, in a state of becoming. It is only by once again situating the new questions, such as assisted procreation, abortion, euthanasia, and cloning, in a humanistic perspective that nurses and other health professionals can gain a clear vision of what is right and, by appealing to the sense of truth which is inscribed upon every man, mobilise the believers of other religions and "men of good will" to restore an authentic conception of life.



2. Catholic Health Professionals and Globalisation

Globalisation affects Catholic health professionals under at least two aspects.

a) *A Lack of Solidarity*

Men and women religious, like most of the Catholics working in health services, do so with an altruistic approach. Many of them care for the poorest in a spirit of charity. Research and the technical enhancement of many health services seem, however, to force them to cease providing care to the poor.

The Catholic tradition shows concern for establishing human relations among health professionals, patients, and patients' relatives, but the conditions under which care is provided permit this less and less.

b) *The Trivialisation of Morality*

The Church's interventions condemning certain practices

by warning about their possible consequences are seen as an abuse by a large part of the public, which does not understand why the Church rejects abortion and euthanasia or expresses reservations about administering certain medicines or intervening surgically on the fetus.

The incomprehension encountered by the Church and Catholic professionals largely arises from the fact that the media currently adopt a manner of understanding life which is opposed to the teachings of the Church. Christian anthropology cannot accept destruction or neglect of the bond between the person and God. To deal with the ideology generalised by the ethics of globalisation, man must not seek maximum personal gain at each moment, but see the instant which has been given to him as a means to choose what leads him to God.

3. The Role of Organisations for Catholic Health Professionals and of CICIAMS in particular in Evangelising their Members

They must offer their members the means to develop their faith in their own milieu: specifically, in the ethics of nursing, Catholic nurses must understand that their faith leads them to protect the basic principles their profession starts from: *the principle of beneficence*, i.e., always to do good to the patient; *the principle of nonmaleficence*, i.e., never to harm the patient; *the principle of autonomy*, i.e., for the patient to be the one to decide, as far as possible, whether or not he accepts the care offered to him; *the principle of veracity*, according to which the patient must be truthfully informed as to his illness and the treatment to be applied; *the principle of the sacredness of life*, according to which human life must always be defended, at both its initial and terminal stages;

and *the principle of justice*, which prescribes that persons be treated equally and be given what each is entitled to.

They must fight for nurses to be genuine professionals and for their work to be recognised as a true profession in all areas of health care.

They must ensure that their members have technical information on new problems in medicine and offer them the means to examine them in a Christian perspective. This means to view positively all advances in medical science and technology, but always in the light of their finality in man and not in terms of an independence which would turn man into an experimental object for the benefit of scientific progress. They must remember that life and health, at whatever stage, and attention to them, ultimately come from God.

In their nursing conduct they must embody a Christian understanding of health, not only as an absence of illness or as the prevention of them, but as dynamic tension moving towards man's physical, mental, social, and spiritual harmony, which enables him to carry out the task God has entrusted to him. Even if it seems contradictory, physical or mental illness is not entirely opposed to integral human health; only those illnesses which at a certain stage in life do not let man carry out the mission God has entrusted to him are opposed to it.

They must teach their members that pain itself can be positive, for if it is offered to Christ, He takes it up and transforms it into a source of salvation and victory over evil. It is joined to the redemptive pain of Christ Himself and becomes redemption for all. They must thus teach that pain is absurd only if it is enclosed in itself, but not if it is opened and offered by the sick in a full gift to Christ our Lord.

They must ensure that their members are able to deal with the new problems their profession must face: new diseases, drugs, AIDS, psycho-

logical imbalances, and so forth. They must stress the worth of the poorest and least protected as those who are the dearest brothers and sisters of the Lord—we shall be judged in accordance with the way we treat them. Particularly, they must instill in their members respect for the unborn and the terminally ill, always avoiding abortion and euthanasia.

Before society and authorities they must defend the right of nurses to conscientious objection, when necessary, since existing legislation often



recognises this right only in the case of doctors. They must strive for their members to create more room for evangelisation and humaneness, for, though in many instances nurses do not hold high-level decision-making positions, they are nevertheless the people who spend the greatest amount of time alongside the sick. Catholic nurses must live out their Christian commitment, in this proximity to the sick, seeking to alleviate their sufferings and illnesses according to the example of the Good Samaritan, who is our Lord Jesus Christ, the physician of the body and the soul.

They must draw inspiration from the address by John Paul II in Spira (in front of the cathedral, 1987), when he stressed that the union of good wills enables us to hope for positive results beyond the reach of a single individual; concretely, the union of Catholic nurses and medico-social assistants is extremely important in the Catholic Church. With its worldwide

repercussions it can create awareness everywhere of the dignity of sick persons and of the need and means to care for them, in keeping with the doctrine of the Church. Now that the culture of death seems to be taking over even the medical environment, those who previously regarded such an eventuality as absurd—namely, Catholic nurses and other health professionals—are faced with the sublime task of proclaiming the culture of life in the most forceful manner. By way of their practice of health care, it is up to them to show that life and health are a lofty gift of God which we must administer as such. The health professions are an ecclesial ministry.

Finally, CICIAMS must try to expand increasingly, especially in the countries where it is still not represented, so that the greatest possible number of Catholic nurses and medico-social assistants will enter its ranks and the culture of life will shine more brightly in the field of nursing around the world.

Conclusion

Globalisation has put the economy at the center of everything; politics and society have developed in accordance with it. Medical science and technology have not escaped this phenomenon. This worldwide event has major disadvantages, for man is left in the background and introduced into the whole as one more cog in the economic machine—and this holds for both individuals and peoples. Globalisation has also entered the world of health, in the field of research and of health science and technology, with all this entails, which in the final analysis means the culture of death.

Not everything, however, is negative. Globalisation, in making possible greater rationalisation of resources and fostering unequalled development of science and technology in general, especially in the area of health, has made more

means available to man and brought about broader access to possibilities for healing and the recovery of health for more nations and peoples, in such a fashion that the WHO motto, "Health for All," is continually coming closer to reality. The condition for this is that man should be the indisputable end of the globalisation process and that we should truly move from economic globalisation to real unity of the human race, and, in health terms, we can conceive of a genuine *international common good of*

health. The requisite for this transcendental step is that man should finally recognise that life and health are a gift of God and that the wonderful world of science and technology is God's gift to his children, not so they will be the slaves and products of industry, technology, and science, but their true lords, who, without destroying nature and in harmony with it, will redirect it back towards themselves.

This will be the mission and responsibility of the International Catholic Committee of

Nurses and Medico-Social Assistants in the context of globalisation: in this beautiful and wonderful world of medical science and technology, to make man the indisputable center of all efforts, for everything has been received as a true gift of God our Lord.

+ JAVIER LOZANO
BARRAGÁN

*Archbishop/Emeritus Bishop
of Zacatecas*

*President of the Pontifical Council
for Pastoral Assistance to Health
Care Workers*



Activity of the Pontifical Council for Pastoral Assistance to Health Care Workers in 1998

1. Celebration of the Sixth World Day of the Sick.

In the year dedicated according to the wishes of the Holy Father to special reflection on the Holy Spirit, the Sixth World Day of the Sick was solemnly celebrated in the Marian Sanctuary of Loreto (Italy) under the heading of the words: "The Spirit makes us a home of health and hope." The pontifical delegation was led by Cardinal Angelo Sodano, Secretary of State and *Legatio Pontificio* of the Holy Father for the World Day of the Sick, and its other members were His Excellency Mons. Javier Lozano Barragán, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, Rev. José L.Redrado, O.H., Rev. Felice Ruffini, M.I., respectively Secretary and Under-Secretary of the same Pontifical Council, and Mons. Timothy Broglio, Adviser to the Apostolic Nunciature.

Three moments marked the various celebrations which took place during this important event: prayer, study, and visits to certain important places. Detailed information on this celebration can be found in our review *Dolentium Hominum*, n. 38/1998. 3

2. Fourth Plenary Assembly of the Ministry.

From 9-11 March the Pontifical Council for Pastoral Assistance to Health Care Workers held its Plenary Assembly, together with its Members and a number of its Consultants, to reflect upon and discuss the model, the goals and the functioning of the Ministry, or rather the new plans for the activity of the Ministry on the threshold of the third millenni-

um. This was done in order to respond in a more effective fashion to the mission entrusted to the Ministry by the Holy Father to be of help in his valuable Pietrine ministry in



the specific field of pastoral care in health.

After a greeting addressed to all those taking part, the President of the Ministry His Excellency Mons. Javier Lozano Barragán began the deliberations by introducing the subjects which would be discussed and the methodologies which would be followed. In the framework thus outlined the following papers on the following subjects were then given: "*Eleven Years of the Pontifical Council*" by Rev. José L.Redrado, O.H., Secretary of the Ministry; "*Point of Departure*" by Mons. Jean-Marie Mpen-

dawatu, Official of the Ministry; "*The Goals of the Ministry*" by His Excellency Mons. Javier Lozano Barragán, President of the Ministry; "*The Effectiveness of the Ministry in the Ministry of the Word*" by Rev. José L.Redrado, O.H.; "*The Effectiveness of the Ministry in the Ministry of Sanctification*" by Don Krzysztof J. Nykiel, Official of the Ministry; and "*The Effectiveness of the Ministry in the Ministry of Communion*" by Rev. Felice Ruffini M.I., Under-Secretary of the Ministry.

During the audience which was granted on the first day of the Assembly, the Holy Father expressed his pleasure and satisfaction at the activity carried out by the Ministry during the thirteen years after its creation in the sensitive and often troubled sector of pastoral care in health and suffering. He then proceeded to exhort everybody to practise the "*Gospel of Life*" and to be inspired by the Divine Master who came "so that they may have life, and have it more abundantly" (Jn 10:10). The Pope emphasised that the "beneficial action of protection and defence of health encounters obstacles not only in the many pathogenic factors, both ancient and recent, which endanger life on earth, but also sometimes in the mentality and behaviour of men...The totalitarian ideologies which reduced man to an object and trod underfoot and excluded fundamental human rights are matched in a worrying fashion by certain forms of use of biotechnological capacities which manipulate life in the name of an unbridled ambition to dominate which deforms aspirations and hopes and increases anxiety and suffering."

3. Participation in the Special Assembly for Asia of the Synod of Bishops.

This Assembly took place in the Vatican from 19 April to 14 May and the President of the Ministry His Excellency Mons. Javier Lozano Barragán took part as a member by right. The Pontifical Council made its contribution at both the preparatory stage and during the Synodical celebration. The contributions which were made were received positively and the speeches on specific topics by the President both in the main hall and during the working groups met with the agreement of the Synodal Fathers who concurred on the importance of pastoral care in health and the need for its expansion in the present-day process of evangelisation in Asia and the world.

4. Inter-Ministerial Meetings

– At the Pontifical Council for the Laity. The Secretary of the Ministry Rev. José L.Redrado O.H. took part on 13 March in the first meeting of the *ad hoc* group on the International Year of the Elderly planned for 1999. Various other meetings of the same group took place subsequently during the rest of 1998, and Rev. J.Redrado was always present.

– At the Pontifical Council for the Family. On 26 March Rev. Don Krzysztof J.Nykiel took part in the inter-ministerial meeting concerned with preparation for the *Third Meeting of the Institutes on the Family and on Bioethics*.

– At the Congregation for the Evangelisation of Peoples. The President of the Ministry His Excellency Mons. Javier Lozano Barragán took part on 30 March in an Ordinary Congregation to discuss the lines of instructions.

– At the Pontifical Council “Justice and Peace.” The Secretary of the Ministry Rev. José L.Redrado O.H. took part

on 30 March in the inter-ministerial meeting concerned with preparations for the next *World Day of Peace* (1999).

– At the Pontifical Council “Cor Unum.” The Secretary of the Ministry Rev. José L.Redrado O.H. took part as a Consultant from 16-19 April in the twenty-third plenary assembly of the same Ministry.

– At the Pontifical Council for Culture. Rev. Don Krzysztof J.Nykiel, Official



of the Ministry, took part on 28 May in the inter-ministerial meeting on the subject: “*After the Special Assembly of the Synod of Bishops for America, Evangelisation of Cultures and Inculturation of the Faith in Latin America: Hope and Challenges*.”

– At the Congregation for the Clergy. On 9 June and 13 November Rev. José L.Redrado O.H., Secretary of the Ministry, took part in the inter-ministerial meetings organised and promoted by the Central Committee for the Great Jubilee of the Year 2000 in order to respond to the publication of the Calendar for the Holy Year 2000.

– At the Congregation for the Evangelisation of Peoples. From 17 to 20 November the President of the Ministry His Excellency Mons. Javier Lozano Barragán took part in the Plenary Congregation.

– During the whole of 1998 there has been intense inter-ministerial co-operation organised at the Pontifical Council for Pastoral Assistance to Health Care Workers on certain active programmes promoted by the Ministry on such subjects as drugs, AIDS, Catholic hospitals, and the anointing of the sick. All these meetings took place under the direction of the Superiors of the Pontifical Council.

5. Participation and Representation at Congresses and Conferences.

JANUARY

– From 17 to 24 January at Geneva the Official of the Ministry Rev. Mons. Jean-Marie Mpendawatu formed a part of the delegation of the Holy See to a meeting of the Executive Committee of the World Health Organisation.

FEBRUARY

– From 18 to 22 February at Rome the President of the Ministry His Excellency Mons. Javier Lozano Barragán led a celebration of the eucharist and inaugurated the deliberations of the Sixth General Assembly of the Pontifical Academy for Life with a greeting to the participants on the subject: “*The Human Personality and the Society of the Future*.”

MAY

– On 4 May the President of the Ministry inaugurated a meeting of the Directive Council of the Pontifical Academy for Life which had the following order of the day: a) choice of the topic for the next General Assembly (1999) and the prospects for the year 2000; b) appointment of a number of correspondent members; c) the

planning of study conferences on the subject of the human embryo; d) other business.

– On 5 May at Rome the Secretary of the Ministry, Rev. José L. Redrado O.H., took part in the “Plenary Meeting” of the International Union of Superiors General of Congregations Dedicated to Pastoral Care in Health (UISG) and presented a paper on the objectives and the principal contents of the First Symposium of Female Religious active in the field of health and health care.

– On 9 May the Official of the Ministry Rev. Mons. Jean-Marie Mpendawatu took part in the “First Study Meeting on the Problems of Biotechnology and Animals and Plants” organised by the Pontifical Academy for Life.

– From 11 to 16 May at Geneva the President of the Ministry His Excellency Mons. Javier Lozano Barragán took part as Head of the Delegation of the Holy See in the fifty-first session of the World Assembly on Health Care, and also took part in the ceremonies to commemorate the fiftieth anniversary of the World Health Organisation with a speech which expressed greetings and congratulations. Rev. Mons. Jean-Marie Mpendawatu, Official of the Ministry, was also a member of this delegation.

– On 18 May in Seville, in response to an invitation by His Excellency Mons. Carlos Amigo Vallejo, Archbishop of Seville, the President of the Ministry took part in a Symposium on the subject of: “*Espiritualidades y Espiritualismo ante el III Milenio*” organised by the Academy of Church History and the Department of History of America of the University of Seville. The subject of his paper was: “*The Spirituality of Pain—a Theological Reflection*”.

– On 21 May at Rome, in response to an invitation by Rosy Bindi, the Italian Minister of Health, His Excellency Mons. Javier Lozano Bar-

ragán took part in the presentation of the National Health Plan for 1998-2000 whose goal is to be a *pact of solidarity for health*.

JUNE

From 8 to 10 June in New York the President of the Pontifical Council His Excellency Mons. Javier Lozano Barragán took part, as head of the Delegation of Observation of the Holy See, in the *Twentieth Special Session* of the General



Assembly of the United Nations on the fight against the illegal drugs trade and gave a paper on the subject of: “*The Fight Against the Illegal Drugs Trade*.”

– On 16 June in the Vatican His Excellency Mons. Javier Lozano Barragán took part in the day of reflection on the topic of “*The Quality of Life of the Terminally ill Cancer Patient*” organised by the “Maruzza Lefebre D’Ovidio” Foundation.

– On 18 June at Rome the President of the Ministry took part in a meeting to commemorate the tenth anniversary of the reform of the organisation

of the Pontifical Commission for Latin America which had been requested by the Holy Father.

JULY

– From 7 to 12 June at the Sanctuary of Our Lady of Guadalupe (Mexico) His Excellency Mons. Javier Lozano Barragán took part in the Third International Meeting of Priests in Preparation for the Great Jubilee of the Year 2000. In his speech the President commented, from a priestly point of view, on the sixth station of the *Via Crucis*.

SEPTEMBER

– From 9 to 13 September at Taipei (Taiwan), accompanied by the Secretary of the Ministry Rev. José L. Redrado O.H., His Excellency Mons. Javier Lozano Barragán took part in the Sixteenth World Congress of the International Catholic Committee of Nurses and Medico-Social Assistants (CICIAMS) on the subject of: “*The Quality of Life and Globalisation*”. The President of the Pontifical Council for Pastoral Assistance to Health Care Workers gave a paper on: “*The Globalisation of Medicine: the Missions and Responsibilities of Catholic Nurses and Medico-Social Assistants*.”

– From 10 to September in New York Rev. Br. Pierluigi Marchesi O.H., Member of the Ministry, represented the Pontifical Council at the Nineteenth World Congress of the International Federation of Catholic Medical Associations (IFCMA) which was held to discuss the topic: “*Medical Ethics in the Third Millennium: Christ’s Healing Love through the Gospel of Life*.”

– From 16 to 20 September in Santo Domingo the President of the Ministry took part in the Third Latin American and Caribbean Meeting on Pastoral Care in Health and gave a paper on the subject of: “*National Episcopal Committees for Pastoral Care in Health*.”

– From 17 to 18 September in Aachen the Consultor of the Pontifical Council, Rev. Bonifacio Honings, represented the Ministry at a day of reflection on the activity of *Action Medeor* in the world of health to commemorate the opening of the offices of this association.

OCTOBER

– From 22 to 24 October in the Vatican at the third European meeting, organised by the Pontifical Council for the Family, on the subject of: “*Human Rights and the Rights of the Family.*” The President of the Ministry took part in the inauguration of the deliberations.

– On 24 October His Excellency Mons. Javier Lozano Borragan and Rev. José L. Redrado O.H. took part in the inaugural session of the Third International Congress on “*The Face of Faces: Christ*” organised by the International Institute of Research into the Face of Christ which took place at the Urbanian Pontifical University of Rome from 24 to 26 October 1998.

NOVEMBER

– On 7 November in Rome the President of the Ministry took part in the Third Public Session of the Pontifical Academies organised by the Pontifical Council of Culture.

– From 11 to 19 November in Mexico City the President His Excellency Mons. Javier Lozano Barragán took part in the deliberations of the Mexican Episcopal Conference and gave a paper on “*Pastoral Care in Health.*”

– On 20 November in Rome His Excellency Mons. Javier Lozano Barragán took part as a Member in the deliberations of the Plenary Assembly of the Congregation for the Evangelisation of Peoples.

– From 27 to 29 November in Madrid the Secretary of the Ministry Rev. José L. Redrado O.H. took part in the deliberations of the National Assembly on Pastoral Care in Health organised by the Spanish Fed-

eration of Health Care Religious (FERS) and at this conference gave a talk on the subject of: “*Evangelisers in the World of Health.*”

– From 30 November to 2 December in Fatima the President His Excellency Mons. Javier Lozano Barragán took part in the deliberations of the Twelfth National Meeting on Pastoral Care in Health in Portugal, and gave a paper on the subject: “*The Culture of Life and the Culture of Death.*”



DECEMBER

– From 2 to 4 December in Noordwijk (Holland) the Official of the Ministry, Rev. Mons. Jean-Marie Mpendawatu, took part as an Observer in the Fifth Session of the International Committee on Bioethics of UNESCO (CIB).

– On 4 December, in response to an invitation given by Br. Pascual Piles O.H., Superior General of the Hospital Order of St. John of God—Fatebenefratelli, the President His Excellency Mons. Javier Lozano Barragán met Major Superiors of the Order at their Central Curia and led a cele-

bration of the eucharist at the conclusion of their meeting in Rome which was held from 30 November to 4 December.

– On 16 December in Rome the President of the Ministry chaired the inaugural day of the study seminar on “*Which Aris for Health Care in the Third Millenium?*” organised by the Religious Association of Socio-Health Care Institutes (ARIS).

6. First Symposium of Female Religious Who Work in the Field of Pastoral Care in Health.

In the Vatican (in the New Hall of the Synod) there took place from 1 to 3 October the First Symposium of Female Religious Active in the Field of Pastoral Care in Health and Suffering on the subject: “*The Consecrated Woman in the World of Health on the Threshold of the Third Millenium.*” This Symposium was promoted and organised by the Pontifical Council for Pastoral Assistance to Health Care Workers.

The meeting, which was much wished for by the Holy Father, sought to reaffirm the importance and the value of the role of consecrated women in the world of health on the threshold of the third millennium and to reflect upon their mission at the service of the suffering today in the light of the Gospel.

470 female religious participated in this symposium—the representatives of 140 religious congregations from fifty countries in five continents.

The symposium was organised into three days of study and reflection which were always accompanied by prayer. Every morning the eucharist was celebrated at the altar of the cathedral of St. Peter’s Basilica.

The President of the Ministry opened the deliberations of the conference with a greeting and words of introduction.

During the conference various subjects were discussed such as: the model of the presence of female consecrated in

the world of health care; the various situations in which female religious are present: Europe, Asia, Africa, America and Oceania; vocation, profession and mission which meet and, in a Christian vision of life and health, unite mutually to achieve the overall health of man; the consecrated woman examined in anthropological, biblical and theological terms; practical pastoral questions, that is to say how to preach, evangelise, celebrate, serve and bear witness in the world of health; the world of health is “*the land of the Gospel*”; charisms, gift of the Spirit received by founders for suffering humanity, call upon the consecrated woman of the twenty-first century; at the service of charity for life—a project of pastoral care in health for Latin America and the Caribbean: goals, challenges, priorities and strategies; the consecrated life: “the epiphany” of the love of God in the world for the union of female religious active in the field of pastoral care in health.

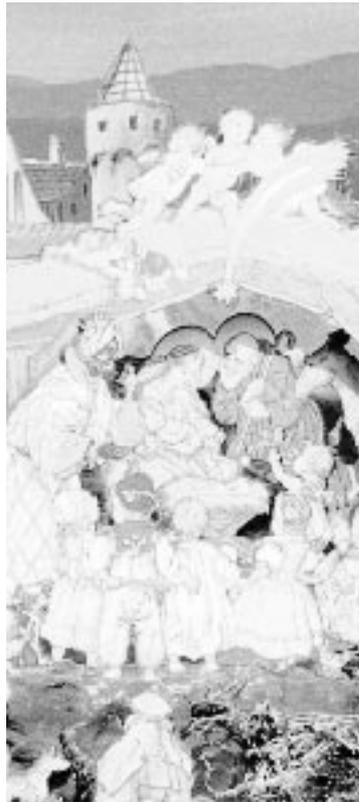
The Holy Father spoke at the end of the deliberations of the symposium and entrusted the consecrated women with a specific mandate: to be the heart and hands of Christ towards the sick in order to meet the challenges posed today to the world of suffering.

7. The Thirteenth International Conference.

The thirteenth international conference was a meaningful and important moment in the activities of the Pontifical Council. This international conference was held in the Vatican (the New Hall of the Synod) from 29 to 31 October. The subject of the conference was “*The Church and the Elderly Person.*” It is to be placed in the framework of, and sought to make a small contribution to, the celebrations of the year of the elderly to be held in 1999 which His Holiness the Pope has entrusted to the Pontifical Council for the Laity.

The conference brought to-

gether about 500 participants from 70 countries. Twenty ambassadors were present, three ministers of health, and two hundred medical doctors who represented Catholic associations and federations from the world of health and health care. There were twenty-eight speakers and of these three were Cardinals and five were Bishops. Other speakers included authoritative scientists, scholars and researchers drawn from the disciplines of anthropology, neuropathology, psy-



chiatry, gerontology and geriatrics, biology, biomedicine, philosophy, ethics, sociology, law and jurisprudence, and moral and pastoral theology.

After the introduction to the deliberations of the conference made by the President of the Ministry, His Excellency Mons. Javier Lozano Barragán and a speech of greeting made to the participants by His Eminence Cardinal F. Angelini, Emeritus President of the Pontifical Council, His Eminence Cardinal Paul Poupard, President of the Pontifical Council of Culture, opened the thirteenth international conference with an address on “*The Elderly in the Word of God.*” This

address dwelt upon the meaning of being elderly in the light of the Revelation of God. Amongst the other eminent speakers were Rosy Bindi who devoted her paper to a discussion of the *political aspects* of the questions and issues raised by the third age at the present time, and Prof. Alexandre Kalache, the representative of the World Health Organisation (WHO), who discussed the demographic aspects of the whole question in the paper he delivered at one of the round table discussions.

At the end of the deliberations of the thirteenth international conference, the Holy Father made an authoritative speech addressed to all the participants. He stressed the need to re-affirm the Gospel of life with authoritativeness, to plan society anew and rediscuss its economic structure, to draw up welfare strategies which lay primary emphasis on the dignity of elderly people and the responsiveness of families. From this perspective the Pope expressed his “no” against all those practices which seek to shorten life which go under the name of “*euthanasia.*” This last is an assault on life which no human authority can legitimise: the life of the innocent is an indispensable good.

8. Publishing Activity.

The Workplan of the Pontifical Council for Pastoral Assistance to Health Care Workers. This is a valuable instrument for the daily work of the Ministry and is the fruit of the last Fourth Plenary Assembly of the Pontifical Council. After receiving Pontifical approval it has constituted the real profile of our Ministry. A copy of this plan was sent to the heads of the other Ministries of the Roman Curia, to the Pontifical Representatives, to the Presidents of the Episcopal Conferences and the Bishops responsible for pastoral care in health, in addition to the Members and Consultors of the Pontifical Council itself. The plan has met with marked interest and

strong appreciation.

The official organ of the Ministry, *Dolentium Hominum. Church and Health in the World*, which is published every four months, was published regularly by the Ministry. It is available in four languages—Italian, Spanish, French and English. One of the editions contains the complete acts of the annual international conference organised by the Pontifical Council.

The Charter for Health Care Workers published in 1994 at the wish of the Ministry is presently available in the following languages: Italian, English, French, Spanish, German, Dutch, Polish, Portuguese, Russian, Czech, Rumanian, and Arabic. With the *nulla osta* of the Pontifical Council editions are now being prepared for publication in the following languages: Hungarian and Lithuanian.

Translations into Madagascan, Albanian and Thai are also being prepared.

9. Conclusion

During 1998 the offices of the Pontifical Council witnessed intense activity. Meetings to prepare for congresses and conferences were organised, and gatherings of experts operating within *ad hoc* study groups to study problems and issues related to drugs, AIDS, Catholic hospitals, and so forth were also promoted. Correspondence by letter with episcopates on specific questions connected with the problems and issues of pastoral care in health, bioethics, publishing activity, and various requests was continued, as was that with pontifical representatives—and in particular those who were appointed recently; with Arch-

bishops and Bishops working in Rome or engaged in an *ad limina* visit or present for other reasons; and with priests, male and female religious, and health care workers engaged in the vast field of health and health care.

These various forms of co-operation at an international level were possible thanks to the growing awareness that pastoral care in health and suffering is an integral component part of pastoral care as a whole.

Assessments and evaluations of the activity of the Ministry were carried out regularly under the guidance of the President His Excellency Mons. Javier Lozano Barragán. They gave rise to satisfaction and demonstrated the syntony of the planning of the work which was performed by the Pontifical Council for Pastoral Assistance to Health Care Workers.

