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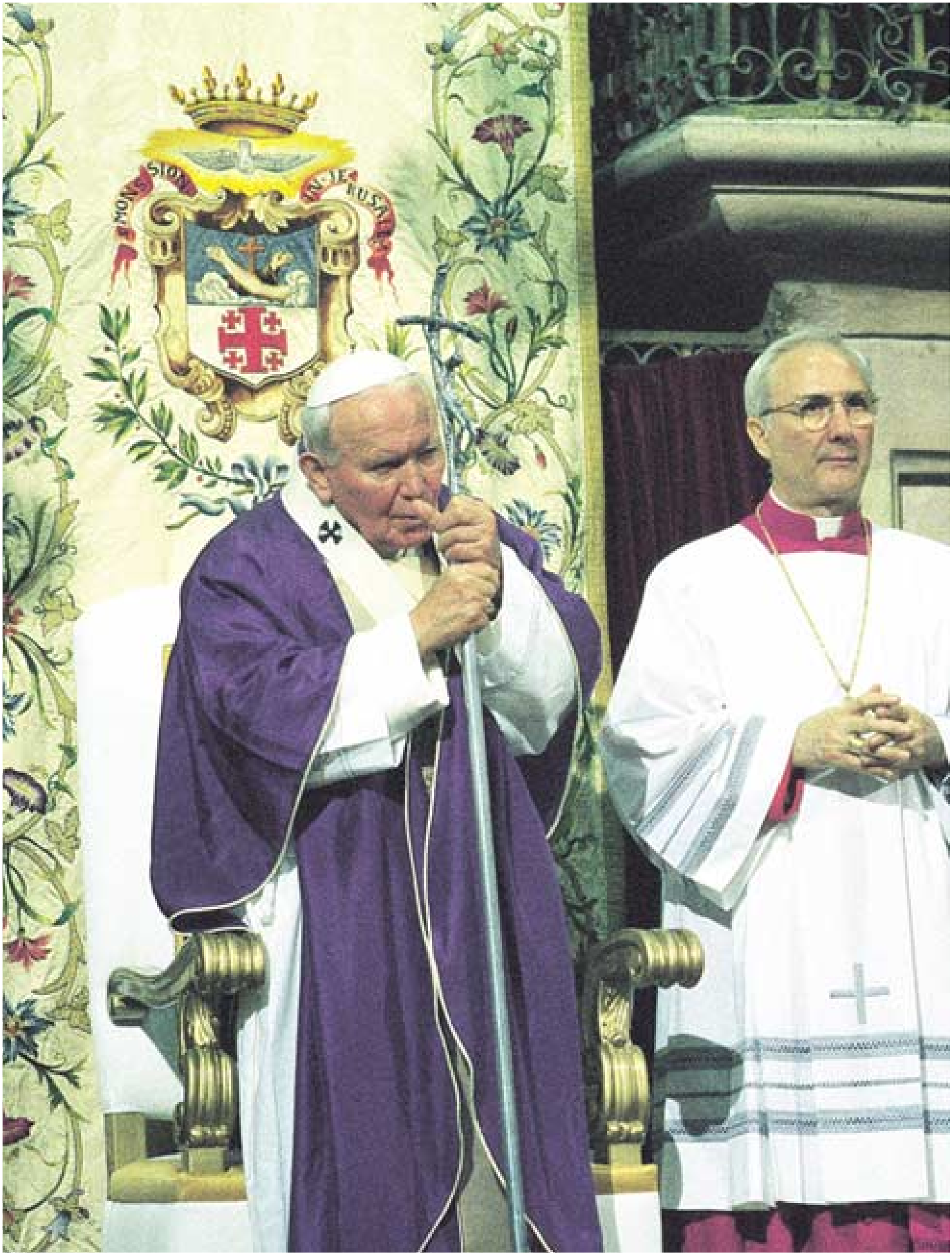


Message of His Holiness John Paul II for the Eleventh World Day of the Sick

WASHINGTON D.C., U.S.A., FEBRUARY 11, 2003

1. "We have seen and testify that the Father has sent his Son as the Saviour of the world... We know and believe the love God has for us" (*1 Jn* 4:14,16).

These words of the apostle John are a good summary of what the Church seeks to do through her pastoral work in the area of health care. Recognizing the presence of the Lord in our suffering brothers and sisters, she strives to bring them the good news of the Gospel and to offer them authentic signs of love.

This is the context of the Eleventh World Day of the Sick, which will take place on February 11, 2003 in Washington, D.C., in the United States, at the National Shrine of the Basilica of the Immaculate Conception. The choice of place and day invites the faithful to turn their hearts and minds to the Mother of the Lord. The Church, entrusting herself to our Lady, is inspired to bear renewed witness to charity, in order to be a living icon of Jesus Christ, the Good Samaritan, in the numberless situations of physical and moral suffering in the world today.

Urgent questions about suffering and death, dramatically present in the heart of every person despite the continual attempts by a secular mentality to remove them or ignore them, await satisfactory answers. Especially in the presence of tragic human experiences, the Christian is called to bear witness to the consoling truth of the Risen Lord, who takes upon himself the wounds and ills of humanity, including death itself, and transforms them into occasions of grace and life. This proclamation and this witness are to be delivered to everyone, in every corner of the world.

2. Through the celebration of this World Day of the Sick, may the Gospel of life and love resound loudly, especially in the Americas, where more than half the world's Catholics live. On the continents of North and South America, as elsewhere in the world, "a model of society appears to be emerging in which the powerful predominate, setting aside and even eliminating the powerless: I am thinking here of unborn children, helpless victims of abortion; the elderly and incurable ill, subjected at times to euthanasia; and the many other people relegated to the margins of society by consumerism and materialism. Nor can I fail to mention the unnecessary recourse to the death penalty... This model of society bears the stamp of the culture of death, and is therefore in opposition to the Gospel message" (Apostolic Exhortation *Ecclesia In America,* 63). Faced with this worrying fact, how can we fail to include the defence of the culture of life among our pastoral priorities? Catholics working in the field of health care have the urgent task of doing all they can to defend life when it is most seriously threatened and to act with a conscience correctly formed according to the teaching of the Church.

The numerous health care facilities through which the Catholic Church offers a genuine testimony of faith, charity and hope are already contributing in an encouraging way to this noble goal. Hitherto these facilities have been able to rely on a significant number of men and women religious who guarantee a high standard of professional and pastoral service. I hope that a fresh flourishing of vocations will enable Religious Institutes to continue their meritorious work and indeed to expand it with the support of many lay volunteers, for the good of suffering humanity in the Americas.

3. This privileged apostolate involves all local Churches. It is therefore necessary that every Episcopal Conference, through appropriate structures, should seek to promote, guide and coordinate the pastoral care of the sick, so that the whole People of God become aware of and sensitive to the many different needs of the suffering.

In order to make this witness of love practical, those involved in the pastoral care of the sick must act in full communion among themselves and with their Bishops. This is of particular importance in Catholic hospitals, which in responding to modern needs are called upon to reflect ever more clearly in their policies the values of the Gospel, as the Magisterium's social and moral guidelines insist. This requires united involvement on the part of Catholic hospitals in every sector, including that of finance and administration.

Catholic hospitals should be centres of life and hope which promote – together with chaplaincies – ethics committees, training programmes for lay health workers, personal and compassionate care of the sick, attention to the needs of their families and a particular sensitivity to the poor and the marginalized. Professional work should be done in a genuine witness to charity, bearing in mind that life is a gift from God, and man merely its steward and guardian.

4. This truth should be continuously repeated in the context of scientific progress and advances in medical techniques which seek to assist and improve the quality of human life. Indeed, it remains a fundamental precept that life is to protected and defended, from its conception to its natural end.

As I stated in my Apostolic Letter *Novo Millennio Ineunte*, "The service of humanity leads us to insist, in season and out of season, that those using *the latest advances of science*, especially in the field of biotechnology, must never disregard fundamental ethical requirements by invoking a questionable solidarity which eventually leads to discriminating between one life and another and ignoring the dignity which belongs to every human being" (No. 51).

The Church, which is open to genuine scientific and technological progress, values the effort and sacrifice of those who with dedication and professionalism help to improve the quality of the service rendered to the sick, respecting their inviolable dignity. Every therapeutic procedure, all experimentation and every transplant must take into account this fundamental truth. Thus it is never licit to kill one human being in order to save another. And while palliative treatment in the final stage of life can be encouraged, avoiding a "treatment at all costs" mentality, it will never be permissible to resort to actions or omissions which by their nature or in the intention of the person acting are designed to bring about death.

5. My earnest hope for this Eleventh World Day of the Sick is that it will inspire in dioceses and parishes a renewed commitment to the pastoral care of the sick. Proper attention must be given to the sick who remain at home, given that less and less time is actually being spent in hospital and the sick are often being entrusted to their own families. In countries without adequate health care facilities, even the terminally ill are left at home. Parish priests and all pastoral workers must be vigilant and ensure that the sick never lack the consoling presence of the Lord through the word of God and the Sacraments.

Proper attention should be given to the pastoral aspect of health care in the formation of priests and religious. For it is in care for the sick more than in any other way that love is made concrete and a witness of hope in the Resurrection is offered.

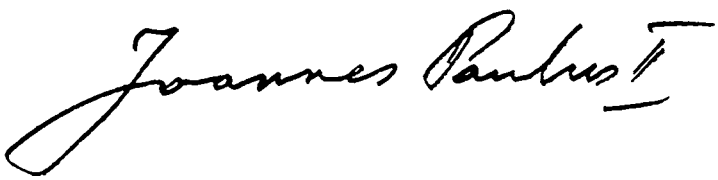
6. Dear chaplains, religious, doctors, nurses, pharmacists, technicians, administrative personnel, social assistants and volunteers: the World Day of the Sick offers a special opportunity to strive to be ever more generous disciples of Christ the Good Samaritan. Be aware of your identity and learn to recognize in those who suffer the Face of the sorrowful and glorious Lord. Be ready to bring help and hope especially to those afflicted with new diseases, such as AIDS, and with older diseases, such as tuberculosis, malaria and leprosy.

Dear Brothers and Sisters who suffer in body or spirit, to you I express my heartfelt hope that you will learn to recognize and welcome the Lord who calls you to be witnesses to the Gospel of suffering, by looking with trust and love upon the Face of Christ Crucified (cf. *Novo Millennio Ineunte*, 16) and by uniting your sufferings to his.

I entrust you all to the Immaculate Virgin, our Lady of Guadalupe, Patroness of the Americas and Health of the Sick. May she hear the prayers that rise from the world of suffering, may she dry the tears of those in pain, may she stand beside those who are alone in their illness, and by her motherly intercession may she help believers who work in the field of health care to be credible witnesses to Christ's love.

To each of you I affectionately impart my Blessing!

From the Vatican, 2 February 2003



Fifth Plenary Assembly of the Pontifical Council for Health Pastoral Care

May 2-4, 2002
Domus Sanctae Marthae
Vatican City

Address of Homage to the Holy Father

Most Blessed Father,

I am happy to introduce to Your Holiness the Members and some of the Consultors that you recently appointed or reappointed to their positions in the Pontifical Council for Health Pastoral Care. They are the most Eminent Cardinals, most Excellent Archbishops, bishops, presbyters, religious and members of the laity that are present here. I would also like to introduce to you the Secretary, His Excellency Msgr. José Luis Redrado O.H., the Under-Secretary, Rev. Felice Ruffini M.I., and the Officials and staff of the Pontifical Council.

During these three days we will meet for our fifth plenary assembly in order to draw up a project for the planning of our dicastery that is in line with your directives for pastoral care in health. We have taken these directives from the *Motu Proprio*, *Dolentium Hominum*, by which Your Holiness established our dicastery, and from the apostolic constitution *Pastor Bonus*, which summarises our tasks. All this is done in the light of the apostolic letter *Novo Millennio Ineunte*, without, however, neglecting the rich doctrine expressed by Your Holiness in the encyclical *Salvifici Doloris*. We want to subject our project to your possible approval so that it can then be the work plan of the Pontifical Council for Health Pastoral Care over the next five years.

The point of departure, the general objective, of our work plan is: to show the Face of Christ, suffering and joyful, in the mystery of his death and resurrection, in order to carry out the New Evangelisation in the world of suffering and health. In this Face we contemplate the deepest meaning of the instinctive perception that Your Holiness had in establishing our dicastery, which expresses the care and concern of the Church for the infirm and the suffering by helping health workers in a spiritual way. The very structure of the triple ministry of the Church has enabled us to organise the work of our dicastery around three specific objectives: the Word of God, Sanctification, and Ecclesial Communion. We have asked ourselves how we can be more effective in helping Your Holiness in the primatial work of pastoral care in health, and our project of planning is that response that we have to delineate, thereby bringing to completion the fifty-one programmes of our dicastery carried out hitherto.

May Your Holiness bless our humble co-operation, indicate your will, and illuminate us with your authoritative words.

H.E. Msgr. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop of Zacatecas,
President of the Pontifical Council
for Health Pastoral Care,
the Holy See.

The New Fronties Opened up by Progress in the Sciences of Life Ought to be Shaped by the Culture of Life, so that the Human Being will Find an Effective Response to his Deepest Longings

THE HOLY FATHER'S ADDRESS TO THE V PLENARY ASSEMBLY OF THE PONTIFICAL COUNCIL FOR HEALTH PASTORAL CARE THURSDAY, 2 MAY 2002

Brothers in the Episcopate
and in the Priesthood,
Dear Brothers and Sisters,

1. I am particularly pleased to have this meeting during the Plenary Assembly of the Pontifical Council for Health Pastoral Care that offers you the occasion to examine and draft a new plan of work for the next five years.

I greet the President of the Council, Archbishop Javier Lozano Barragán and thank him for his cordial words expressing your sentiments of esteem. I greet the Cardinals and my Brothers in the Episcopate, the members, consultors and experts of the Council, the Secretary and the Undersecretary as well as the other officials, priests, religious and lay people. I thank you all for the precious help you give me in such a critical area of our Gospel witness.

2. The great amount of work that your Council has accomplished in the 17 years since its foundation confirms how necessary it is that among the offices of the Holy See there should be one that is specifically designated to manifest *"the Church's concern for the sick, assisting those who serve the sick and the suffering, so that the apostolate of mercy on which they rely may respond ever better to the new needs"* (Apostolic Constitution *Pastor Bonus,* art. 152).

Let us thank the Lord for the wide range and variety of pastoral activities carried out in the field of health care around the world with the stimulus and support of your Council. I encourage you to continue in that direction with zeal and confidence, so that you can offer to the people of our time the Gospel of hope and mercy.

3. Taking a cue from the Apostolic Letter *Novo Millennio ineunte,* at your meeting you

plan to reflect on the best way to *reveal the suffering and glorious face of Christ enlightening* the world of health care, suffering and illness with the Gospel, *sanctifying* the sick and health-care workers and *promoting* the coordination of pastoral health care of sick persons in the Church.

During this Easter season, we contemplate Jesus' *glorious face* after meditating, especially in Holy Week, on his *sorrowful face.* It is in these two dimensions that we find the core of the Gospel and of the Church's pastoral ministry.

I wrote in my Apostolic Letter *Novo Millennio ineunte* that Jesus "at the very moment when he identifies with our sin, "abandoned' by the Father, he "abandons' himself into the hands of the Father". In this way he lives "his profound unity with the Father, by its very nature a source of joy and happiness, and an agony that goes all the way to his final cry of abandonment" (n. 26).

In the suffering face of Good Friday is hidden the life of God, offered for the salvation of the world. Through the Crucified One, our contemplation must be open to the Risen One. Comforted by this experience the Church is ever ready to continue her journey to proclaim Christ to the world.

4. Your plenary assembly focuses on programmes that aim at enlightening the entire world of health care with the light of the *sorrowful and glorious face of Christ.* In this perspective, it is crucial to reflect more in depth on topics that are bound up with health care, sickness and suffering, guided by a concept of the human person and his destiny that is faithful to the saving plan of God.

The new frontiers opened up by progress in the sciences of life and the applications deriving from them, have put enormous power and responsibility in man's hands. If the *culture of death* prevails, if in the field of medicine and biomedical research those doing the research let themselves be conditioned by selfish and Promethean ambitions, it is inevitable that human dignity and life itself will be dangerously threatened. However, if work in the important health care sector is shaped by the *culture of life,* under the guidance of right conscience, the human being will find an effective response to his deepest longings.

The Pontifical Council will not fail to contribute to a new evangelization of suffering, that Christ takes on and transfigures in the triumph of the Resurrection. In this regard, the life of prayer and recourse to the Sacraments are essential, for without them the spiritual journey of the sick and of those who take care of them becomes difficult.

5. Today, the sector of health care and suffering face new and complex problems that demand a generous commitment from everyone. The dwindling number of women religious involved in this field, the difficult ministry of hospital chaplains, the problem of organizing a satisfactory and effective health care apostolate at the level of the local Churches and the approach to health-care personel who are not always in accord with the Christian vision, form a plethora of complex and problematical topics that you have certainly noticed.

Faithful to its mission, your Council will continue to show the pastoral concern of the Church for sick people, it will help all who care for the suffering, and particularly those who work in hospitals, always to respect the life and dignity of the human being. To achieve such objectives it will be useful to collaborate generously with the international organizations concerned with health care.

May the Lord, the Good Samaritan of suffering humanity, help you always. May the Blessed Virgin Mary, Health of the Sick, sustain you in your service and be your model of acceptance and love.

As I assure you of my prayers, I cordially impart to you my Apostolic Blessing.

An Account of the Assembly

On 2-4 May the Pontifical Council for Health Pastoral Care met for its plenary assembly together with its Members and some of its Consultors. The task of the participants was to:

1) Assess the implementation of our programmes according to the goals that we have set ourselves over the last five years.

2) Make suggestions to shape the practical purpose of our Pontifical Council at the beginning of the third millennium according to the Apostolic Constitution 'Pastor Bonus', the Motu Proprio 'Dolentium Hominim' (the document that established this dicastery), and the Apostolic Exhortation 'Novo Millennio Ineunte'.

3) Make suggestions in the light of what has been said to improve the existing programmes, renew them or add others.

After a greeting addressed to all the participants, the President of the dicastery, H.E. Msgr Javier Lozano Barragán, opened the proceedings by presenting the subjects that would be addressed and the methodology that would be followed. The objective of this general assembly was to make the Pontifical Council an instrument that was more suited to the Holy Father for the new evangelisation of pastoral care in health at the beginning of the third millennium. Indeed, according to the Apostolic Constitution 'Pastor Bonus', at n. 152, 'The Council expresses the care and concern of the Church for the sick by helping those who provide service to the sick and suffering so that the apostolate of mercy, which they await, will respond increasingly better to new needs'.

This task has been performed with reference to the following guidelines, which are also indicated by number 153 of the Pontifical Council's Constitution, namely: '1. It is the responsibility of the Council to make people know about the doctrine of the Church on the spiritual and material aspects of illness and the meaning of human pain. 2. It offers its co-operation to local Churches so that pastoral workers can receive spiritual assistance in the performance of their activity in line with Christian doctrine; and so that there is no lack of adequate support in the carrying out of their work for those who engage in pastoral action in this sector. 3. It fosters theoretical and practical activity, which in this field is developed in various ways (both as regards international Catholic organisations and as regards other institutions). 4. It closely follows the new developments in the legislative and scientific field which see health as the principal goal of the pastoral action of the Church'.

In the Pontifical Council we tried to implement the mandate of the Holy Father by engaging in a programming of the work of the Dicastery, and this gave rise to another fifty programmes which were organised according to the three classic sub-headings of the Church, namely teaching, sanctifying and engaging in communion.

During the papal audience in the Sala Clementina, granted to those taking part in the Plenary Assembly, on the first day, Thursday 2 May, the Holy Father, after expressing his happiness at the activity carried out by the dicastery, emphasised: 'your Assembly has as its objective to reflect upon how to better *show the face of suffering and glorious Christ* by *illuminating* the world of health, suffering and illness with the Gospel, *sanctifying* the sick and health care workers, and *promoting* the co-ordination of pastoral care in health within the Church'. His Holiness added: 'the new frontiers opened up by the progress of the life sciences…have placed an enormous power and responsibility in the hands of man. If the *culture of death* prevails…it is obvious that human dignity and life itself will be dangerously threatened. If, on the contrary, the work in this important sector of health is marked by the culture of life, under the guidance of an upright conscience, man will find valid answers to his deepest hopes'.

The fruit of the V Plenary Assembly is the work plan of the Pontifical Council for Health Pastoral Care, a valid instrument for the daily work of the dicastery. Approved by the Holy Father, the work plan involves fifty-three programmes organised around the Ministries of the Word, of Sanctification, and of Communion, and is entrusted to those who make up the dicastery: Superiors, Officials, and voluntary helpers.

A copy of 'The Work Plan 2002-2007 of the Pontifical Council for Health Pastoral Care' has been sent to the heads of the dicasteries of the Roman Curia, to the representatives of the Pope, to the Presidents of the Bishops' Conferences, to bishops responsible for pastoral care in health, and to the Members and Consultors of the Dicastery.

H.E. Msgr. JOSÉ L. REDRADO, O.H.,
Secretary of the Pontifical Council for Health Pastoral Care, the Holy See.

Homily at the Opening Holy Mass

2 MAY 2002

Your Eminences, Your Excellencies, dear Members, Consultors, Officials and other Staff-members of our dicastery,

I would like to welcome you to begin with to our fifth plenary assembly of the Pontifical Council for Health Pastoral Care. And I would like to congratulate you because it is a great privilege to be able to help the Holy Father to carry out his primatial mission in pastoral care in health. This, indeed, is the purpose of our fifth plenary assembly.

We will begin by invoking the Holy Spirit and asking him to guide us and illuminate us in the bringing up to date of our mission in this both difficult and important field. This is because the new evangelisation has its critical juncture precisely when it manages to give or to find a suitable answer to the problems that we are dealing with, namely those that are connected with pain, suffering and, principally, death. Our response to health, and to life, as we can answer precisely during these days of Easter, with that mystery that is the key to the great turning point of history, is the death and the resurrection of Jesus Christ. We implore the Holy Spirit to want to open up to us new horizons, so that we can evangelise this secularised world which has so much fear of death and indeed does everything it can to conceal death.

In this Eucharist we ask help from the Holy Spirit to understand the fundamental gospel-based lines of pastoral care in health, contemplating as we do the Lord Jesus healing the sick and giving back life to the dead. The gospel text that we have listened to tells us about all the miracles regarding health taken as a whole, but I believe that it would be useful to make a brief mention of each of the individual gospels in order to find their shared elements and thereby discover the lines that the Good Shepherd wants to show to us so that we can carry out this specific pastoral action.

St. Matthew tells us about four healings: that of the servant of the centurion; that of the two blind men; that of the blind and dumb man; and that of the two blind men in Jericho (Mt 8:5-13; 9:27-31; 12:22-23; 20:29-34).

St. Mark tells us about eight miracles: the healing of St. Peter's mother-in-law of her fever; the healing of the leper; the healing of the paralytic who was let down from a hole in the roof in the house where Christ was speaking and teaching; the curing of the man with the withered hand in the synagogue; the raising from the dead of the daughter of Jairus; the healing of the woman suffering from an issue of blood; the healing of a man who was deaf and dumb; and the healing

of the blind man of Bethsaida (Mk 1:29-32; 40-45; 2:1-12; 3:1-6; 5:21-43; 7:31-37; 8:22-26).

St. Luke gives accounts of five examples of healings: the raising from the dead of the son of the widow of Nain; the healing of the woman with a bent back who was in the synagogue on the day of the sabbath; the healing of the man suffering from dropsy: the healing of the ten lepers; and the healing of Malchus's ear which took place in the garden of Gethsemane (Lk 7:11-17; 13:10-13; 14:1-6; 17:11-19; 22:50-51).

St. John tells us about four miracles involving healing: the healing of the son of the royal official; the healing of the paralytic of the pool of Bethzatha; the healing of the man who had been blind from birth; and the raising of Lazarus from the dead (Jn 4:46-54; 5:1-9; 9:1-7; 11:38-44).

Thus the Evangelists tell us about twenty-one acts of healing. Some are all narrated by the three synoptic gospels but others are described by one Evangelist alone – St. John. Different kinds of infirm and sick people are described by the gospels: the blind, the dumb, the deaf, the lame, paralytics etc. And there are also those people who are already dead. Some miracles are repeated; others are not. Fever is healed twice, health is restored to a terminally ill person, a person suffering from dropsy is healed, three paralytics are healed, six blind men can see, a blind and deaf man sees and speaks, a deaf and dumb man hears and speaks, an ear is restored, eleven lepers are healed, and three dead people are brought back to life.

In these miracles the following elements are emphasised: the miracles are the sign that the Kingdom of God is present; liberation from sin and liberation from illness appear as being directed towards the great miracle of the resurrection of Christ. The physical contact of Christ with the sick people is very important, it presents itself as a sign of the transmission of life, as an expression of the love of God and of the King-

dom. The sacred time, that of the Sabbath, is joined to the miracles as being contact with God, as a return to original harmony, as the time of waiting for the continual celebration of heaven, as the salvific presence today of the Lord, and as absolute trust. The restoration of sight appears as a symbol of the light that is Christ, who lights up the world; and the steps that take place in one instance to restore sight indicate the painful and slow pathway that leads to growth in faith. The importance of the gratitude of those who are healed also appears as being important, and the same may be said of the reintegration of those who had previously been excluded back into the community. Those people who have been the objects of miracles spread the fame of the Lord; today, we could say that upright public opinion comes to be formed. Much emphasis is also placed on prayer, praise of God, the action of forms of grace, faith, effective compassion, and dominion over life.

According to this lesson of the divine Teacher and Physician, it seems that our pastoral care in health should emphasise the following points:

– To present pastoral care in health as a sign that the Kingdom of God has arrived, as a return to original harmony, as the time of waiting for the continual celebration of heaven.

– To root pastoral care in health in the prayer of petition, praise and worship of God the Almighty Father.

– To create a vital contact between Christ and the world of health and health care.

– To hear God and make Him be seen in pastoral care in health, to identify with the sick person, and to merge oneself into the passion, death and resurrection of Christ.

– To work in such a way that all our actions converge in the resurrection of Christ and in our resurrection.

– To show that Christ is the Lord of life, a full source of love, and a salvific presence.

– To animate the three theological virtues of faith, hope and charity; perhaps laying emphasis on hope in this secularised world.

– To develop pastoral care that is full of friendship and sensitivity, assimilating oneself to every sick person, and having real compassion for him or her.

– To forgive; to banish all those procedures that could alienate people.

– To foster an environment of trust, free giving and gratitude in pastoral care in health.

– To adapt oneself to the rhythm of faith and illness present in every patient and suffering person.

– To unite the suffering and the sick with their own families and communities.

– To spread a Christian culture of health.

May the Holy Spirit help us in this fifth plenary assembly to understand and experience at a deeper level the suffering Face of Christ as health, life and resurrection, as we are now celebrating it in this Eucharist!

H.E. Msgr. JAVIER LOZANO BARRAGÁN,
Archbishop-Bishop of Zacatecas, President of the Pontifical Council for Health Pastoral Care.

Homily for the Second Day

3 MAY 2002

Praise be to Jesus Christ,
'Whatever request you make of the Father in my name, I will grant' (Jn 14:13)

Your Eminences, Your Excellencies, Most Dear Brothers and Sisters,

This verse from the Gospel according to St. John, which I have chosen as the theme of our reflection here today, seems to me rich in theological meaning. It opens up to us unimaginable horizons. The Lord implicitly invites us to pray to his Father in heaven. He assures us that our prayer will certainly be heard. He imposes upon us, however, a condition, and that is that this prayer must be directed to the Father through him, the only Begotten Son.

1. It is Holy Thursday and Jesus is washing the feet of his disciples, he neglects Judas the traitor and gives the disciples a new commandment: that of the love that they must have for each other. Then he goes on his way. Peter, however, cannot follow him: 'Simon Peter said to him, Lord, where art thou going? Jesus answered him, I am going where thou canst not follow me now, but shalt follow me afterwards. Lord, Peter said to him, why cannot I follow thee now? I am ready to lay down my life for thy sake. Thou art ready, answered Jesus, to lay down thy life for my sake? Believe me, by cockcrow thy wily thrice disown me' (Jn 13:37-38). This was a harsh lesson that Christ gave to Peter and it amounted to the idea that one should never rely upon one's own strengths and force but only upon those that come from on high. This was the first speech that Jesus made to his disciples as he was about to return to the Father. It was,

however, to be followed by another – that of the farewell that he gave to them. And it was precisely in this context that Jesus invited his disciples to pray, saying to them the following words: 'whatever request you make of the Father in my name, I will grant'.

The *Catechism of the Catholic Church* teaches the following about prayer: 'When Jesus openly entrusts to his disciples the mystery of prayer to the Father he reveals to them what their prayer and our must be, once he has returned to the Father in his glorified humanity. What is new is to 'ask *in his name*' (Jn 14:13). Faith in the Son introduces the disciples into the knowledge of the Father, because Jesus is the 'way, and the truth, and the life (Jn 14:6)'' (*Catechism of the Catholic Church*, 2614).

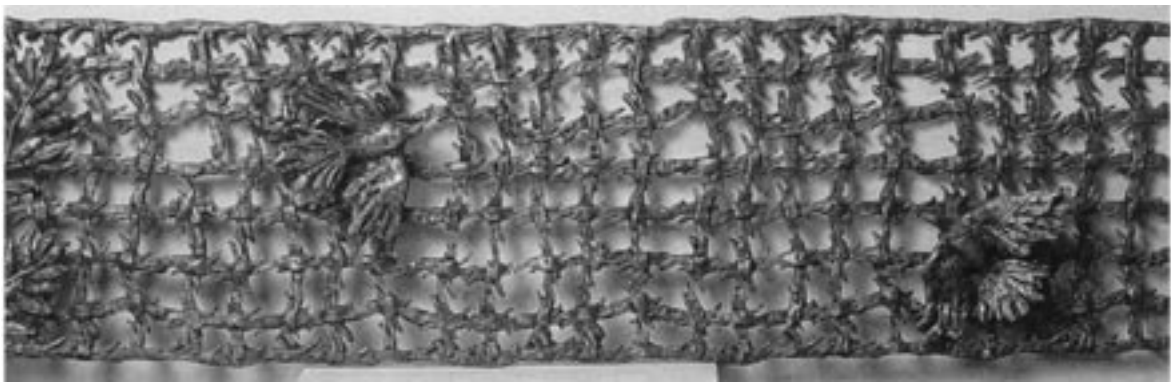
2. This is certainly not the first time that the Lord invited us to pray. It was Jesus who taught us to pray following his example, and above all else taking him and his dedication to prayer as a model. It was Jesus who said to us: 'when you are at prayer, do not use many phrases, like the heathens, who think to make themselves heard by their eloquence. You are not to be like them…This, then, is your prayer, Our Father, who art in heaven…'(Mt 6:7, 9). Furthermore, the person who has faith, strengthened by this prayer addressed to the Father in the name of the Son, will perform the same works as Jesus did, and indeed will perform even greater ones. How much do we need to penetrate the salvific words of Jesus! After all, only faith in God can make peace rule in a soul that is subject to pain and fear. It is true that we are on a journey, as long as we are here on this earth, in the darkness of faith – perfect vision, indeed, belongs only to eternity. And it is this faith that leads us to that blessed eternity if we believe in this unity that exists between the Father and the Son, and if we make our requests to the Father in the name of the Son. The Father answers the prayer of Jesus, just as Jesus has answered the prayers of so many sick people who asked him to be cured. St. Augustine summarised the three dimensions of prayer in an admirable way as follows: 'He prays for us because he is our Priest, prays with us because he is our Head, and is prayed to by us because he is our God. We thus recognise our voices in him and his voice in us'.

3. The apostolic letter *Motu Proprio* by which the Holy Father established the Pontifical Commission for Pastoral Assistance to Health Care Workers declares as follows: 'in its approach to the sick and to the ministry of suffering, the Church is guided by a precise conception of the human person and his destiny in the plan of God. She believes that medicine and therapeutic treatment should aim not only at the good and the health of the body but at the person as such who in his body is afflicted by evil. Illness and suffering, indeed, are not an experience that concern only the physical substratum of man but regard man in his entirety and in his somatic-spiritual unity. It is known, for that matter, that at times an illness which manifests itself in the body has its origins and its real cause in the recesses of the human psyche' (par. 2). Now the human spirit is only raised with that peace that Christ alone knows how to give. Did he not perhaps say: 'Peace is my bequest to you, and the peace which I give you is mine to give; I do not give peace as the world gives it' (Jn 14:27)?

During the speech that he gave to those taking part in the last plenary assembly of the Pontifical Council for Health Pastoral Care, the Holy Father pointed out certain obstacles that men encounter in the defence of health: 'Violence, drugs, kidnappings, the marginalisation of immigrants, abortion, and euthanasia, are attacks on life that result from human initiative' (n. 3) Is this not perhaps what prevails in the lives of so many people nowadays? Is it possible not think of what happened on 11 September 2001 in the United States of America and what is happening now between Palestinians and Israelis in the Holy Land where Christ was born, lived, died on the cross and rose again? Or rather, do this land and the whole of its region run the risk of being without Christian witness?

Let us pray to the Lord of life and death to give us a heart of flesh which knows how to help people and how to pray. We have faith in what he said to us: 'Whatever request you make of the Father in my name, I will grant'.

His Eminence Cardinal
NASRALLAH PIERE SFEIR,
Patriarch of the Maronites of Antioch, the Lebanon.



Homily for the Third and Last Day

4 MAY 2002

Dear Brothers and Sisters,

The text of Isaiah on a virgin who would give birth to a son can be read from an immediate historical perspective: the Prophet was in fact referring to the son of King Ahaz, that is to say Ezekiel, who was to be born as a sign of God that the dynasty would continue. But the greatness and solemnity of the dialogue between God and the king, the highly symbolic name of the child, who was called 'God with us', and the messianic reading that the People of Israel gives to the text, place it within a privileged prophetic perspective. The Greek version by the seventy sages always translated the term 'girl' or 'maiden' with 'virgin' and this was how the Christians received it. The evangelist St. Matthew does not hesitate to proclaim this passage as an announcement of the virgin birth of Jesus, to whom, for that matter, the name of God for us perfectly applies (Mt 1:23).

With this dual prophetic force, Isaiah presents us with a dialogue between God and King Ahaz in which the Lord shows his generosity and Ahaz displays his lowness. God proposes to the king that he should ask for a sign from heaven. This is a divine proposal. God is not a tempter who is seeking to deceive the king, indeed he allows him the freedom to choose the kind of sign that he wants, whether in the heights of heaven or the depths of the underworld.

But Ahaz seems not to acknowledge the immensity of God and His goodness. It is though he was doubting God's intentions, which always go in the direction of mercy and love. In essential terms, Ahaz fears the responsibility that every sign from heaven brings with it. The burning bush was the sign that God gave to Moses and which led him to a mission that asked for the sacrifice of his life for his people. What, therefore, would God have asked of King Ahaz? This suspicion worried him and he was afraid of what the Lord could have required of him – perhaps a difficult mission full of sacrifices involving the leadership of his people, Ahaz then covered himself with false humility and fake reverence and answered 'no'.

This well-known prophecy of Emmanuel provokes wonder in us every time that we compare and contrast it with the declaration of the angel to Mary, who answers with an unequivocal 'yes' to God, and thus, through her, the 'God with us', who was only an announcement, became flesh and really came to live amongst us.

Mary is the girl who is married to Joseph but with whom she has never had carnal relations: *I have no knowledge of man*. She is the Virgin suddenly placed in front of the sign that God gives to her: an angel who greets her calling her *full of grace*. Mary was surprised at that greeting and was afraid.

But the fear of Mary was not like the fear of Ahaz – it was the reverential fear of not knowing how to please God, who has visited her with so much sensitivity; it was like the concern of a flower faced with dew which renders it even more beautiful; it was the amazement produced in her by the mystery that surrounded her; it was the fear of a humble person face to face with the immense, provoked in her by thinking that the wonderful reality that surrounded her could overcome her smallness. She was going to give birth to a son…it was to be the Son of the Most high, but what was she to do? How was all this possible? Do not be afraid, Mary, the Holy Spirit will cover you with his shadow. And Mary said: I am the handmaiden of the Lord.

And the word was made flesh and came to live amongst us.

In Mary, everything is the welcoming of grace and self-dedication to the inscrutable plan of God.

Mary knew whom she could trust; she did not know the plan of God in its sublime details but she knew Whom she was placing her trust in. For this reason, the Mother of the Saviour is the model for the believer.

King Ahaz did not trust what God wanted from him and vacillated, not out of weakness but out of calculation. In his way of thinking there was a contorted idea of God. He does not discover God in all his greatness and goodness and for this reason he tries to avoid Him. There is blasphemy in his action. And this is his great sin.

In Mary, trust in God floods the scene of the Annunciation with serenity and peace. He who has sent the angel loves her. He greets her with fine words, envelops her with his shadow to protect her and makes her womb fertile, and she is all trust and readiness to do what is bidden of her.

When one believes as Mary did there are no doubts; there are no trials which torment us forever, insuperable anxiety, depression in the face of adversity. This is because *for God nothing is impossible*.

Blessed are you for your believing, Elizabeth said to Mary when receiving her in her home.

All the generations will count me blessed, the moved Mary answers her in her canticle of praise. We, saved by Jesus, the fruit of the womb of the Virgin Mother, beseech Mary to free us from the sadness of not believing, or the sadness of believing in a contorted way, with a lack of trust, like King Ahaz. We ask the Mother of the Lord to help us to discover in the face of her Son the one and true God, who is love, whose mercy reaches his faithful from generation to generation, even to our times, which are apparently cold and without belief.

The men and women of today want to see Jesus. They expect from us an answer rooted in our faith that will foster their encounter with Jesus. Let us distance from ourselves the calculated evasiveness of King Ahaz; may our hearts open to a faith which is trusting and able to accept risks, like the faith of Mary!

Contemporary secularism, a lukewarm attitude to evangelising, pessimistic sociological considerations that paralyse religious faith, and the insensitivity and indifference of the Christian peoples towards the impoverished masses who are sick and hungry – all these forms of acute poverty of the spirit which seem to permeate the Christian of today come from the lack of faith of the disciples of Jesus. With our gaze upon Mary, the model for the believer, we repeat to Jesus in this Eucharist the plea of the father of the epileptic: *I believe Lord, but increase my faith*.

His Eminence Cardinal
JAIME ORTEGA Y ALAMINO,
Archbishop of La Habana, Cuba

Topics

The Humanisation of Death

The Pastoral Accompanying of the Dying

Informed Consent: Between Ethics and Law

Duc in altum! Medical Doctors and the New Evangelisation

St. Josemaría Escrivá

The Humanisation of Death

1. Man Faced with Dying

Down the centuries, the sets of questions and issues connected with the culture of death have helped to form a certain 'idea' of death, or better a different way of 'living death', according to the different cultural sensibilities of the various historical periods.

Philipe Ariès is the historian who more than any other has studied the subject, and his work has become an obligatory work of reference.[1] In his inquiry he identifies four great periods.

a. The first period was that of *tamed death*. In practice, it lasted for millennia and continued until the medieval period. Man knew that he had to die and waited for this event with a certain peace of mind; often he knew that little time living remained to him, but he was not worried about this fact. At times, indeed, he prepared himself to wait for death with ritual acts (he crossed his arms over his chest, he lay down in the direction of Jerusalem, etc.). The event was not experienced in the darkest loneliness, indeed it was almost an organised public ceremony: 'the room of the dying person then became transformed into a public place. People could enter it freely. The physicians of the end of the eighteenth century who discovered the first rules of hygiene were little concerned about the crowding of the rooms of the dying. Still at the beginning of the nineteenth century, the passers-by who in the street met the small procession following the priest who was carrying the viaticum accompanied him and behind him went into the room of the sick person. The relatives, the friends and the neighbours of the sick person had to be present. Children were brought in: until the eighteenth century, indeed, there is no picture of the room of a dying man which does not have children in it. When one thinks about the precautions that are taken today to distance children from the room of a dying person! Lastly, a final observation, and the most important one: the simplicity with which the death rites were accepted and carried out, in a ceremonial way, but without a dramatic character and without excessive emotion'.[2]

b. From the twelfth to the eighteenth centuries the 'socialised' dimension to death began to retreat, and death came in an increasingly exclusive way to involve only one individual. This is what Ariès calls *death on one's own*. 'The generally apocalyptic tomb paintings of the past were substituted by 'personalised' elements which contained judgements on one's own works: Christ the judge, Our Lady and the saints asking for intercession at her feet, the 'book' of works hung around a person's neck, etc. In the iconography, the rooms of dying people are crowded with new figures: angelic and infernal forces struggling for his soul. Because of the influence of the mendicant orders as well, the assessment of the works done by the person during his life acquired an increasing relevance. Lastly, the 'macabre themes' appeared: skulls, bones, corpses, lugubrious and shadowy images. This was the sign of a 'horror' which began to advance and which emphasised the element of 'detachment from the goods enjoyed during one's lifetime. In practice 'a drawing near of two categories of mental depictions took place: those of death; of the knowledge that somebody had of one's own biography; of passionate love for the things and beings possessed during one's lifetime. Death became a place where man became most aware of himself'.[3]

c. Beginning in the eighteenth century, death underwent a new process of socialisation that did not retrieve the taken for granted aseptic character of 'tamed death' but developed, added to and projected the experience of 'death on one's own' – *this is the death of the other person.* 'Death in one's own bed, as once happened, had the solemnity but also the banality of seasonal ceremonies. Everybody expected them and participated in the rights established by custom. Instead, during the nineteenth century a new passion gained hold of the onlookers. Emotion agitated them; they wept, prayed and gesticulated. They did not reject the gestures dictated by custom – on the contrary. But they carried them out in a way that deprived them of their banal and customary character. By now these gestures were described as though they had been invented for the first time, as thought they were spontaneous, inspired by a passionate pain, which was unique of its kind. Certainly, the expression of the pain of the survivors was due to a 'new intolerance towards separation'. But the disturbance did not survive only the bedside of the dying person or the memory of those who had passed away. The idea of death in itself was emotionally moving'.[4]

d. The final period, which goes from the nineteenth century to today, is that of *forbidden death*, the fruit of a vast cultural movement that probably originated in America and from there was extended for the most part to the countries of the Western world.[5] A profound change in sensibility, attitudes and forms of behaviour towards death arose, which, given the repercussions for the ethical questions that we are addressing in this paper, requires detailed analysis.

2. 'Forbidden Death' in Contemporary Western Society

In seeking to investigate the characteristics of this 'forbidden death', as it is so defined by Ariès, we can summarise them with a few key concepts of an anthropological-cultural character. They may be deliberately confined at the level of analysis to Western society given that experience of such forbidden death has been clearly of a very different nature in oriental or tribal cultures.

a. *Denial*. This is expressed essentially in the various forms of 'censorship' to which contemporary culture has subjected death. First of all, there are *social forms of censorship*, as result of which, as a very effective phrase of one scholar would have it, a real 'pornography' of death has now become established.[6] What was once the taboo of sex is now the taboo of death – it is simply that the object subjected to a taboo has changed.

From this springs various forms of oral censorship: it is no longer children who are born under cabbages but grandparents who go off for a long trip or for a walk in a large garden.[7] Death is no longer talked about, addressed, or discussed; its very name is euphemistically masked and avoided – the loved person 'is no longer with us'; he 'has gone away', or he has been 'lost'.

The masking of death is even more evident in the visual *forms of censorship* that take place *de facto* in the common American practice of the *maquillage* of corpses, a practice by which the dead person must not appear as such but must almost appear as a living person who is asleep. The *physical forms of censorship* could also be seen in this light. These take concrete form today in the increasing preference for cremation in the place of more customary burial, which may be seen as almost the expression of a wish to bear witness to a refusal of that physical nature which is destined to decay.

But the greatest example of the application of a taboo is certainly achieved in *cognitive forms of censorship*, where death is often concealed from the dying person himself. From a correct criterion of 'psychological proportion', of adaptation to the receptive capacities of the subject, we have passed, in fact, to the arbitrariness and by now almost universal custom of concealing the seriousness of a pathological state or the imminent possibility of death from the interested party. The idea of harming him thus provokes a certain 'expropriation' of the event, which belongs to him and which he has the right to experience in full knowledge. This praiseworthy but superficial sensitivity towards the dying person even leads to the request, on the part of the relatives of the comatose person, 'not to speak because *he can hear* us' or to the construction of very complicated intrigues marked by lies involving the medical doctor who is asked by the relatives to 'take part in the game that is being played'.

b. *Privatisation*. At one time death was a kind of death that was greatly participated in by people. Those in the neighbourhood expressed their solidarity in a notable way providing meals for a number of days or by doing the housework. Close at hand during joyous events (marriages, births, baptisms), other people were also near at the moment of pain.

All this has been progressively disappearing. Pain, but also death as a 'social' event, has been increasingly interiorised, and to such a point that the 'other person', who was at one time sought out for his comfort and help, now is a factor of disturbance. He is told: 'forget about the visits'. Twentieth century man wants to be left alone with his pain, but above all else he wants to be left alone with his death.

This privatisation does not only affect the individual sphere, it also affects the social sphere. Although, on the one hand, the idea is to leave people alone with their own pain, on the other hand, it is not felt necessary to point out such suffering to society. The external trappings of mourning disappear; indeed, they give rise to irritation. Obituary notices on walls no longer exist, and often the death of a relative is not communicated at all. Today, funerals, and not only funerals that are strictly religious in character, are becoming increasingly simple: a *simple* coffin is wanted, a *simple* funeral, and a *simple grave*. The baldachins in front of the church are disappearing, as are the eight days of mourning, the lengthy examples of 'accompanying'. Undertakers, for their part, have become transformed linguistically – they have become 'funeral companies'.

c) *Loneliness*. On another front, however, such radical privatisation is also an expression of the loneliness that surrounds the dying person. Everybody flees from him. First of all, his family relatives flee from him, either because they are weakened by being present in a powerless way at the side of a long experience of suffering or because they are incapable of transmitting the inevitability of the event to their loved one.

Secondly, the health care workers flee from the dying person. From this point of view, the usual question of whether to tell the truth or not to the sick person should be inverted. Too often, in fact, one is dealing with a false problem

which in reality conceals the difficulty that is encountered – the embarrassment felt by, or the real and effective inability of, the medical doctor when it comes to communicating a bad prognosis to the patient or to being prepared to answer the many questions that the sick person will ask him because of that communication.

Lastly, the whole community, both in its civil and church forms, also flees from the dying man. Reference has been made previously in this paper to the irritation that a visit of condolence, or in some way an approach to a person who is in mourning, provokes. This irritation also continues afterwards, during the subsequent stages, when in fact the community should be of determining importance in favouring the evolution of the mourning itself, which, instead, in most cases, comes to be abandoned to the person's own rhythms, separately from any positive help provided by other people. But the Church as well, and this point has to be conceded, is also to be blamed. An overall and rich pastoral approach to the dead is absent. In parish communities, the various groups that are present are concerned with many different kinds of activity, all of which are, it must be recognised, admirable, but they find notably little space to accompany the sick people of their parishes to their final point of arrival.

d) *Secularisation.* Having touched on the question of the responsibilities of the Church, we cannot but bring out another failing, which from certain points of view is even more serious: the process of secularisation, which has pervaded our society, has had some undoubted repercussions as regards people's ideas about life, death, and the life beyond.

This is not the place to analyse the possible responsibilities of the Church as regards this process. What we must certainly emphasise is how from all of this there has derived, in the theological-pastoral sphere as well, a weakening of the original eschatological tension of the Christian message, Naturally, this does not in the least mean that we should retrieve or propose once again the 'exercises of a good death', the thundering sermons on the fires of hell, the obfuscation of Christian joy and so forth. We must, instead, find new paths, with wise pastoral creativity, to give impetus to an eschatology that is suitable to the third millennium. Such an eschatology should be based upon resurrection more than upon eternal punishment, but it should also be informative as regards the whole existential journey of man.

Perhaps we should also attribute this catechetical void to an undoubted impoverishment of the cult of the dead, which is now in large measure a cult connected with the cemetery or even at times reduced to a mere cult of corpses. It is not to be excluded that some of the concern about the donation of organs is rooted specifically in this cultural background.

e) *Medicalisation*. This is one of the saddest and most inhuman aspects of contemporary death. The increase in average life expectancy, the advances in medicine, and the increase in individual and social prosperity all mean that people die in their homes increasingly rarely and that increasingly often they die in hospitals, where death is no longer the concluding event of a long life but rather the terminal event of an illness.[8] The general validity of this statement becomes of even greater contemporary relevance when it is applied to the death of young people, or, in any event, to cases of people who have not yet reached the so-called 'third age', for whom, indeed, every kind of medical treatment, even the most extreme, is sought after, asked for, and demanded in every way.

In contrary fashion, 'death at home' is limited to terminally ill people for whom it is thought nothing can be done, or to elderly people who have been rejected by hospitals or abandoned to themselves because of the laziness of their family relatives. Death in such cases becomes an almost anomalous event. One can thus well affirm that a 'natural' death no longer exists.

The 'medical' dehumanisation of death, in addition, is not only a question of social context but also of social relations. I mean by this not only that it is in some way 'unnatural' to medicalise death to this point but also that it is unnatural to handle it in such an inhuman way. Here the *humanitas* of the medical doctor comes into play, as well as his ability to empathise with the sick person (in this case with a dying person) and with his family relatives without distancing them from one other. This is, therefore, a very complex phenomenon but it is of primary importance that the absolute and incumbent aseptic approach of the medical doctor/technician (which cannot be and must not be in any way disturbed by emotional factors) is mixed with the warm capacity for relationships of the medical doctor/man who is fully and quali-

fiedly involved in the event that he is following.

f) *Objectification*. Whereas in the past death was an event that deeply involved the subjectivity of the individual and did not go beyond that boundary, today death presents itself in its 'objective' dimension and it is possible to experience it as such. The first change in direction took place during the last century with the advances in *pathological anatomy*. Death was no longer only ascertained but also explored, analysed and defined. The causes of its occurrence were looked for, it was studied on the anatomical table, the alive existential nature of an individual was transformed into the cold objectivity of a corpse. Far from wanting to demonise the benefits that accrued from such advances, I should nevertheless state that it is evident that they affected the intangible sacredness of the deceased person much more than the simple anatomical studies had previously done. Such studies, in fact, confined themselves to a descriptive account of a corporeal reality that was no longer alive; they dug deep into that corporeal reality in order to discover the causes of death.

A second objectifying element came from *representative fiction*. It is certainly the case that theatre, from time immemorial, has portrayed death, but only with the advent of cinema and television did fiction reach such a high and sophisticated level in imitating reality. The result has been that people have grown used to the – albeit fictitious – death of another person seen in a calm way from an armchair. From here to witnessing 'online death' is a but a short step, and at the time of some natural catastrophe this takes place, certainly with great exterior distress, but in actual fact with absolute indifference on the part of the average viewer.

The last contribution to this progress in the objectification of death took place, once again, with science, and in particular with the *medicine of transplants*. The most elementary of ethical analyses (which for that matter overlap with usual common sense) believe that for the individual to be 'dead' is an indispensable element before proceeding to the removal of unique and vital organs of the body such as the heart, the liver, and the pancreas. However, whereas, on the one hand, death must be certain, on the other hand, death cannot be so advanced as to no longer allow the use of the organ. Hence the need to define the reality of death with absolute certainty – on the one hand, without committing the tragic error of having people who are only clinically and not cerebrally dead (who are described at the level of the mass media as people 'apparently dead'), and on the other hand, without going beyond the time limit when the organ is no longer available at a biological level. For that matter, the equation 'he is no longer breathing = he is dead', given the modern advances in resuscitation, is no longer possible for those who want once again to 'anatomise death' by defining those characteristic features beneath which there is life and above which there is its irreversible loss.

g) *Paradoxes*. Side by side with the forms of behaviour which have just been analysed and which tend to censure, distance, deny, and conceal the reality of death, we find others in which death is the protagonist and the specific subject of human action. First of all, *there is the wish to inflict death*. I am not speaking here so much of the criminal murderer or of the psychopathic killer but of the very large number of people who are absolutely in favour of the death penalty. This, for that matter, is not seen as a painful but inevitable necessity but as a correct punishment which delegates personal vengeance and the inability to dispense capital punishment oneself to the state.

Suicide, instead, can be a paradoxical denial of death, where the request for death is that times only a request for meaning, and thus a wish for life, for a good life, and for that joyful life that the person is unable to obtain – it is not life that is denied, but, in a certain sense, the component of death that life involves.

In the same way, a kind of confrontation with death takes place, almost a desire to challenge it in a competition, through *forms of behaviour at risk*, such as games involving death (Russian roulette, racing in cars with the headlights turned off, and so forth) or the more innocuous but symbolically no different 'extreme sports'. From certain points of view, even if only implicitly, a component of this kind can also be found in drug-addiction.

Lastly, the strong resurgence of forms of animism should not, in the cultural global context of rejection of death and also, as has already been observed in this paper, of the absence of a strong eschatology, escape our attention. Such phenomena are not so much the spirit worship of the past or dabbling in the occult as the animistic component of parapsychology or a large number of oriental religions. Here, one needs only observe the popularity of television personalities who teach people to communicate with the 'world beyond' or the 'accounts' of the life beyond this which in various forms are present in the mass media.

3. Humanising the Culture of Death

From what has been said hitherto in this paper springs our first task in the humanisation of death – to humanise *the culture* of death. It is precisely this culture that constitutes the humus from which spring the contemporary approaches of 'incomprehension' towards death, from which, in turn, forms of behaviour involving anti-values derive (first and foremost euthanasia and exaggerated forms of treatment).

a) *Overcoming taboos*. The first task in this sense should be that of the removal of taboos from death. This is not an impossible undertaking. In the case of sexuality such a radical change has taken place; indeed, there has been a move to the opposite extreme. To remove the taboo of death means to be able to speak about death, to speak its name and to speak

about every other reality with which it is connected. If today we promote sexual education, and this certainly is a correct policy, has not perhaps the time also come to think about 'death education'. Certainly, there are different ways of speaking about death. Not hiding the reality of death does not mean to slap it in the face with great violence. Yet at the same time it means 'managing' to speak about it, managing not to conceal it, and first of all from ourselves. It is very evident that the difficulties that are encountered in speaking about death, in the absolute and with the dying person, are a projection of one's own difficulties in addressing one's own death. For this reason, the first process of this removing of taboos from death must concern first of all ourselves. A real distancing from the lugubrious presence of death cannot be carried out with varyingly elegant forms of superstition, but by overcoming the barriers of an inability to communicate which separates it from us.

b) *Giving a meaning to the event of death*. It is clear that this process cannot be achieved if it is not located within the ultimate meaning of life. The real meaning of death, in fact, is the meaning of life. An unknown death, which ends an empty and fatuous life (which clearly does not mean a life full of 'successes' or rich in 'important' things), is a death that provokes fear and as such cannot be referred to. But a death that is an epilogue to an authentically and fully human life passed to the best of one's potential becomes a 'mentionable' death because it is full of mystery, and in the case of the death of another person also of pain. We need, therefore, to manage to install a sort of dialogue with our own death, we need to discover its face. The *estote parati* that the Gospel urges us to engage in (Mt 24:44), has a meaning that transcends a purely religious logic by acquiring an absolutely universal dimension which every man should make his own.

c) *Renewing eschatology*. The shadowy over-emphasis of past centuries has been rightly contrasted with a horizontal dimension of Christianity which has remained far too much in the background, which, in its turn, runs the risk of being eclipsed or of portraying itself in tones that contemporary man is not able to understand and accept. Vatican Council II profoundly renewed ecclesiology, the liturgy and ecumenism, and established the foundations for a renewal of morality, but I believe that we still have in front of us the arduous task of a profound reconsideration of eschatology. It is not the case that this has not been done at a theological level, but it is still completely lacking at the catechetical and sermonising level. The difficulties that are today encountered in accepting the very idea of a 'hell' (the word itself provokes profound discomfort); the difficult reconciliation between the earthly dimension and the achievement of the Kingdom; and the nebulous meaning attributed to the resurrection of Christ (which in general is perceived as the prodigious self-resuscitation of a corpse) are all elements that should lead us to a pastoral reflection that is more concerned with the sensibility of contemporary man. Furthermore, the desire for, and the 'fascination' of, a life beyond this one is as alive as ever before. This is something that is demonstrated by an increasing recourse to the occult to 'communicate' with one's deceased loved ones or by the interest provoked by so-called 'pre-death experiences'. What has been said, once again, does not only have value in the sphere of Christian faith but through it acquires an inevitable and much broader consequence at a cultural level.

d) *Rethinking the cult of the dead*. Still today the cult of the dead matches in practice the 'cult of corpses'. With the exception of some liturgical moments when death draws near or in the first religious remembrances after death, our cult of the dead is a cult largely based on the cemetery. There can be no doubt that gathering together around a grave can have a strong symbolic role just as praying at the foot of a statue of a saint or going to a famous sanctuary can do the same. But this must not lead us to an undue sacralisation of the body of the corpse, a practice that runs the risk of having dangerous implications – for example, the difficulties encountered in giving organs which encounter in this attitude one of the obstacles in the way of a more generous approach to this practice.

e) *Placing death in the home*. Even though hospitals are an almost obligatory or at least intermediate stage, we should manage to create an approach which serenely, and without fearing forms of behaviour that conceal intentions involving euthanasia or feelings of not having done the utmost, leads the sick person, when this is possible, to die in his own home surrounded by his own family relatives (if, indeed, they have not run away!), by his things, by his memories, and by his affective and emotional experiences. It is possible that all this will shorten his existence by a day or two but to do it enriches that existence with a sense of profound humanity. Today, there is a great deal of talk about quality of life. Well, there is also a quality of death and if we believe that it is Christian and human not to oppose life, then we should be able to perceive the incumbent need not to oppose in an extreme way a death which is by now imminent, but, rather, to make its drawing near as less traumatic as possible.

5. Humanising our Relationship with Death

The general ethical commitments that were previously analysed at the level of the cultural humanisation of an anonymous society, acquire a countenance and a specificity that require a more direct and mediated approach to the general questions, when, that is, such a question bears upon man.

a) *Forms of 'painist' consolation*. Even though this phenomenon has been left behind at the level of philosophical reflection, and for the Catholic

Church also at a doctrinal level, there remain in the approach to the dying person major distortions at the level of pain. This is not the place to investigate this question, which, indeed, has remote origins and complex configurations. In a few words, we can say that 'painism' is an interpretation of pain which attributes to it a value which exalts it, and in some cases involves it being deliberately sought after. It is by now only too obvious that in the Christian vision pain is never a good in itself, rather it can be transformed and lived for the benefit of good. The emblematic summary that John Paul II makes of this in *Salvific Doloris* is that 'Christ has taught man to do good by his suffering and to do good to those who suffer' (n. 30). Now, precisely in this perspective, the good to be done to other people lies in leading them to an objective overcoming of their suffering and this should involve active resistance and not passive resignation. The 'painism' to which reference is being made is expressed in frequent pseudo-Christian or pseudo-consolatory approaches with an invitation, for example, 'to abandon oneself to the will of God'. A very great deal of emphasis in this perspective has been placed on matching the reference to the will of God with the occurrence of an unpleasant event. Such 'painism' has often led to people being invited to feel 'that they are ill because they are the chosen ones of God' and not, as is right, the 'chosen ones of God because they are ill'.

b) *The approach of listening*. Unfortunately, we live in an epoch which has totally eliminated the ability to 'listen'; this ability has been replaced with the ability to 'see'. Ancient cultures, which certainly had very significant modalities of visual expression (one need only think of forms of painting and sculpture that were certainly more important than their equivalents today), laid stress on the dimension of listening: the approach of the mentor who listened to the disciple, for example, or the oral transmission of literary or historical memories, or the religious dimension itself of listening.

With regard to the approach to the dying, such an aptitude for listening must involve the active renunciation of omnipotence that we often attribute to our words. In many meetings with groups of voluntary workers or agents of pastoral care in health we often ask ourselves 'what we should say' to the sick person or to the person who is near to death. This is a sign of an oral concern which pushes in front of what should be the real concern, that is to say a concern to hear. The most correct question should be: 'how should I listen?' There are no magic recipes, nor should we fall into the opposing extreme of a 'silent' listening that does not know the right moment to intervene with intelligence and discretion. A listening approach means an ability to allow ourselves to be filled with what the person in front of us wants to communicate to us, even in a non-oral way, with a gesture, a sigh, or an act of reticence. It means knowing how to understand 'what is not said' more than what is said, to bear witness through one's own presence to the fact that there is somebody who is interested in that person's experience, especially when that experience is the last of the meaningful experiences that he will undergo.

c) *The appreciation of the past as an inheritance for the future*. There is an approach which is almost constant in the unfolding of mourning. This consists in a 'positivisation' of the figure of the deceased person whose positive aspects are remembered and exalted and whose negative aspects are minimised or denied. This process of positivisation, which in the case in question arises spontaneously, should also be promoted in the company of the dying person, One of the most frequent causes of sadness is a very low view of one's own past which seems to be empty, inconclusive, wasted, or a lost opportunity to realise all the potential one feels within oneself. The 'good death' that we all want to have, and thus that we should help others to have, involves, in addition, dying at peace with ourselves. This should not only be said in religious terms but also in strictly human terms. No past is really 'empty'. Behind the most 'useless' life there is a set, if nothing else, of forms of suffering and erroneous choices which can be re-read in the light of the present situation.

d) *The mediating function in the relationships of the sick person*. To humanise death means not so much to abolish human forms of reaction in the face of the nearness of death, which are in some way 'normal' and belong to the process of adaptation to its reality, but to channel them, direct them and transform them into active resources with which the pa-

tient can face up to his situation with strength. This means first and foremost taking seriously into consideration the object itself of his reactivity, which is not a distorted vision of things or the approach of a person who feels that he is a victim, but an effective interior tension which lacerates the balance that the person has with realities which until yesterday were not considered a problem. Once again in this work of mediation, great space should be given to listening because it is also through the progressive process of verbalisation on the part of the patient that that journey is followed which from initial denial leads to a final acceptance of his condition.

e) *Understanding the cultural universe of the patient*. This does not only involve the choices as regards values to which reference has already been made in this paper, but, on a larger canvass, the entire horizon of meaning that the dying person attributes to his existence. Obviously enough, sharing is a process which is equidistant between assimilation and detachment. To understand means in a certain way to see the world with the eyes of the person who is in front of one, without necessarily having to share his vision. It is to a certain extent a filter to be adopted to understand the perceptions and the provocations that the dying person is receiving, in the same way as they are deciphered from his personal cultural codes. It is clear that this task becomes easier the more such codes are known. And it is precisely for this reason that I believe that of especial importance here is an adequate knowledge of the cultural background that can most frequently be encountered in a geographical area in which there is a strong Jewish or Muslim community, or a context in which a strong migratory flow has taken place. Every culture and every religion (as well as every individual) has a specific way of feeling about death and this is a way of thinking that should be respected because it intimately structures the existence of the subject.

f) *The prudential proposal of the Christian horizon*. What has been said in this paper regarding respect for the religious-cultural universe of the subject does not in the least mean that one must not offer the dying person the resource of Christian hope. Indeed, having an approach which is sensitive to the values of the dying person and the rejection of an 'exaggerated desire to convert' must not hide the duty to engage in evangelisation which, until and precisely at the point of death, can appear even stronger. It is certainly the case that we need to know how to be discerning in relation to various situations, have the capacity to do all of this without the obsessive idea of seeing next to one only 'souls to be saved', and to understand that when a person is about to die as well the administration of the sacraments is not the only salvific path that God employs. The primary importance of evangelisation, as people love to say today, must be kept present in such circumstances as well. God leaves man free and uses sensitivity and respect towards him. The person who addresses himself to a dying person can do no less, even if he has the duty to offer, with tact and human sensitivity, the horizon of the Christian eschatology in those ways and forms that are most in harmony with the sensibility of contemporary man.

g) *The acceptance of defeats*. Lastly, I believe that whoever draws near to a dying person, as in the case of any person who is in a state of need, must also bear in mind a sense of the limitation of his own action. There is always the risk, indeed, of a subtle messianic temptation. It is not rare to see people animated by the best of intentions (above all in the case of groups of voluntary workers) ready to draw near to the sick person with the strong intention of 'converting him' or at least of making him accept death in a serene way, or, as far as I know, of making him become reconciled with his wife and children. In reality, it is necessary to be ready to accept failures as well, which in this field as in others are often more frequent and painful. Above all in the absence of a horizon of faith which opens the door to hope, there remains the bitter feeling of a 'success' that could not be attained. The sense of 'free-giving' inherent in the approach to the dying person must then constitute a sort of guiding value for the direction of one's actions.

6. Two Concluding Metaphors

Obviously enough, one can never say that the analysis conducted in this paper is ever complete. But if I had to find a concluding formula, I would like to do so with two formulas, The first is the one that the film director Bergman depicts so admirably in 'The Seventh Seal'; the second is provided by the ancient but always topical ascetic-devotional exercise of the *Via Crucis*.

a) *The seventh seal*. As is well known, this film takes its title from the description that we find in the Apocalypse regarding the opening of the last seal, closed with a ring, that the Lamb opens. The text reads: 'When the Lamb opened the seventh seal there was silence in heaven for half an hour' (Ap 8:1) The film by Bergman centres around this strange 'wait' which is expressed in this half hour of silence. The action is set in the medieval period and a knight meets death, who is ready to take his life. But the knight challenges death to a game of chess and asks death to keep him alive until the end of the game. If the knight wins he can go free, but if death wins the knight will have to surrender to his destiny. Death accepts the agreement. The chess player thus takes advantage of this period of time to deal with various situations of his existence, giving his existence the time that previously he had not known how to give or wanted to give. In one of the episodes described in the film, the knight confesses, but in reality the confessor is death dressed as a friar who asks him how he will manage to win the chess

game. At this point, death abandons the pretence, learns the secret of the knight and takes his life. In this unfolding of a fear of an inevitable event, but at the same time of a strange kind of agreement that is made with that event, I seem to see all the taboos and contradictions to which reference has been made in this paper. The last is specifically the one that the film by Bergman, seen again in a positive light, proposes to us: victory over death does not exist at the level of material defeat, because the game being played is always a losing one. Instead, it can be won in an existential sense by giving meaning to life, from which, indeed, all its positive elements can be drawn.

b) *The Via Crucis*. A metaphorical reading of the Gospel tale and its renewed proposal at the level of devotion appears to us, in fact, to be a tragic example of accompanying a person to death with all the variegated emotional universe that accompanies such a process: from the flight of loved ones (in the abandonment on the part of the apostles we can see the contemporary flight of family relatives and friends) to the unsuspected presence of people who are thought not to be strong (in the culture of the time, women, for example).

At the foot of the cross, on the other hand, a dismayed small group of people remain when everyone else has gone away. It is precisely these people who help the dying man not to be 'alone', to look into the eyes of a friendly face who offers him an expression of affection as the last memory of the life that he is leaving.

The event of death often 'forces' people to help a dying person, if only because that person is within a family unit to which he belongs: like Simon of Cyrene who returns from the fields and is forced to carry a cross that is not his, a cross and a form of help that irrupt into the routine of his day.

If, on the one hand, some people are forced to do this, on the other hand, some voluntarily offer to dry his tears, and like that woman to whom the name of Veronica (in reality true image, 'real icon') was given by the author of an apocryphal work, go back home carrying within them something of the person whom they wanted to console.

And the care of the person who is dying towards those who stay is born witness to by that entrusting of Mary and John to each other, which is not only an invitation to look after a mother who has been left on her own but an invitation to the 'reciprocity' of giving each other the gift of welcome.

Even in the dividing up of the clothes by the soldiers we can read not only the sad and still present conflicts over inherited possessions but the inheriting in the highest and most noble sense of the legacy of the person who is dying. What remains belongs to who remains: not only a tunic or an article of clothing, but also, and above all else, a memory, the memory that the Evangelists handed down to us with their account of the cross.

Lastly, when everything seems to be over there emerges the courage of people like Joseph of Arimathea, who had the courage to take Christ down from the cross. Every person who seeks (beyond every effective 'success') to take his neighbour down from the cross should identify with Joseph of Arimathea. This will not always be practicable at a material level (even though every effort should be made to help one's neighbour) but it must also be possible at a psychological and human level. A person can be taken down from the cross by eliminating the cross or by helping that person to give a meaning to it by knowing how to look 'beyond': the ethics of the humanisation of death can be summed up in this commitment.

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Notes

[1] P. ARIÈS, *Storia della morte in occidente* (Milan, 1980).
[2] *Ibid.*, pp. 24-5.
[3] *Ibid.*, pp. 24-5.
[4] *Ibid.*, p. 53.
[5] *Ibid.*, p. 68.
[6] This is the thesis of G. GÖRER in his 'The Pornography of Death', *Encounter*, October 1955, in which he in effect argues that today 'death occupies the place of sex in the area of the unmentionable'.
[7] P. ARIÈS, *op. cit.*, p. 73 (where, however, he repeats the thought of Görer).
[8] C.A. MALLIANI, 'La morte improduttiva', in AA.VV., *La morte oggi* (Milan, 1985), pp. 102-106; see also I. ILLICH, *Nemesis medica* (Mondadori, Milan, 1977), pp, 214-233, who even speaks about 'fear of immediate death'.

The Pastoral Accompanying of the Dying

One of the privileged spheres of pastoral action is accompanying the dying. Pastoral care for the dying is very much conditioned by the cultural climate that pervades contemporary society, which has the tendency to to exorcise death. The *cultural aspects* that help to complicate our encounter with death are the following:

– the climate of hedonism and materialism in today's world;

– the denial of death, which is considered a taboo;

– medicalisation and emphasis on technology, which dehumanise dying;

– institutionalisation, which confines dying to health care institutions,

– the removal of death from daily life;

– a language imbued with euphemisms which mask reality, by which, for example, cancer becomes 'that bad malady' or a 'neoplasia'; death is described with the phrases 'he has gone', 'he has left us', 'he has passed away', because to say 'he has died' is thought to be inhuman;

– paternalism, which is expressed in protective approaches;

– a biological emphasis, which reduces dying to a physical process without embracing the overall being of the person.

Humanising Dying

For everybody death is the sole certainty of life. The risk we run, however, is that fear will prevail and will wound our freedom and paralyse human creativity. The challenge is to act within culture in order to gradually reduce the influence of the attitudes and influences mentioned above which prevent more mature choices in the face of an event that renders all human beings alike.

The stages by which to humanise dying include the following:

– *to become aware* that life is imbued with death and that death is fertile with life;

– *to address* death in the first person by understanding and not fleeing from those opportunities that arise which allow us to look death in the face and reflect upon its meaning;

– to learn to give a name to *one's own fears* and anxieties in the face of the possibility of one's own death or the death of another person;

– to take part in *formative* moments on the subject so as to attenuate the burden of the mechanisms of defence and to expand the horizon of interior freedom;

– *to appreciate* the advisability of communicating with those who are ready to speak about their own dying so that one does not to entrust one's own feelings and thoughts to silence.

The Process of Dying: Attitudes, Feelings and Resources

The drawing near of death produces in those who are experiencing it a deep sorrow prior to the event that is expressed in a set of attitudes and states of mind.

These *attitudes* are influenced by a variety of factors such as: one's own character, the roles that one interprets, the presence or otherwise of faith, the way in which one looks at one's own past or one's projects for the future, one's reconciliation or otherwise with one's weakness and temporary condition, and so forth.

Recurrent attitudes towards death are the following:

– confusion and bewilderment;

– resignation;

– rebellion or protest;

– closure;

– desperation and/or dejection;

– flight and/or avoidance.

These attitudes are accompanied by a variety of *states of minds and feelings*, amongst which may be listed: shock, anxiety, distress, fear, sadness, loneliness, depression, resentment, anger, a feeling of guilt, envy, and shame.

The dying person can draw upon a mosaic of both internal and external resources in order to face up to his possible separation from his possessions and his dear ones.

The quantity and quality of these resources directly affects the way in which a person lives out the experience of dying.

Amongst the *external resources,* we may list the following:

– the availability, within the neighbourhood and vicinity, of suitable health care centres, health care personnel, and drugs and medicines;

– the support of one's own family;

– membership of a community or a religious faith;

– the nearness of sensitive people, such as priests, voluntary workers…;

– economic resources.

Amongst the *internal resources*, we many list the following:

– one's own philosophy of life;

– the gifts or qualities that the individual possesses (for example patience, courage, tenacity etc.);

– the ability to open oneself to, to communicate and to interact with other people;

– satisfaction with one's own past;

– trust in the future;

– the quality of one's own faith and spirituality;

– knowing how to make pain fertile;

– prayer…

The following conversation brings out the reactions and attitudes of a dying person and the relational style of a pastoral worker who is paying her a visit.

This Illness is Destroying what is most Dear to me in the World

Information

Laura has been admitted to hospital and is in an oncological ward. She is about fifty-years old, she is married, and she has three daughters. The diagnosis is that she has liver cancer. The patient has been in hospital for ten days to undergo a course of chemical therapy; she has already undergone other such courses. This is the first time that I have had a dialogue with her.

Conversation:
L: Laura D: David

(*After finishing a conversation with a patient in a bed next to Laura's I draw close to her bed, I realise that she is sleeping, and I am about to go away when Laura stops me*).

L1: I am not sleeping, I was listening to what you said to this lady (*in a voice that is not harsh but marked by disquiet*).

D1: I thought you were sleeping…

L2: No, it's just that I don't feel like seeing people; you know this place depresses me a great deal…

D2: If you want I can go away…(*I answer with a certain embarrassment*)

L3: No, please stay, don't worry (*the tone of her voice is more welcoming*).

D3: My name is David and I work with the chaplains (*she interrupts me abruptly*).

L4: Yes, I saw you last week, you were here, but I pretended I was asleep.

D4 (*I am confused for a moment about what I should say*). I imagine you are suffering a great deal, that's the reason why you don't want to see anyone…

L5: Yes, this illness is causing me a lot of suffering and I can't find any way out (*her openness surprises me and at the same time causes me difficulty; for a few moments I am in a state of silence not knowing what to say. Them she starts talking again*). I asked the Lord to heal me but he hasn't heard my prayers (*she begins to cry and I give her my handkerchief*). But what kind of a life is this? This illness has been destroying me for seven years…it began in my breast…despite the operation the tumour has spread.

D5: I can see that you have a lot of pain inside you…

L6: Yes, I do, but the thing which causes me greatest suffering is not much the illness inside me but the fact that I am the cause of so much suffering for my children and my husband. I can see when they are here that they are suffering more than me.

D6: Are you very worried about them…

L7: Yes, we don't say anything…I suffer and so do they, we can't speak. I don't want to…(*she starts crying*).

D7: (*I don't say anything for a while and feel compassion for her, I don't know what to say to her, then I have the courage to speak about death*). Do you have problems with your children and your husband because of what can happen to you, because of your tumour?

L8: Yes, and it is exactly that which is causing me anxiety. How can I say to them that I am dying? They are already suffering a great deal because of me…

D8: Don't you think it would be better to speak with them about the fact that you are about to leave them and face up together to this question of death, this experience of separation?

L9: I can't do that, I would make them suffer even more.

D9: You love your children very much, don't you?

L10: They're the most important thing I have, but now this illness is destroying what is most valuable to me in the world – my family. But what is the reason for this suffering? What's the point of being here and living the life of a dog?

D10: (*I keep silent not knowing how to answer…then I take the patient's hands, and she is crying*). Is this suffering of yours teaching you something?

L11: It's made me understand that my husband and my children are the people I really care about…(*she smiles at me, crying*).

D11: What you said is very beautiful (*I keep silent, and then after a while go on*). Do you want to say a prayer and ask help from the Lord in this difficult moment?

L12: I don't feel like praying, but please don't feel bad about it.

D12: Absolutely not; if you want I can pray for you.

L13: Yes, please do; thank you. I feel far away from God.

D13: I think that the Lord is near you (*smiling and receiving a non-verbal answer of welcome to the words that I had spoken to her*).

L14: Goodbye and thank you.

Assessment of the Meeting

Laura transmits her interior trial with clarity – the resentment towards God who had not healed her, the sense of the uselessness of pain (L5 'what kind of a life is this?'); 'what's the point of being here and living the life of a dog?' (L10); the feeling of guilt at causing suffering to her relatives (L6, L7, L8, L9, L10).

The pastoral worker overall shows that he has a good ap-

proach: he is sensitive and respectful when speaking, manages silence well, is capable of empathy, knows how to communicate with gestures, and is honest and introspective in confiding his unease.

He also touches on the sensitive subject of death (D7), although he respects the limits set out by Laura.

Some of his observations could have been more focussed (e.g., D2, D8, D10); in addition, the prayer at the end seems advisable to express the trial, the feelings and the needs of Laura.

In general, his action is beneficial – for a while, Laura abandons the refuge of loneliness to entrust to someone, and to confide, her pain and her wounds.

The conversation offers a starting point to suggest the following orientations for those who accompany the dying.

Attitudes that should be Avoided and Attitudes that should be Cultivated

In essential terms, a list of ten attitudes that should be avoided in the company of dying people emerges. People should avoid:

– having an unhappy face;
– communicating pity rather than respect;
– treating such people as sick people (for example with cancer, AIDS) rather than as persons;
– remaining within the physical horizon without moving into the other dimensions of the person;
– using already formulated phrases that disturb rather than comfort;
– imposing one's own values or schemes of reference;
– expecting dramatic changes now that they are about to die;
– minimising or banalising their losses in order to keep their morale up;
– judging their feelings (e.g., 'don't speak like that', 'you shouldn't feel like that' etc,);
– giving false hope.

On the other side, another ten list of attitudes to be cultivated so that people can be better 'travelling companions' of those who are dying also emerges. People should:

– appreciate the gift of their presence;
– favour non-oral communication and contact;
– listen and live well with silence;
– respect different choices and beliefs;
– revisit the past and welcome memories;
– uphold the experiences and the achievements of the person who is dying;
– accept confessions, forms of remorse and regret at failure or things that have not been achieved;
– make great value out of small things and small actions;
– bring out the human and spiritual resources of the person with whom one is speaking;
– keep the visits brief and pray where circumstances suggest that this should be done.

A sensitive presence can help the dying person to hope in a realistic way and to remember with gratitude and to live out in a positive way the mystery of life and death.

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Informed Consent: Between Ethics and Law

1. Informed consent: Between Ethics and Law

Medical practice cannot depart from the at least implicit consent of the person who has to be treated: a surgical operation or medical treatment carried out against the will of the patient, or beyond his consent, is a violation of his dignity as a person. The sick person, in such a case, would be treated as an object of medical science and not as a subkect to whom is due free self-determination.

The duty to request consent and the right to give consent, after information has been provided on the purpose and nature of the action involved, its consequences and its possible risks, remain an authentic ethical requirement, as well as a deontological requirement.

This greater concern princpally derives from the evolution of medicine (which has become increasingly complex from a technical point of view) and from the relationship between the health care worker and the patient, where the latter is increasingly aware of, and a participant in, the choices that relate to his health.

Whereas in traditional medicine the medical doctor acted 'for' and 'instead of' the patient (Hippocratic-paternalistic medicine), and decided what he thought was most useful for the sick person, in the modern epoch the patient co-operates with the medical doctor, taking part personally in what is done (medicine based on the idea of the contract). In the contemporary context, consent has become an instrument by which to promote and ensure the autonomy of the patient. The consent of a simple medical act has become a synonym for a capacity for interchange and co-operation between the health care worker and the user.

1.1. The Origins and Spread of Informed Consent

As a result of cultural dynamics, of English and American pronouncements at the level of legislation and jurisprudence in which the right of the patient to complete information has been upheld, the ethical and legal need for informed consent has over recent decades also been accepted in Italy.

In our country this specific ethical-juridical formula only gained significant ground at the beginning of the 1990s, whereas in the United States of America – seeen as being the country which first gave rise to informed consent – and in many other countries it has been widespread since the beginning of the last century.[1]

The reasons behind the spread of informed consent[2] in recent years are to be attributed to:

– a new attitude on the part of people towards their own health, a phenomenon that has been the outcome of a rapid change in social sensitivity in relation to this question;

– an increase in the number of complex surgical operations, which indeed, often involve a high level of risk for the patient;

– numerous 'clinical trials', for which are envisaged an adherence to the formula of consent;

– an increase in legal actions made by patients against health care workers;

– the progressive establishment in legal culture of the recognition of the principle of the autonomy of the patient and his capacity to decide for himself; and

– a change in the relationship between the health care worker and the person he is treating.

Today, the patient no longer entrusts himself blindly to the medical doctor, but, aware of his own rights, strives to understand, and to actively take part in, the decisions that are taken regarding his treatment. Thus it is that we have passed from a paternalistic form of medicine to a form of medicine based on the idea of the contract, and which respects the personal values of the individual.[3] Consent thus becomes a contract between the health care worker and the patient, where the latter no longer offers mere passive adherence to a medical decision but rather provides an expression of his full wishes, something that is made possible by his receiving adequate information.

1.2. The Juridical Principles

The informed consent of the patient is an essential pre-condition for the beginning and the carrying out of a health care action. It is based upon juridical foundations, which, on the one hand, protect the medical activity involved, and, on the other hand, defend and uphold the rights of the patient.

At an international level, the Nuremberg Code of 1947, a consequence of the experiments carried out by Nazi doctors during the Second World War, reaffirmed the right of the person to understand the medical research involved and to decide freely whether to take part in that research. This Code also restated the duty of the medical doctor to explain to the sick person in a clear way what his medical situation is, the possibilities that exist at the level of treatment, the risks-benefits ratio, and the possible complications.

Subsequently, the Helsinki Declaration of 1964, drawn up by the World Medical Association and added to by later adjustments, formulated leading recommendations for medical doctors in biomedical research that involves human beings with a view to safeguarding their safety. In particular, it upheld respect for the personal integrity and well-being of individuals, who were seen as agents really responsible for themselves.

Upon this Declaration are based the rules of 'good clinical practice', in which the duties and rights of the medical doctor and the patient are defined so as to ensure the highest protection possible for the subjects of clinical trials.[4]

The Principles of European Medical Ethics of 1987 state that 'except in the case of an emergency, the medical doctor will illustrate to the patient the predictable effects and consequences of the treatment. He will obtain the consent of the patient above all when the actions proposed involve a serious risk. The medical doctor cannot substitute his own idea of quality of life for that of his patient' (it is not in fact in this said in this document that what is deemed good by the medical doctor always coincides with what is deemed good by the patient).

The National Committee for Bioethics published its document 'Information and Consent to the Medical Act' in June 1992, and in this document the characteristics that render consent valid are specified: the quality of information, the fact that it is understood, the decision-making freedom of the patient, and his ability to decide.

More recently, the European Convention on Human Rights and Biomedicine (1996), in article 5, states that 'an intervention in the field of health cannot be carried out without the person involved giving his free and informed consent'.

For that matter, in our Constitution as well, we find explanatory references to the importance of consent being given to the medical act. Article 13 states that 'personal freedom is inviolable. No form of detention, inspection or personal search is allowed, nor any other restriction on personal freedom, unless by an act justified by the judicial authority and only in cases and ways laid down by the law'. This is an article that is very general but which is useful when we reflect on the nature of the freedom of the individual (the principle of self-determination). Article 32, instead, restates that the defence of health is a fundamental and inalienable right-good of the person, and excludes every form of obligation to undergo treatment on the basis of the principle of the autonomy of every individual, albeit with the exception of forms of treatment envisaged by the law: 'nobody can be obliged to undergo specific health care treatment unless by requirements of the law; the law can in no case violate the limits imposed by respect for the human person'.[5]

And article 33 of the law which established the National Health Service (Law 833-1978) laid down that obligatory health care investigations and forms of treatment must also be accompanied by initiatives directed towards ensuring the consent of those who are subjected to such obligation.[6]

Some articles of the Penal Code also constitute important juridical references to informed consent. Article 50 explains: 'A person who injures or endangers a right with the consent of the person who can dispose of it, in a valid way, cannot be punished'. The health care act is justified by this declaration, and the same is true where damage can be caused to a person, as long as there is 'the consent of the person who has that right' and personal freedom is thus respected. All of this takes place within the limits imposed by article 5 of the Civil Code which forbids 'acts available to one's body when they give rise to a permanent diminution of physical integrity, or when they are otherwise contrary to the law, to public order, and to public decency'. When it is not possible for the medical doctor to obtain consent because of the serious conditions of the patient, article 54 of the Penal Code declares: 'A person is not punishable for having committed the act when he has been forced to do so by the need to save himself and others from actual danger'. This article then stresses that this danger must not be potential but actual, that it must be serious and imminent; that it must take the form of 'a serious injury to the person, a danger not caused voluntarily by him, nor otherwise avoidable, and always where the fact is proportionate to the danger'. We are dealing here with a 'state of need': the health care worker carries out an action because he is obliged to save the life of a person because the gravity of the situation does not allow him to abstain from acting.

Once again in the Penal Code, article 728 punishes the practice of any treatment that leads to the subject losing consciousness without his consent; article 610 refers to private crime when anybody compels other people to do, tolerate, or omit to do something.[7]

In a recent decision of the Penal Supreme Court of Florence ('Cass. Pen. N. 5639/1992, sul caso Massimo'), the judges restated the right of a patient not to undergo forced health care treatment with the exception of cases specifically envisaged by the law, and thus stated that 'the medical doctor cannot do anything without the consent of the patient or even against his will'.

This demonstrates that the principle of the self-determination of the sick person has acquired in Italy as well connotations that are by now shared at an international level and that jurists have recognised for some time.

1.3. The Ethical Principles

Consent does not have principally a juridical value (defensive medicine) but rather an ethical value. We should not, therefore, limit ourselves to seeing consent as a form of juridical protection. We should see it, rather, as a valid instrument for the defence of autonomy in relation to decision-making and the freedom of the sick person.

In American society in the early 1960s a growing affirmation of the personal values of freedom and autonomy began to be perceived, and in the face of the decision-making power of the state, citizens came to claim and uphold their own space.

The North American movement regarding principles in this area had the advantage of seeking an understanding between the different ethical currents: in the 1980s, in North America, the philosopher Beauchamp and the deontologist Childress[8] identified the leading principles to be applied in relation to a health care problem of a technical-operative kind that involve decision-making of ethical relevance:

The principle of doing good: this principle forms the basis of the relationship between the health care worker and the sick person. It implies doing good to people in need or at least to the largest number of such people (we encounter here a tendency to utilitarianism).

The principle of not doing harm: this expresses the need to promote the good of, and avoid

causing injury to, every person:

The principle of autonomy: this principle affirms respect for self-determination, which is arranged around authenticity (the consistency of the actions of the sick person with his abilities and his values) and independence in relation to choices (the subject is aware of the problem; he has the ability to reason and to act).

The principle of justice: this principle emphasises that all people belong to the community and have equal access to its structures; as a result, people must be treated equally and each person must be offered what is due to him.

These are *prima facie* principles: they all have the same ethical-decision making force, but, according to the conditions involved, one of these principles can stand out and dominate all the others. They are thus variable, applicable on the basis of the actual situation that arises between the health care worker and the clinical decision-making problem.

These principles have been criticised by personalism because of their fluctuation and their lack of an anthropological foundation. The principles of ethical-personalist action,[9] instead, affirm:

The principle of the sacredness of life and its inability to be disposed of at will: the right to life is natural and inviolable. Physical life is a primary although not supreme good, and it cannot be disposed of at will.

The principle of totality or the therapeutic principle: the person must be approached in his totality, that is to say in terms of his physical, mental and relational component parts; there is a relationship between 'a part' and 'the whole', and a part is subordinated to the whole.

The principle of the dual effect: according to this principle an action can have a positive effect or a negative effect. However, the positive effect cannot be subordinated to the negative effect.

The principle of solidarity: man is a social being and the good of each individual has a relationship with the good of society as a whole.

The principle of subsidiarity: all people must be allowed to participate actively in individual and collective development.

The principle of the exception: this principle enters the picture when there is a conflict of values and involves the impossibility of respecting norms (conscientious objection; the principle of the lesser evil and co-operating in evil).

From an ethical point of view, the question of consent is to be located within the sphere of the principle of freedom-responsibility, the principle of autonomy, and the principle of doing good. The health care worker must be aware of this fact in order not to act in an ethically illicit way.

One can thus affirm that both the ethical aspect and the juridical aspect of informed consent set themselves the same objective: namely, the defence of the human person with his rights and values.

1.4. The Characteristics and Modalities of Consent

As has already been observed in this paper, consent is a right-duty which has ethical and juridical characteristics in relation to any health care act.

The premises for the validity of consent, according to the document of the National Committee for Bioethics on 'Information and Consent to the Medical Act' of 1992, are as follows:

The quality of information: the information must be clear, true, essential and exhaustive. It should be provided in a quiet environment, guarantee privacy, and requires time – in order to allow the sick person to understand what is being proposed – in addition to an ability to listen.

The understanding of information: the information must be adapted to the level of education and learning of the patient; the language must be simple, understandable, and not technical in character; and whether the information has been understood by its recipient is something that must be assessed through verification.

The decision-making freedom of the patient: this means that the patient must not be influenced by people or situations (and the information offered by the medical doctor must not be directed towards an end). In addition, the consent must come from autonomous and aware reflection on the part of the patient.

The decision-making capacity of the patient: the patient must be of adult age and in full possession of his mental faculties; he must be autonomous and aware so that he can understand the diagnostic-therapeutic process, assess and evaluate the risks involved, and decide upon what his treatment should be.

In order have an ethical value, consent must thus be:

Informed: the information, which allows the person to be aware and active, must allow the patient to have knowledge about his clinical situation and the possibilities that exist at the level of treatment, and this knowledge should be sufficient and of a kind such as to enable him to achieve an autonomous change in his behaviour.

Explicit: the consent should be real, specific and documented, and expressly provided by the sick person, especially in the case of forms of treatment which can involve serious risks to the person.

Free: the information should not be influenced from outside (persons or situations), but must derive from an autonomous and aware inner reflection.

Authentic: the consent must come from the person who is the bearer of the right and is a personal choice in the name of the principle of self-determination.

Immune from elements that make it invalid: the person must be of sound mind in order to understand the diagnostic-therapeutic process so that he can assess and evaluate the risks and benefits involved and make a decision on the basis of his sound mental capacities.

In order to be in the full possession of his faculties, the subject must be of adult age: a minor is not seen as being capable of responsible actions and according to article 2 of the Civil Code only 'with adult age does one acquire the capacity to perform all those acts for which a different age has not been established'. But the opinion of a minor is taken into consideration as an increasingly determining factor, of course according to his age and level of maturity: it is by now widely taken for granted that between the ages of fourteen and eighteen a minor must take part in the medical decisions that concern him.[10]

If the patient finds himself in a state of momentary incapacity (for example he is not conscious as a result of anaesthesia) and a condition of emergency does not prevail, 'respect for the principle of explicit consent involves the need to wait until the person involved is once again able to express his own will'.[11] As regards the form of consent,[12] there is no juridical obligation for this to be in written form. The exceptions to this are situations involving the donation or receiving of blood, non-therapeutic clinical trials, and the test for HIV (Decree of 15 January 1991).

The requirement of consent in written form (which is obligatory only in the above-mentioned cases) as regards actions of greater importance and involving danger, satisfies a legitimate caution on the part of medical doctors expressed in the drawing up of documentation that could facilitate their work were judicial contestations to arise.

What has been said above also applies to information that is supplied by the medical doctor: written documentation of consent alone, and not of the information which has been really provided, can legitimately lead to the supposition that consent has been acquired without due explanations being given to the patient. Although there is no express legal obligation to do so, therefore, it is correct conduct to provide a form indicating the information supplied by the medical doctor to the patient and signed by both parties and to attach it to the clinical papers of the patient.[13]

In whatever form, whether written or oral, consent, however, must be explicit and informed: after clarifying his own doubts, the sick person must clearly express what his wishes are.

1.5. The Information Needed for the Obtaining of Informed Consent

Consent always takes place after information has been provided: a lack of, or defective, information, in fact, leads to the voiding, the non-validity, of the consent, with all the consequences of a penal character that this has for the health care worker.

Adequate information allows a guidance of the self-determination of the sick person and his involvement to the full, strengthening, thereby, the therapeutic alliance between the medical doctor and the patient.

The obligation to inform[14] lies with the medical doctor responsible for treatment, the person, that is to say, who formulates the proposed course of treatment and puts its into effect. In complex structures, if the subject has been hospitalised, this obligation lies with the person who is responsible for the ward, in line with the hierarchy set out by the hospital law n. 128 of 1969. The head physician, however, can delegate this task to those who help him or to an assistant.

Although information is a medical act to the utmost, the nurse, in the name of the defence of the rights of the sick person (in this case the right to informed awareness) is under an obligation to inform the patient. In the deontological code for nurses, article 42 lays down that the 'nurses listens to, informs, and involves the person…in order to explain the level of care that is guaranteed and to allow the person cared for to express his own choices', and article 4.5 observes that the 'nurse, in helping and supporting the person in his therapeutic choices guarantees the provision of information concerning the plan of treatment…He or she works so that the person has available overall, and not only clinical, information, and also recognises his right to choose not to be informed'.[15]

The information provided must be effective, essential and exhaustive,[16] and in the case of a surgical operation it must concern: the diagnosis; the prognosis; the modalities of intervention; the modalities of anaesthesia; possible complications; the post-operative course; and alternative forms of treatment. All further information requested by the patient must also be provided.

The information provided is not always sufficient: on its own, in clinical practice, it does not allow the medical doctor to establish a human relationship, or one based on trust, with the sick person. It is communication, literally 'being in contact with', that brings together the subjects of the relationship, at the level of attitudes that may even be unconscious, and which allows a psychological openness on the part of the patient, thereby facilitating the establishment of a very good relationship characterised by transparency, respect and mutual trust.[17] The relationship between the medical doctor and the patient, therefore, must always be personalised and must be based upon criteria of humanity.

The information provided must be truthful and in proportion to the patient's capacity to understand it, something that is determined by the level of education and learning, and the psychological condition, of the patient himself. The language employed must be simple, understandable, not technical in character, and suited to the recipient of the information.

Taking into account the emotional condition of the sick person is of fundamental importance: he is often fragile, anxious about the diagnosis, and worried because of fear or a lack of knowledge, and he is for this reason less well prepared for an understanding of the information that is provided to him. The age of the patient must also be carefully assessed: the relational approach varies according to whether one is dealing with an elderly person, a woman, or an adolescent.

With the exception of emergency cases, information should thus always be given, especially before a surgical operation given that it is considered as being on a par with a personal injury (Carnelutti, 1938).[18]

To conclude this section, respect for the principle of truthfulness is an essential pre-condition for the creation of a relationship based on trust with the patient: 'not telling the truth means not recognising that the patient has a capacity for self-determination, preventing him from deciding, and this to the detriment of the relationship itself with the health care worker, which should be marked by trust and respect for personal wishes'.[19]

2. Informed Consent in the Medical Doctor-Nurse Relational Dynamics

2.1. The Evolution of the Relationship between the Health Care Worker and the Patient

Until a few decades ago, informed consent was taken as granted because of the dominance of an approach involving benevolent paternalism on the part of the medical doctor.

Indeed, from the Hippocratic age onwards the following model of medical ethics dominated: the medical doctor sought to secure the good of the patient (a good identified with the elimination of the illness) and he was the principal decision-maker, the person who took decisions on behalf of the patient. The patient, for his part, was the 'object of treatment', a mere observer who obeyed because of the fact that as a result of his condition he was not capable of self-determination.[20] During that period all the other health care workers, including the nurses, were mere executors of the decisions taken by the medical doctor.

However, the approach involving benevolent paternalism entered into crisis about twenty years ago when people asked whether it was true that the real purpose of medicine was to secure the good of the patient and whether it was not the case that, in addition, medical practice had to respect the person when it came to his choices and values. This crisis involved a declaration of the end of inequality in the relationship between the medical doctor and the patient: the authority of the health care worker was now democratically shared with the patient, who no longer sat back and watched events but actively took part in the decisions regarding his treatment.

In this way, and in this approach, health care action is decided through a process of negotiations where consent is the central point. The nurse is still a helper of the medical doctor but has acquired greater importance in the 'medicine of dialogue' because he or she facilitates communication, thereby helping the patient to be more autonomous and more informed.

The medical doctor and the nurse must contribute to the independence of the sick person and provide him with the knowledge necessary to ensure that his choices correspond to his real interests, but at the same time the medical doctor and the nurse cannot become the passive executors of his will.[21]

The autonomy of the patient, in fact, is not absolute and does not take away the responsibility of the health car workers for his treatment: the patient has the duty not to make unsuitable requests as regards the beliefs of the medical doctor and his right to freedom and responsibility. The health care workers, in addition to curing the illness, must guarantee the forms of daily activity that keep the patient alive and also help to foster his participation in the process of care (Collière 1992).[22]

2.2. The Integration of the Medical Doctor and the Nurse

Medical doctors and nurses are the two professionals of the relationship,[23] and to inform the patient is an action which in addition to being human and ethical is also highly professional. These two figures should work together and unite their capacities so as to offer better information and care to the patient. However, such co-operation is still rare in contemporary clinical practice.

Such a difficulty may derive from the authority of the medical doctor (understood as a power legitimated by law or morality which involves the right to give orders, to advise, and to command respect) and from the excessive technical character of the services that are provided, a phenomenon due, in part, to a lack of time.

Although working together with the medical doctor, the nurse should maintain his or her own personal and professional autonomy, which, indeed, will allow him or her to understand what is right and suitable for the patient by exchanging opinions with his or her colleagues and thus not confining himself or herself to an approach of passive acceptance and the mere carrying out of the provision of care.

With regard to consent, the nurse should not confine himself or herself (as, indeed, is often the case) to being responsible for the delivery or collection of a form: he or she is a mediator and should, on the one hand, solicit initiatives in this area on the part of the patient, reminding him, for example, that if he has doubts then the time has come to express them, and, on the other hand, he or should solicit initiatives in this area from the medical doctor, possibly posing certain questions about the medical treatment to be followed, so as to achieve the provision of clear and explicit information. To achieve this end, both the medical doctor and the nurse should want to co-operate

with each other, and there should be a joint acceptance of respective roles, mutual respect, good dialogue, and concern for the values of the person.

Conclusions

In recent years, the patient has moved from being the mere recipient of choices made by other people to being the protagonist of the decision-making process affecting his health. The epoch marked by an approach based on the benevolent paternalism of the medical doctor, where this last was the chief determiner of the situation, has been left behind, and now the health care worker has established a new relationship with the user, a relationship based upon sharing. The user now has the opportunity to choose the treatment he wants, to agree to the treatment proposed, or even to reject it. The need for the patient to be informed is thus now greater.

In hospital wards there are often difficulties at the level of communication between the personnel and the patients, as well as the presence of a conflict of interests which involves, on the one hand, the need to respect the autonomy and freedom of the patient, and on the other hand, the duty of the health care workers to ensure the patient's well-being.

In a context such as this, informed consent is at the centre of important discussions: because it requires negotiations between the health care worker and the patient, informed consent has become a litmus test for the good feeling that has become established (or otherwise) between these two figures.

Without suitable information, information that is to say which is clear, exhaustive and adjusted to the level of education and learning of the subject, consent cannot be acquired in a valid way. For this reason, medical doctors and nurses must offer the patient all the information that is needed to enable the patient to be aware of the situation and thus autonomous as well.

Better communication between the health care workers themselves would make the exchange of information that is needed for the treatment and care of the sick person more effective. Ward meetings, a more open and sincere dialogue, the joint acknowledgement of respective roles and mutual respect between medical doctors and nurses would foster an alliance between these two figures, an alliance directed towards guaranteeing the good of the patient.

In addition, health care workers should receive on-going training, constant up-dating, and should also learn to engage in research: daily experience, that is to say the attempts made and the errors committed, allow them to understand what is not working and to introduce possible changes into the way that care and treatment are practiced.

Greater information, close co-operation between the staff of the ward, and a more critical attitude towards one's own work – these are the elements that are essential if we want to improve not only the practice of informed consent but all the forms of care and treatment that are provided.

It is important to engage in discussion because only in this way is it possible to accept change. The alteration of activity involving care and treatment can cause concern within a team, especially if one is dealing with forms of activity that have been acquired and consolidated over time. But the desire to improve must overcome this difficulty, and it must be remembered that the primary goal of care and treatment is the well-being of the patient.

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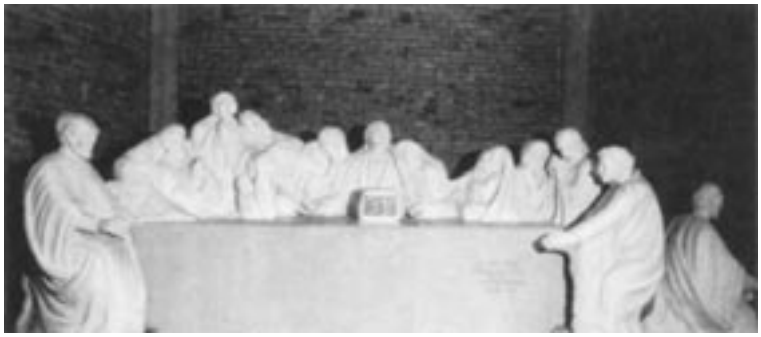


Duc in Altum! Medical Doctors and the New Evangelisation

1. The Responsibility of the New Evangelisation

The year 2000 was the year of the Great Jubilee. The Church commemorated the two thousand years that had passed since the Incarnation of Christ, that great event that divided history and which the Church herself continues to actualise in time. The Jubilee was an occasion marked by giving thanks, praise, and conversion. During it we experienced the mercy of God.

We Catholic medical doctors as well experienced the grace of the Jubilee, both at an individual level in the secrecy of our hearts and at a diocesan and national level during the occasions promoted by our Church, when on 11 February 2000 we took part in Rome in the Jubilee of the Sick and Health Care Workers, and when, on the occasion of the twentieth World Congress held in Rome on 3-7 July, we experienced together with the Pope the Jubilee of Medical Doctors.

Now that the Jubilee has finished and we have returned to the daily facts of our professional life and our pastoral commitment, we ask ourselves: what remains of the Great Jubilee? Was it only a moment of celebration? Or did the grace and the mercy given to us in abundance give us new strength and new impetus in our lives as Christians?

These very questions of ours have been the subjects of deep reflections on the part of the Holy Father John Paul II. At the end of the Great Jubilee, he thought it advisable to submit them to the whole of Christianity in his Apostolic Letter *Novo Millennio Ineunte* (henceforth *NMI*), which was published on 6 January 2001.[1]

In this encyclical letter, the Pope invites us to go on, to look at the third millennium of the Church, to put out into the deep with the boat of Peter so as to bring all men the announcement of grace and Christian joy. *Duc in altum*! This is the exhortation by which the Pope, proposing anew the words of the Lord Jesus, invites us to bring the happy news of the Gospel to all men: the new millennium, like the fruit of the Great Jubilee, must be the millennium of the new evangelisation.

In this paper I would like to read the Apostolic Letter *Novo Millennio Ineunte* with reference to our professional life and the life of our associations of Catholic medical doctors, in the belief that, following the path indicated to us by the Pope, we will be a factor in changing individuals, medical culture, and the whole of society.

The exhortation to evangelisation, indeed, runs throughout the *NMI*, indeed from its very *incipit*, where the Pope writes: 'At the beginning of the new millennium, and at the close of the Great Jubilee during which we celebrated the two thousandth anniversary of the birth of Jesus and a new stage of the Church's journey begins, our hearts rung out with the words of Jesus when one day, after speaking to the crowds from Simon's boat, he invited the Apostle to "put out into the deep" for a catch: "*Duc in altum*" (Lk 5:4). Peter and his first companion trusted Christ's words, and cast the nets. "When they had done this, they caught a great number of fish" (Lk 5:6)' (*NMI*, 1). Later in the same encyclical the Pope states that at the beginning of the new millennium 'the work of evangelisation…is surely a priority for the Church…. Even in countries evangelised many centuries ago, the reality of a "Christian society" which, amid all the frailties which have always marked human life, measured itself explicitly on Gospel values, is now gone. Today we must courageously face a situation which is becoming increasingly diversified and demanding in the context of "globalisation" and of the consequent new and uncertain mingling of peoples and cultures. Over the years I have often repeated the summons to the *new evangelisation*. I do so again now, especially in order to insist that we must rekindle in ourselves the impetus of the beginnings and allow ourselves to be filled with the ardour of the apostolic preaching which followed Pentecost. We must revive in ourselves the burning conviction of Paul, who cried out: "Woe to me if I do not preach the Gospel" (I Cor 9:16)' (*NMI*, 40). 'This passion will not fail to stir in the Church a new sense of mission, which cannot be left to a group of "specialists" but must involve the responsibility of all the members of the People of God. Those who have come into genuine contact with Christ cannot keep him for themselves, they must proclaim him. A new apostolic outreach is needed, which will be lived as the everyday commitment of Christian communities and groups' (NMI, *40*).

To evangelise means to spread the light of Christ to those who do not know it or do not see it. Thus the Pope writes: 'Ours is the wonderful and demanding task of becoming its "reflection". This is the *mysterium lunae*, which was so much a part of the contemplation of the Fathers of the Church, who employed this image to show the Church's dependence on Christ, the Sun whose light she reflects. It was a way of expressing what Christ himself said when he called himself the "light of the world" (Jn 8:12) and asked his disciples to be "the light of the world" (Mt 5:14)' (*NMI*, 54).

Today, however, evangelisation is viewed with suspicion by modern societies and it is out of fashion within the Church itself. In the name of

inter-religious dialogue and out of respect for the seeds of truth contained in the other religions, many people renounce proposing Christ, the light of the world, arriving in fact at a sort of religious indifferentism. The axiom at the base of this approach is that we should not impose anything on anybody. But this kind of approach is misleading. We must not impose but we have the mission of presenting our faith. It is surprising, for example, that in European societies, where Islam is the second confession, and at times the first in terms of religious practice, that no effort is made to present the Christian Good News. We seem to be indifferent to the faith of our brothers and sisters. Again, it is not a problem of imposition but rather of being convinced of the beauty of the Christian life that is proposed, for us in the medical field and for others in other temporal realities.[2]

This is also the view of the Pope who invites Christians to develop dialogue without abandoning bearing witness to the faith that is within us: 'Dialogue, however, cannot be based on religious indifferentism, and we Christians are in duty bound, while engaging in dialogue, to bear clear witness to the hope that is within us (cf. Pt 3:15). We should not fear that it will be considered an offence to the identity of others what is rather the joyful proclamation of a gift meant for all, and to be offered to all with the greatest respect for the freedom of each one: the gift of the revelation of the God who is Love, the God who "so loved the world that he gave his only Son" (Jn: 3:16). As the recent declaration *Dominun Iesus* stressed, this cannot be the subject of a dialogue understood as negotiation, as if we considered it a matter of mere opinion: rather, it is a grace which fills us with joy, a message which we have a duty to proclaim' (*NMI*, 56).

Although Christians are asked to engage in dialogue in a way where they are internally ready to listen, nonetheless, states the Pope, the Church: 'cannot forgo her missionary activity among the peoples of the world. It is the primary task of the *missio ad gentes* to announce that it is in Christ, "the Way, the Truth and the Life" (Jn 14:6), that people find salvation. Inter-religious dialogue "cannot simply replace proclamation, but remains oriented towards proclamation"' (*NMI*, 56).

2. The Contents of the Christian Message

Hitherto we have seen the urgent importance of evangelisation by, the responsibility of, and the *commitment of Christian communities and groups*. We can now ask ourselves what the good news to be proclaimed consists of, or in other words, what the contents of the Christian message amount to.

What we proclaim is certainly not a thing, it is not a programme, it is not a philosophy or an ethical vision, albeit of a very noble kind. In evangelising the world we proclaim a person, Jesus Christ himself. We proclaim the absolute news of a God who became man, took on human flesh and for man suffered, died and rose again. This is the event that shook history, inflames our hearts and gives a sense to our action. This is also what the world is waiting for. The world, however, more than hearing Christ spoken about, expects from us that we show it Christ; it wants in looking at us to see Jesus. '"We wish to see Jesus" (Jn 12:21). This request, addressed to the Apostle Philip by some Greeks who had made a pilgrimage to Jerusalem for the Passover, echoes spiritually in our ears too during this Jubilee Year. Like those pilgrims of two thousand years ago, the men and women of our own day – often perhaps unconsciously – ask believers not only to "speak" of Christ, but in a certain sense to "show" him to them. And is it not the Church's task to reflect the light of Christ in every historical period, to make his face shine also before the generations of the new millennium? Our witness, however, would be hopelessly inadequate if we ourselves had not first contemplated his face' (*NMI*, 16).

Contemplation of the face of Christ is proposed by the Pope to the devotion of all Christians as a foundation of the new evangelisation. This involves, obviously enough, contemplating the face of Christ so as to be able to reflect his light. There is, however, a face of Christ that especially poses questions to we medical doctors. Used as we are in our profession to being near people who suffer, we are particularly fascinated by the suffering of God who became Man; by the suffering face of the Man of Gethsemane and the *Via Crucis*; and by the face covered with bruises, wounds and blood of his passion and handed down to us in the linen of the Turin shroud.

In contemplating as medical doctors this suffering face, we find the strength and inspiration to contemplate the face of every suffering person, to look him or her in the eyes, with new eyes, as the face saved by the bleeding face of Christ; as a valuable face, because redeemed at a dear price; as a face endowed with divine dignity even when disfigured and almost unrecognisable, because the face assumed by God who made Himself Man.

In contemplating the Face of the passion, we exercise our profession with a new heart and with new eyes and make the world see Christ, see his radical newness.

These ideas, which are apparently ancient, are in fact radically new for today's medicine. Medicine today, indeed, encounters difficulty in recognising the dignity present in every human being and can thus be prepared to manipulate human beings at the embryo stage; it can take part in the suppression of human beings at the foetus stage through abortion; through euthanasia it can take part in the elimination of human beings who are said not to have a sufficient quality of life due to the fact that they are terminally ill or because in them the light of the human mind has become extinguished due to a persistent vegetative state or because they are gravely retarded or affected by dementia.

In addition, when we lose

from sight the idea that all men, at all the stages of their lives, possess the same dignity as persons, medicine can be tempted to turn in a selective way to those who have the financial means to be cared for and treated, or it can contribute to directing public funds towards problems that regard elites, thereby forgetting problems that concern other parts of the population but which are of lesser scientific-technological interest. Or it can approve a distribution of resources on a planetary scale that seems to passively accept the fact that groups of people exist who are condemned to malnutrition, to epidemics, and to child mortality. For this kind of medicine, the Christian message, indeed Christianity, are concepts of absolutely newness, the foundation of a practice of medicine that is totally different to dominant medicine.

3. The Conditions to Proclaim the Good News

The Face of Christ thus makes up the contents our new evangelisation. But, we ask ourselves, how should we proclaim it? What must we do to bring the good news to everyone? The Pope invites us first and foremost to not fall into a misunderstanding: 'No, we shall not be saved by a formula but by a Person, and the assurance which he gives us: *I am with you!* It is not, therefore, a matter of inventing a "new programme". The programme already exists: it is the plan found in the Gospel and in the living Tradition, it is the same as ever. Ultimately, it has it has its centre in Christ himself, who is to be known, loved and imitated, so that in him we may live the life of the Trinity, and with him transform history until its fulfilment in the heavenly Jerusalem. This is a programme which does not change with shifts of times and cultures, even though it takes account of time and culture for the sake of true dialogue and effective communication' (*NMI*, 29).

This programme, which is the same as ever, is also our programme for the third millennium. It is for this reason that the Pope confines himself to indicating the requirements, the conditions for effective pastoral work which is capable of proclaiming the good news.

This is not the place to examine in detail the conditions that the Pope proposes to us. I believe, however, that it is incumbent upon me to refer to some of them. 'First of all', writes the Pope, 'I have no hesitation in saying that all pastoral initiatives must be set in relation to

holiness'(*NMI*, 30). 'In fact, to place pastoral planning under the heading of holiness is a choice filled with consequences' (*NMI*, 31). 'It would be a contradiction to settle for a life of mediocrity, marked by a minimalist ethic and a shallow religiosity' (*NMI*, 31). 'The whole life of the Christian community and of Christian families must lead in this direction. It is also clear however that the paths to holiness are personal and call for a genuine "training in holiness", adapted to people's needs. This training must integrate the resources offered to everyone with both the traditional forms of individual and group assistance, as well as the more recent forms of support offered in associations and movements recognised by the Church' (*NMI*, 31).

I ask myself whether in the realm of our associations of Catholic medical doctors such *teaching regarding health*, precisely because of the specific needs of medical doctors, should not be more concerned with proposing models of men and women who have sanctified their own lives by exercising the medical profession.

In the historical calendar there is no lack of saints who were medical doctors. I believe that our profession is the one that is the most represented within the array of saints, after, obviously enough, bishops, priests and nuns. However, the thought comes to me that perhaps our profession could have been the most numerous category if, speaking in epidemiological terms, there had not been at work a bias in selection: the whole process of selection is in fact in the hands of the clergy and we medical doctors are called solely to assess the veracity of miracles.

In his recent volume of essays, Dr. Richard Webster of New Jersey proposes a list of at least thirty-three saints to us and says that he is convinced *a priori* that the list is not complete. Some of these saints are known to everyone, such as our patron saint, St. Luke the Evangelist, or the siblings Cosma and Damian, called *anargiri* because they did not allow themselves to be paid for the care and treatment that they provided (is it perhaps for this reason that it has become more difficult for us to become saints?)

Then there are saints who are for the most part unknown, such as St. Pantaleon, St. Diomendes, and St. Emilian, or very famous saints in medicine such as Nicolò Stenone or Antonio Maria Zaccaria.

Lastly, there are very modern saints who were medical doctors, such as Prof. Giuseppe Moscati and Dr. Gianna Beretta Molla. Both were members of the laity. The first, made a saint almost by popular demand, taught and exercised his profession in Naples; the second, a paediatrician in Milan and a member of the local association of Catholic medical doctors, after a fertile bearing of witness in her profession and her family, sacrificed her life out of love for life, renouncing treatment

in order to ensure that her last daughter was born.

Other medical doctors have not yet been beatified but it would almost be a moral duty in our associations to propose the cause of beatification for them. I am thinking, for example, of Prof. Nagai, a Japanese convert who taught at the University of Nagasaki, and who died after engaging in evangelisation and after long years of suffering caused by the atomic bomb that was dropped on the centre of the district inhabited by the flourishing Catholic community of Nagasaki, bringing about its destruction. Nagai's wife. who had also converted to Christianity, died in the explosion as well. (In those times as well the Americans talked about 'intelligent bombs'!)

I am thinking of Jerôme Lejuene, who made his life, and his scientific research, passionate, coherent and intelligent witness to the beauty and the humanity of the Magisterium of the Church, and who with faith and hope offered the suffering that accompanied the final stages of his life as a sacrifice to God to obtain from Him the protection of human life at the moment in which it is attacked, throughout the world, by medical doctors themselves. I thank the Lord that I had the privilege to meet him on more than one occasion and to discuss with him the possibility of scientific research on behalf of man, above all as regards children with mental disabilities.

Other saints awaiting recognition, lastly, although they were not medical doctors, deserve a *honoris causa* degree in medicine. For example, Dr. Marcello Candia, a businessman who, like the young St. Francis, dispossessed himself of all his wealth in order to build help-centres for lepers and live amongst them in Brazil. One day I had the great fortune to eat with him in his Milan, to which he periodically returned to hold out his hands (and he had been rich) to ask for alms for his Brazilian lepers.

We thus have, fortunately enough, only an embarrassment of choice in proposing both contemporary and historical models to follow to our medical doctors. But in order to be educated and educate in health care, writes the Pope, we need a Christianity that stands out first of all 'in the art of prayer' (*NMI*, 32).

It is a given fact that in today's world, despite the process of secularisation, a widespread need for spirituality is present. This expresses itself specifically in a renewed need for prayer (*NMI*, 33). Is it not perhaps our responsibility as individuals and as associations if often it is felt that this need is not met within the Church and seeks to be met through a flight to other religions and to sects? Is it not perhaps the responsibility of we Catholic medical doctors as well if contemporary man looks to these sects, to

new and at times ancient forms of spirituality, for an answer to his need for physical and spiritual healing as well?

The Pope rightly invites is to regain the great mystical tradition of the Church of both East and West. He invites us to ensure that our Christian communities become 'genuine "schools" of prayer, where the meeting with Christ is expressed not just in imploring help but also in thanksgiving, praise, adoration, contemplation, listening and ardent devotion, until the heart truly "falls in love". Intense prayer, yes, but it does not distract us from our commitment to history: by opening our heart to the love of God it also opens it to the love of our brothers and sisters, and makes us capable of shaping history according to God's plan' (*NMI*, 33).

This is a request and a project that is also applicable to our associations of Catholic medical doctors: to be *genuine schools of prayer.*

The Pope then invites us to make the maximum effort in the Sunday liturgy of the Eucharist; to rediscover the sacrament of reconciliation, so as to experience the mercy of God and face up to the crisis regarding a sense of sin that afflicts contemporary society; and to give renewed attention to the Word of God, so as to revitalise the work of evangelisation.

Holiness, prayer, listening to the Word, the Sunday liturgy of the Eucharist, the sacrament of reconciliation: this is the itinerary that the Pope points out to us so that we can take hold of our work of evangelisation. Following this itinerary, the work of evangelisation will perhaps not be easier but it is certainly the case that we will be able to address it without any worry, free above all else from the anxiety of doing and planning.

'There is a temptation which perennially besets every spiritual journey and pastoral work: that of thinking that the results depend on our ability to act and to plan. God of course asks us really to co-operate with his grace, and therefore invites us to invest ourselves of all our resources of intelligence and energy in serving the cause of the Kingdom. But it is fatal to forget that " without Christ we can do nothing" (cf. Jn 15:5). It is prayer which roots in us this truth. It constantly reminds us of the primacy of Christ and, in union with him, the primacy of the interior life and of holiness. When this principle is not respected, is it any wonder that pastoral plans come to nothing and leave us with the disheartening sense of frustration? We then share the experience of the disciples in the Gospel story of the miraculous catch of fish: "We have toiled all night and caught nothing" (Lk 5:5)' (*NMI*, 38).

4. The Characteristics that Make the Work of Evangelisation Credible

Together with the Pope we have gone over the conditions that are needed to propose the encounter with Christ to others. The Holy Father has also pointed out to us the characteristics that make the work of evangelisation credible. They can be summed up in a single fundamental characteristic: Love.

'"By this all will know that you are my disciples, if you have love for one another" (Jn 13:35). If we have truly contemplated the face of Christ, dear Brothers and Sisters, our pastoral planning will necessarily be inspired by the "new commandment" which he gave us: "Love one another, as I have loved you" (JN 13:34)' (*NMI*, 42).

The fundamental characteristic of Love is expressed in turn in three signs of the credibility of the announcement: ecclesial communion, ecclesial co-responsibility, and charity.

5. Communion

First and foremost: communion. The Pope invites us to 'make of the Church the home and the school of communion: that is the great challenge facing us in the millennium which is now beginning, if we wish to be faithful to God's plan and respond to the world's deepest yearnings' (*NMI*, 43).

This is also applicable, obviously enough, to our own associations, from which nobody should feel excluded. They should be homes of communion and schools of holiness in which holiness is proposed as a pathway and not asked for as a requirement. For them their relationship with the other Church associations and movements should not be one of competition but one of co-operation. For them, communion with their bishop and the Holy See is a need of the spirit before being a duty.

6. Church Co-responsibility

'Therefore the Church of the third millennium will need to encourage all the baptised and confirmed to be aware of their active responsibility in the Church's life' (*NMI*, 46). To reflect upon our pastoral responsibility does not, obviously enough, mean thinking first of all about our participation in the pastoral councils of hospitals or in the committees for pastoral care in health of the dioceses. It means above all else that within hospitals the Catholic medical doctor can contribute in a notable way to the pastoral work of the Church in situations where men and women find themselves facing the most dramatic questions of their lives, those at the basis of their religious experience: who am I? Why are we born? What is the meaning of suffering? Why do I have to die and what is there after death? In some circumstances, the Catholic medical doctor can be more important than the priest, at least when the priest is not available or is not accepted.

Moreover, in the parishes and in schools as well the Catholic medical doctor can play an important role: during courses to prepare people for marriage, or in sexual education for young people. The Catholic medical doctor is an agent in the pastoral work of the Church; he or she shares in her apostolic mission. Christ sent the Apostles to proclaim the Kingdom of God and to heal (Lk 9:2).

But, the Pope adds, 'in a special way it will be necessary to discover ever more fully the specific vocation of the laity, called "to seek the kingdom of God by engaging in temporal affairs and by ordering them according to the plan of God"; they "have their role to play in the mission of the whole people of God in the Church and in the world…by their work for the evangelisation and the sanctification of people" Along these same lines, another important aspect of communion is the promotion of forms of association, whether if the more traditional kind or the newer ecclesial movements, which continue to give the Church a vitality that is God's gift and a new "springtime of the Spirit". Obviously, associations and movements need to work in full harmony with the universal Church and the particular Churches, and in obedience to the authoritative directives of the Pastors. But the Apostle's exacting and decisive warning applies to all "Do not quench the Spirit, do not despise prophesying, but test everything and hold fast what is good" (1 Th 5:19-21)' (*NMI*, 46).

How can we not see in this summons of the Pope a pressing invitation to develop and strengthen the work of our associations of Catholic medical doctors so that, beyond personal witness, the face of the Church, that is to say the face itself of Christ in today's times, is immediately visible in our action.

7. Charity

'Beginning with intra-ecclesial communion, charity of its nature opens out into a service that is universal; it inspires in us a commitment to practical and concrete love for every human being. This too is an aspect which must clearly mark the Christian life, the Church's whole activity and her pastoral planning. The century and the millennium now beginning will need to see, and hopefully with still greater clarity, to what length of dedication the Christian community can go in charity towards the poorest. If we have truly started anew from the contemplation of Christ, we must learn to see him especially in the faces of those with whom he himself wishes to be identified: "I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me" (Mt 25:35-37). This Gospel text is not a simple invitation to charity: it is a page of Christology which sheds a ray of light on the mystery of Christ. By these words, no less than by the orthodoxy of her doctrine, the Church measures her fidelity as the bride of Christ' (*NMI*, 49).

8. The Style of the Good Samaritan

Our work, if well done, if done recognising in the face of the patient the suffering face of Christ and his dignity, is already a work of charity; it is an original and very special participation in the ministry of salvation. As the Pope says, it 'is a testimony to the nature of God's love, to his providence and mercy; and in some way history is still filled with the seeds of the Kingdom of God which Jesus himself sowed during his earthly life whenever he responded to those who came to him with their spiritual and material needs' (*NMI*, 49).

What is the Gospel in fact if not an announcement of salvation, an announcement of health and healing? Jesus passed by proclaiming the Kingdom of God and healing the sick. Salvation also makes physical health possible (go on your way, your faith has saved you, Christ says to the blind man). In opposite fashion, it was the healings that gave the first witness to the power of the Saviour and made his preaching credible. The work of charity, and even more the work of we Catholic medical doctors, if carried out recognising the face of Christ in our patients and with the style of the Good Samaritan, can give special credibility to the proclaiming of the Gospel.

The pastoral work of the Church in the world of health and health care needs members of the laity to carry out the mandate of Christ: to proclaim the Gospel and heal the sick. To heal the sick is not of secondary importance but is almost an integral part of evangelisation, it is what makes it credible. Jesus himself defined his preaching as 'healing the sick'.

The merciful and thaumaturgical love of Christ is expressed especially when we agree to offer our skills to those who can give us nothing in exchange. We have the responsibility to show the face of Christ to those who are poor or do not have access to standard levels of medicine because of their economic status or their social and psychological conditions.

9. The Creativity of Charity: New Works for New Needs

But it is not enough for us to be Good Samaritans as individuals. The Pope proposes to us a much greater horizon within which there is great space for associated forms of witness, such as our associations of Catholic medical doctors are or can be: 'In our own times there are so many needs which demand a compassionate response from Christians. Our world is entering the new millennium burdened by the contradictions of an economic, cultural and technological progress which offers immense possibilities to a fortunate few, while leaving millions of others not only on the margins of progress but in living conditions far below the minimum demanded by human dignity. How can it be that even today there are still people dying of hunger? Condemned to illiteracy? Lacking the most basic medical care? Without a roof over their heads? The scenario of poverty can extend indefinitely, if in addition to its traditional forms we think of its newer patterns. These latter often affect financially affluent sectors and groups which are nevertheless threatened by despair at the lack of meaning in their lives, by drug addiction, by fear of abandonment in old age or sickness, by marginalisation or social discrimination…This means carrying on the tradition of poverty which has expressed itself in so many different ways in the past two millennia, but which today calls for even greater resourcefulness' (*NMI*, 50).

Down the centuries, the Church has developed deaconates, hostels for pilgrims, monastic infirmaries, and religious orders dedicated to assistance for the sick. It is for this reason that the Church invented the idea of the 'hospital' and amply contributed to developing those characteristics that we know today. Even when modern states began to become interested in health and health care after the French revolution, the Church, in order to maintain the ideal of health care, fostered the foundation of Catholic health care institutions all over the world: from the large and prestigious hospitals and faculties of medicine of the Catholic universities to clinics in where missionary activity was being carried out. Still today, the Church is the principal non-governmental supplier of health care services in the world.

This enormous effort is not directed solely to remedying the fact that governments have not demonstrated any interest in certain forms of poverty and marginalisation; this effort was and is witness to the fact that attention paid to the human person is not real unless it involves the whole man, even when he is fragile, weak, and unless all men are involved, even when they have been abandoned and their social weight and their importance in the society of productivity and goods is no longer significant.

It is for this reason that we can say with pride that the effort of the Church in the world of health and health care has notably contributed to the development of human civilisation, fostering throughout the world the growth of a culture of mercy and compassion, of rights and respect for man in all the situations of his life and at all the stages of his existence.[3]

Today, however, 'is the time for a new "creativity" in charity, not only by ensuring that help is effective but also by "getting close" to those who suffer, so that the hand that helps is seen not as a humiliating handout but as sharing between brothers and sisters. We must therefore ensure that in every Christian community the poor feel at home. Would not this approach be the greatest and most effective presentation of the good news of the Kingdom? Without this form of evangelisation through charity and without the witness of Christian poverty, the proclamation of the Gospel, which is itself the prime form of charity, risks being misunderstood or submerged by the ocean of words which daily engulfs us in today's society of mass communications. The charity of works ensures an unmistakable efficacy to the charity of words' (*NMI*, 50).

The presence of the Church in the health care world was, and is, dictated by an awareness that it is precisely when man expresses the need to be healthy that he is led to ask himself fundamental questions about life: the meaning of being born, of suffering, and of dying. The Church is aware that a correct answer to these questions can also condition the reply to other questions on which is based the religious consciousness of man. Who am I, Where am I going? What is the meaning of my life? The need to regain health can lead man to ask for salvation (*salus*).

It is for these reasons that in non-Catholic hospitals as well the Church always fosters the

presence of chaplains, nuns who belong to nursing orders, doctors and women nurses with a Catholic training and faith, and volunteers inspired by the model of the Good Samaritan.

If these are the reasons for such a presence, how can one not hear the Pope when he speaks about malnutrition, the lack of basic medical care, hopelessness, drugs, the abandonment of the elderly and the sick, social marginalisation; this summons to we medical doctors; this re-proposal of the spirituality of the Good Samaritan; this invitation to individual medical doctors and even more to our associations of Catholic medical doctors to invent new forms of service to the poor, to discover new forms of health care assistance for the new forms of poverty that are present even in cities of wealth, to be present in the scenario of international health care co-operation with developing countries? 'Countless are the emergencies to which every Christian heart must be sensitive' (*NMI*, 51). And the Pope also refers to an 'ecological crisis', to 'the problems of peace', to 'contempt for the fundamental human rights', 'especially of children'.

10. Bio-medical Science

An important sphere of charity is that of bio-medical science. This is the most important charity, intellectual charity, so that medical science does not lose its purpose of helping man and does not become, rather, an instrument for the destruction and selection of human life. The Pope then goes on to add: ' A special commitment is needed with regard to certain aspects of the Gospel's radical message which are often less well understood, even to the point of making the Church's presence unpopular, but which nevertheless must be a part of her mission of charity. I am speaking of the duty to be committed to respect for the life of every human being, from conception until natural death. Likewise, the service of humanity leads us to insist, in season and out of season, that those using the latest advances of science, especially in the field of biotechnology, must never disregard fundamental ethical requirements by invoking a questionable solidarity which eventually leads to discriminating between one life and another and ignoring the dignity which belongs to every human being. For Christian witness to be effective, especially in those delicate and controversial areas, it is important that special efforts be made to explain properly the reasons for the Church's position, stressing that it is not a case of imposing on non-believers a vision based on faith, but of interpreting an defending the values rooted in the very nature of the human person. In this way charity will necessarily become service to culture, politics, the economy and the family, so that the fundamental principles upon which depend the destiny of human beings and the future of civilisation will be everywhere respected' (*NMI*, 51). 'Clearly, all this must be done in a specifically Christian way: the laity especially must be present in these areas in fulfilment of their lay vocation, without ever yielding to the temptation to turn Christian communities into mere social agencies' (*NMI*, 52).

11. The Inculturation of the Christian Message

In the work of evangelisation the Pope invites us to be careful about the different cultures in which the Christian message must be placed so that the specific values that animate them are not denied but purified and led to their fullness. This is applicable in a special way to medical culture which has been for a long time an ally of the Church in the defence of the dignity of man: 'In the third millennium, Christianity will have to respond ever more effectively to this need for inculturation. Christianity, while remaining completely true to itself, with unswerving fidelity to the proclamation of the Gospel and the tradition of the Church, will also reflect the different faces of the cultures and peoples in which it is received and takes root' (*NMI*, 40). 'Charity will necessarily become service to culture' (*NMI*, 51).

Until a few decades ago, in fact, the morality of medical doctors and Catholic morality were rarely in contrast with one another and the Catholic medical doctor did not encounter any difficulty in making available to his or her patients everything that medical science had to offer, without for this reason suffering from conflicts of conscience. It is true: there were always medical doctors and midwives who practiced abortion, but they did this outside the common morality recognised by the profession and they did it in a hidden way because they would have been censured. When I studied medicine, the textbook on legal medicine identified only four kinds of abortion: miscarriage, therapeutic abortion (abortion practiced solely to save the life of the mother), eugenic abor-

tion, and criminal abortion. In relation to the last two kinds of abortion, professional censure was extremely clear.

Over the last decades the situation has changed profoundly. The availability of pharmacological methods of contraception, the feminist movement, the introduction of abortion into a high number of sets of legislation, the increasing possibilities offered by genetics to discover illnesses before the birth of the child, the development of techniques of *in vitro* fertilisation, the consequent production of embryos to cure sterility, their availability for scientific research, the discovery of the potential of embryo cells for the development of tissue useful for transplants in the treatment of degenerative illnesses, the hypothesis of total or partial cloning, something that is already being applied in the animal kingdom, all this has radically changed the scenario.

Pregnancy and birth are no longer seen as acts that are in most instances of a physiological character; often, instead, they are seen as a misfortune and an illness that the medical doctor has to treat. A child is no longer seen as a gift but as an object of desire who is brought into this world only if he or she is wanted, and who is accepted only if the gift is well wrapped and not damaged. Medicine no longer has as its primary goal the defence of life – it is more concerned about the quality of life.

International organisations have given up struggling to ensure that the fundamental rights to health are upheld for all populations and social strata; they are concerned solely with reducing the demand for such rights, and favour a fall in birth rates throughout the world.

The ambiguous term 'reproductive health' has been invented, behind which, in addition to the prevention and control of gynaecological illnesses, contraception, abortion, sterilisation and low birth rates are publicised, offered, and also imposed on governments and health care workers. In contrary fashion, we are still too little concerned about the death of mothers at childbirth, which is still very high in some countries of the world and in some social strata, even in developed countries.

Catholic medical doctors, and in particular Catholic gynaecologists and obstetricians, naturally find themselves in the midst of these tensions and these changes.[4]

We must show the courage to once again ask ourselves the fundamental questions of life, suffering, and death. The pagan vision which is behind the cult of health fears suffering, old age, death, and even birth. In the face of this vision we must bear witness to the Christian approach, seeing birth, illness, pain, treatment, healing and death as opportunities for growth. The experience of our limits helps us to discover the infinite and the reality about ourselves, breaking the dream of omnipotence and invulnerability.

Every medical doctor should feel personally committed to limiting the medicine of desires, to checking the technological invasion of medicine, and to limiting the social invasiveness of medicine. On the other hand, we should strive to develop an idea of medicine based upon prevention, upon education in medicine, and upon the correction of inappropriate lifestyles; in other words, an idea of medicine based upon the responsibility of the person.

In this time of limited resources we must save resources thanks to a culture of responsibility within medicine and use them to create valid health care systems in developing countries.

This responsibility should be felt especially by those who are involved in teaching and who have great responsibility in the education and training of the new generations of medical doctors.[2]

12. Socio-political Responsibility

'Charity will necessarily become service… to politics, the economy and the family, so that the fundamental principles upon which depend the destiny of human beings and the future of civilisation will be everywhere respected' (*NMI*, 51). 'The ethical and social aspect of the question is an essential element of Christian witness: we must reject the temptation to offer a privatised and individualistic spirituality which ill accords with the demands of charity, to say nothing of the implications of the Incarnation and, in the last analysis, of Christianity's eschatological tension. While that tension makes us aware of the relative character of history, it in no way implies that we withdraw from "building" history. Here the teaching the Second Vatican Council is more timely then ever: "The Christian message does not inhibit men and women from building up the world, or make them disinterested in the welfare of their fellow human beings: on the contrary, it obliges them more fully to do these very things"' (*NMI*, 52).

We are called to humanise medicine and the places where we practice it, and to ensure that technological progress is not used against human rights. We are called to serve public health care, promoting health care policies that respect the life, the dignity and the nature of the human person.

12.1. Professional Orders

The medical profession raises itself above the law and lives in the dimension of ethics, even if it cannot distance itself from the deontology and the laws that concern medical practice. Medical laws without appropriate ethics would amount to mere arbitrariness, perhaps based upon unnameable interests. In contrary fashion, if ethics were not translated into deontology and laws, they would be confined to general principles and would be without any direct application.

The rules and regulations of medical law should be clear and short enough to facilitate the action of medical doctors. The guiding principle is always the same: the medical doctor is called to help and to heal and never to harm and never to kill.

It is for these reasons that the medical doctor must co-operate in the application of good laws, except when there is the duty of

conscientious objection, when civil law does not respect human rights, especially the right to life. For the same reasons, the medical doctor who respects the dignity of his or her profession will refuse to become an instrument in the violent and oppressive application of medicine.

12.2. Ethical Committees

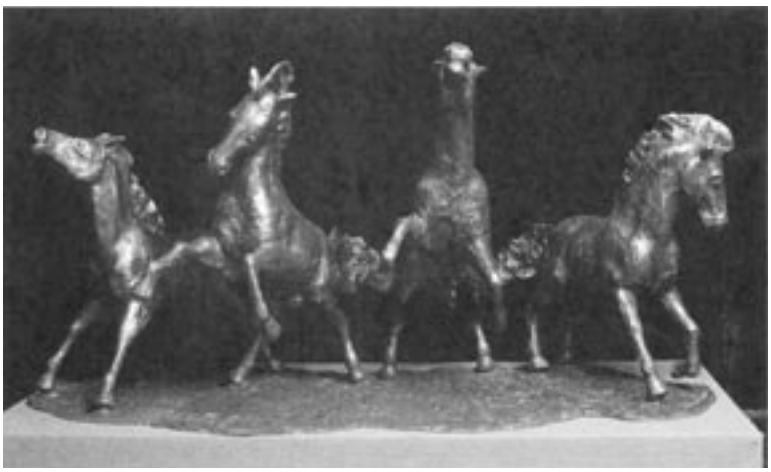
The medical doctor should be competent in the ethical field, even without being a specialist. For the same reason, ethical committees are needed in every health care centre and ethics should be taught to medical students in an open dialogue with specialists who belong to the various relevant disciplines.

12.3. Health Care Policies

Hemmed in between a utilitarian idea of health, which recognises only certain rights that are considered socially promoting legislation in favour of life and human rights.

This is not only a matter of resisting the temptations of abortion, of the waste of embryos and of euthanasia. We must feel committed to promoting social conditions where life can be accepted and to fighting situations where the dignity of life is humiliated. Indeed, respect for, and the promotion of, life and other human rights is the basis of every social union worthy to be considered human. To work in favour of life and the rights of man is probably the most important contribution there is to the growth and development of human civilisation.

We chose to be medical doctors to heal, to alleviate suffering, to have compassion, to comfort, and to accompany. We cannot be passive witnesses to a slow and apparently inevitable transformation of medicine into a profession enslaved by today's cultural trends or by the compromises of politics.



useful, and the ideologies of health, which propose health practices as a sort of cult of a new kind of religion for which death seems almost avoidable and health and physical fitness are modern divinities, we cannot simply withdraw to the line of a business ideal of medicine where (personal and institutional) profit is the yardstick for what is right.

Once again, we must place the subject at the centre of our attention and promote a network of human relationships based upon solidarity.

Lastly, we have the enormous socio-political task of We should, instead, find the courage to strongly oppose all of this, convinced as we are that neither governments nor parliaments have any right to enact laws that go against fundamental human rights and against the professional ethical codes of medical doctors.

Human rights are based upon the single root of the dignity of the person, and the legitimacy of states and governments is based upon such rights. This is applicable in particular to the right to life.

This fundamental right is guaranteed by moral duty; and it is respect for this right that gives meaning and legitimacy to human co-existence, laws, and civil institutions.

The protection of the right of every individual belonging to the human species, especially if weak and powerless, is what marks the difference between the state and a lobby, corporation or any kind of criminal association.[4]

Duc in Altum! Let us cast in the nets once again!

'The Christ whom we have contemplated and loved bids us to set out once more on our journey: "Go therefore and make disciples of all nations, baptising them in the name of the Father, and the Son, and the Holy Spirit" (Mt 28:19). The missionary mandate accompanies us into the Third Millennium and urges us to share the enthusiasm of the very first few Christians' (*NMI*, 58) 'After the enthusiasm of the Jubilee, it is not to a dull every day routine that we return…The Risen Jesus accompanies us on our way and enables us to recognize him, as the disciples of Emmaus did, "in the breaking of the bread" (Lk 24:35). May he find us watchful, ready to recognize his face and run to our brothers and sisters with the good news: "We have seen the Lord!" (Jn 20:25) (*NMI*, 59).

Prof. GIAN LUIGI GIGLI
President of the FIAMC

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[3] G. L. GIGLI, 'The Catholic Doctor's Challenges for the New Millennium', paper given at the time of the Jubilee of the Sick, Rome 9 February 2000, the text is available at www.fiamc.org.

[4] G. L. GIGLI, 'The Importance of the Practice of Obstetrics and Gynaecology to the Health Ministry of the Catholic Church', paper given at the time of the international conference of Catholic obstetrics and gynaecologists, Rome 18 June 2001, text available at www.fiamc.org.

St. Josemaría Escrivá: the Value of the Prayer and the Suffering of the Sick

In the cathedral of Almudena there are a number of side chapels dedicated to saints or blesseds who were born in that city or who carried out their apostolic work in it. Although St. Josemaría Escrivá was born in Barbastro (Huesca) in 1902, it was in Madrid that the Lord made him see Opus Dei, a path of sanctification and of apostolate in the world and in professional work. In that city he carried out for many years his priestly mission. In memory of this there is a chapel which contains a fine portrait of him. Two bas-reliefs commemorate the tie between St. Josemaría and the capital city of Spain: in the one on the left he can be seen praying in the Cuesta de a Vega in front of an image of the Virgin of Almudena, and in the other he is seen consoling a sick person. Each bas-relief has its own explanatory caption. In the first can be read 'On many occasions the Blessed Josemaría came to pray on his knees on the pavement in from of the image of Our Lady of Almudena which is in the wall that surrounds this cathedral. With unshakable faith and filial piety he turned to the Mother of God and our Mother beseeching from her protection for the inhabitants of this city and the whole world'.

The second bas-relief, the one that most interests us, states: 'In order to carry out the mission that God had entrusted to him, he also sought the help of pain, working heroically for many years in the hospitals and the poor areas of town to the point of stating that Opus Dei was born amongst the poor and the sick of Madrid…'

In fact, St. Josemaría often repeated that Opus Dei was born amongst the abandoned poor and sick of Madrid hospitals, and that thanks to the prayer and the suffering that these people offered to God he could persevere in the task which God had entrusted to him. He first worked as a chaplain to the Patronage of the Sick of the Apostolic Dames of the Sacred Heart.[1] This he did until November 1931.[2] Then he began to work with the Congregation of San Filipo Neri (whose members were known as 'Filipini'), visiting the sick of the general hospital.[3] In the summer of 1932 he began his work as a chaplain at the royal hospital.[4]

Sister Engracia Echevarría, who was then Mother Superior of the Daughters of Charity, who worked in the hospital, testified that 'at that time we did not have a chaplain and in such circumstances D. Josemaría Escrivá de Balaguer introduced himself to me. He was then a young priest who had just reached the age of thirty. He told me not to worry about not having an official chaplain and said that at any time of day or night, and under my authority, I was to summon him according to the gravity of the condition of the sick person who was asking for the sacraments'.[5]

Work in the Madrid hospitals required a more direct contact with physical suffering. The offering up of the pain and prayer of the sick were the bases from which the young Josemaría drew supernatural vitality to carry on his founding mission. (We will not speak here about moral suffering, which Josemaría knew from a very early age and which accompanied him for the whole of his life; we will mention only the contact that he had with other's people's sickness, and we will also exclude from our study the role that pain and illness had in his life).[6]

In 1974 he answered in the following way to a question that had been addressed to him during the course of a conversation in Santiago in Chile: 'And this priest aged thirty-six, with the grace of God, with a good spirit and nothing else, had to do the Work of God. Do you know how he did it? Thanks to the hospitals, to that general hospital of Madrid which was full of sick people, very poor people, laid out in the corridors because there were no beds, and at that hospital, the King's Hospital it was called, where there were only people suffering from tuberculosis, and at that time tuberculosis could not be cured... These were the weapons with which to win! This was the treasure by which to pay! This was the strength to go on!'[7]

He often observed that the sick were the treasure of Opus Dei. On 19 March 1975, when he was in Rome, he told a group of people how Opus Dei came into being: 'I went to seek strength in the areas of the very poor in Madrid…In the hospitals and those homes there were sick people, if one can call those hovels homes... They were abandoned and sick people… Thus it was that I went to find the means to do the Work of God in all those places. They were intense years during which Opus Dei grew from within without us being aware of the fact. I want to say to you, however, that the human strength of Opus Dei was the sick people of the hospitals of Madrid: the most abject, those who lived in their homes, who had lost all human hope; the most ignorant of those outer suburbs… the incurably ill, the abandoned poor, children without families and without any education, homes without a fire, without heat, and without love'.[8]

St. Josemaría saw illness as a source of virtue, as something that often brought about a great deal of suffering but which at the same time was not only valuable but could even become a reason for joy. The Catechism of the Catholic Church teaches that in illness man experiences his powerlessness, his limitations, and his finitude; illness, however, can also make the person more mature, help him to discern what is essential in his life and what is not; and often lead him to search for God and to a return to God.[9] St. Josemaría experienced all this. During the hours spent every day at the side of the sick, at one with their pain, a witness to their acute hardships, consoling them through his presence and eliminating the acute hardships of their souls with the sacrament of penitence, he ended up by seeing the lovable and suffering figure of Christ, weighed down by the weight and the ugliness of sin, the Christ who takes our pain and our trials upon himself. The

priest, another Christ, identified with the sick in pain and mercy. He was deeply concerned to see Christ in sick people and to lighten Christ's suffering within them.[10]

In his most famous work, *Camino,* he wrote: 'Child, Sick Person, in writing these words do you not feel tempted to use capital letters? This is because for a loving soul children and the sick are Christ'.[11] Other words of his, although hard (though in reality they are connected to the whole of the Christian tradition on the subject), in my opinion, complete what has just been observed. They are words that also appear in *Camino:* 'May pain be blessed! May pain be loved! May pain be sanctified! May pain be glorified!'[12]

One of his biographers has observed: 'I know of no phrase which so contradicts the spirit of our twentieth century, and above all else of the last three decades, more than this 'beatitude of pain'. It is easy to condemn it as 'masochistic', scandalous, or merely 'abnormal'. What we could call a 'healthy nature' has always been allied with the rejection of the Cross and contempt for it. As St. Paul wrote, the Cross was (and continues to be) 'to the Jews, a discouragement; to the Gentiles, mere folly' (1 Cor 1:23).[13] However, continues the author, 'the only possible point of view, although this is incomprehensible, is that the Cross is the path of the Love of God, the path of the happiness of free men; only this Love can integrate and rise above the Cross'.[14]

On some occasions words such as these have been accused of being 'painism' (as though they sought the mere exaltation or glorification of pain), and this is probably the result of an approach created on the basis of positions which are rather theoretical. For this reason, we also need to remember other words of our new saint in which he encourages people to fight pain and not to resign themselves to merely accepting it: 'physical pain, when it can be left, should be left. There is already enough suffering in life! And when it cannot be left, it should be offered'.[15] We are not, therefore, in front of a simplistic acceptance of the pain of life, pain that we should seek to eliminate, but rather it is a matter of finding in them, when they appear, their full meaning in the plan of the Redemption.

In any case, we are face to face with a profound mystery: pain, in itself bad, can also be transformed into a sign of the love of God, and thus into a source of joy. Since pain is a part of human existence, it must have a meaning in the plans of God. John Paul II has observed that pain is in itself absurd, and that only when it is accepted and offered to Christ, in union with his sufferings, does it become life and resurrection: 'In the Body of Christ, which is ceaselessly born of the cross of the Redeemer, it is precisely suffering permeated by the spirit of Christ's sacrifice that is the irreplaceable mediator and author of the good things which are indispensable for the world's salvation. It is suffering, more than anything else, which clears the way for the grace which transforms human souls. Suffering, more than anything else, makes present in the history of humanity the powers of the Redemption.'[16]

Cardinal Ratzinger states that 'pain accepted and borne in communion with Christ, who was crucified and rose again, finds a deep meaning for the individual person and for others, indeed it can become a force for healing'.[17]

Seventy years have passed since those first experiences of our new saint with the sick of the Madrid hospitals. Since then, medicine has made great strides forwards and now, at least in industrialised countries, it is not easy to be in situations such as those that he experienced. But contemporary medicine also needs this plus of humanity that is to be found in the teachings of Jesus of Nazareth: 'His nature is, from the first, divine, and yet… he lowered his own dignity, accepting an obedience which brought him to death, death on a cross' (Phil 2:6,8). Following this trajectory, there are many Catholic institutions throughout the world dedicated to care that seek to secure this wished for humanisation of health by following the teachings (charity, spirit of service, etc.) of Jesus Christ.[18]

The dedication of St. Josemaría to sick people continues, as a legacy, in various health care centres as the fruit of the professional practice of many people who take advantage of the instruments of

Christian training provided by Opus Dei and who seek to live out his spirit in health care centres promoted by the faithful and those who co-operate with the Prelature in many countries in the world: the University Clinic of Navarre, which was an initiative directly promoted by him;[19] the Biomedical Campus of Rome; the Monkole Hospital of Kinshasa (the Democratic Republic of the Congo); the Niger Foundation Hospital and Diagnostic Centre of Enugo (Nigeria); the Austral University Hospital of Buenos Aires (Argentina) etc.

In all of these health care centres is to be found the approach of St. Josemaría to pain and illness: a vision that transcends the purely physical level and which is fused with the purest love of Christ, because Christ is present in every sick person. For this reason, to be sick means to be a person chosen by Christ, and thus if strength and grace are obtained from Christ, there is no better path – after the sacraments – by which to obtain sanctification (full union with Christ) than that of the suffering of, and drawing near to, the suffering sick person, consoling him and helping him in his needs.[20]

The present Prelate of Opus Dei remembers certain words that he heard directly from the mouth of St. Josemaría, and which sum up, in my judgement, what this paper has sought to remember: 'Suffering, in Opus Dei, if we live the spirit that the Lord has wanted for us, is transformed into love, and into love with joy. Do not forget this, time will pass, I will have gone to answer to God, and you will be able to repeat to your brothers that you heard me say that suffering, when it comes, we love it, we bless it and we transform it into an instrument to render glory to God, always with joy, which does not mean that it does not have its cost… Illness, when it comes, has to be loved, and we must know how to sanctify it because it is 'the professional work' that the Lord in those moments places in our hands'.[21]

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Notes

[1] This was a foundation of Dña Luz Rodríguez-Casanova: cf. A. VÁZQUEZ DE PRADA, *El Fundador del Opus Dei,* vol. I (Rialp, 5th. ed., Madrid, 2001), pp. 274 ss.

[2] In his Apuntes íntimos he wrote: 'Otro favor del Señor: ayer hube de dejar definitivamente el Patronato, de enfermos por tanto: pero mi Jesús no quierbe que le deje y me recordó que Él está clavado en una cama del hospital': VÁZQUEZ DE PRADA, *op.cit.,* p. 425.

[3] Cf. VÁZQUEZ DE PRADA, *op.cit.,* p. 425.

[4] Cf. VÁZQUEZ DE PRADA, *op.cit.,* pp. 432-444. A patient in this hospital was one of the first women to become a member of Opus Dei, María Ignacia García Escobar. Cfr. J.M. CEJAS, *La paz y la alegría* (Rialp, Madrid, 2001).

[5] VÁZQUEZ DE PRADA, *op.cit.,* pp. 436-37. In this work it is observed how the political conditions of that moment were adverse to the presence of the Church in public life.

[6] On these points the reader is referred to the recent work by D. MARTÍNEZ CARO e A. CANTERO FARIÑA, *'¡Santificado sea el dolor! Aspectos médicos de la biografía del Beato Josemaría Escrivá de Balaguer',* in Scripta Theologica, vol. XXXIV, fasc. 2, May-August 2002. This study is based upon the notes and minutes of the medical report carried out for the process of beatification of Josemaría Escrivá, where the whole of the pathological processes which could be seen as his 'illnesses' during the course of his life, and especially during the years 1966-1975, are listed. See also, ECHEVARRÍA, J., *Memoria del Beato Josemaría* (Rialp, Madrid 2000), pp.27-43.

[7] G. HERRANZ, *Sin miedo a la vida y sin miedo a la muerte,* En memoria de Mons. Josemaría Escrivá de Balaguer (Eunsa, 3rd. edn, Pamplona, 1977), pp. 139-40.

[8] G. HERRANZ, *op.cit.,* p. 141.

[9] Cf. *Catechism of the Catholic Church,* nn. 1500-01. On this subject see: M.A. MONGE and. J.L. LEÓN, *El sentido del sufrimiento* (Ed. Palabra, 3rd edn., Madrid, 2002).

[10] Cf. VÁZQUEZ DE PRADA, *op.cit.,* `pp. 426-27.

[11] Cf. n. 419.

[12] Cf. n. 208.

[13] P. BERGLAR, *Opus Dei, Vida y obra del Fundador Josemaría Escrivá de Balaguer* (Rialp 3rd edn., Madrid, 1988), p. 66.

[14] Ibidem.

[15] G. HERRANZ, *op.cit.,* p. 153.

[16] Apostolic Letter, Salvifici doloris, n. 27.

[17] Cf. J. LOZANO BARRAGÁN, *Teología y Medicina* (Instituto Mexicano de Doctrina Social Cristiana, México, 2000), p. 14.

[18] Cf. Pontificio Consiglio per la Pastorale della Salute, Index 1994, where 21,757 Catholic health care institutions are listed.

[19] It is widely known that when Josemaría Escrivá went to Pamplona as Grand Chancellor of the University of Navarre or for any other reason he never failed to visit sick people of the Prelature who had been admitted to the University Clinic and to bring them comfort.

[20] Cf. J. HONORATO, *'La enfermedad y la vida en el pensamiento de Josemaría Escrivá de Balaguer',* Día a Día en la Clínica Universitaria, n. 44, February-March 2002, p. 4.

[21] J. ECHEVARRÍA, *Memoria del Beato Josemaría,* op.cit., p. 39.

Testimony

The Life and Work of
Fra Pierluigi Marchesi

The Marathon
against AIDS

The Episcopal Department
for Pastoral Care in Health
of the Bishops' Conference
of Peru

The Life and Work of Fra. Pierluigi Marchesi

THE COMMEMORATIVE DAY IN HIS MEMORY, CELEBRATED IN MILAN ON 26 OCTOBER 2002

Introduction

It is not easy to speak about men and members of religious orders such as P. Marchesi. He was a volcano, an impassioned servant of the sick, whom he loved and defended strongly with intelligence and with great responsibility.

It is not easy to speak about P. Marchesi, a religious with a vision which was ahead of its time at the level of social and Church questions. It is not easy to speak about him when the 'character' involved had the charism of alive welcoming and who was thus a creator and an inventor; when the 'character' was a prophet of welcoming, although a prophet only recognised after his death because when still alive a prophet is difficult to deal with; he is only accepted abroad, not in 'his own country'. A prophet has to die to be recognised. Such was the case with P. Marchesi. Such was the case with the Prophets of the Old Testament. Such was the case with the New Testament and the figure of Jesus of Nazareth. Such has also been the case during the whole history of the Church, and such is the case even now, and such will be the case in the future as well.

This day, this commemoration of P. Marchesi, makes me very happy. And I prepared this paper of mine with great affection, with much love; with the same affection and admiration that I had for him was he was alive. I have divided this paper into three parts: a brief biographical sketch; the leading facts of his period of office as Superior General; and finally his values, his human and religious dimension.

1. Biographical Notes on Fra. Pierluigi Marchesi

Fra. Pierluigi Marchesi was born in Cardano al Campo (VA) on 22 March 1929. While still young, in 1940, he entered the Fatabenefratelli Order as a novice in Brescia. He professed the simple vows of chastity, obedience and hospitality in 1946, and took the solemn vows on 30 March 1953. He held the office of provincial secretary, superior, provincial counsellor and provincial of the Province of Lombardy-Veneto, a service that he performed from 1968 to 1976. At the General Chapter of 1976 he was elected Superior General, and led the Order for two six-year periods until 1988.

At the time of his death he was provincial counsellor and director of the Centre for Studies and Formation of his religious province. At an ecclesial level, Fra. Pierluigi made a wise contribution: from 1986 onwards he was a Member of the Pontifical Council for Pastoral Assistance to Health Care Workers. He also held the position of President of the Association of Catholic Hospitals and in this capacity he was a delegate of the Holy See as its representative at important international conferences and meetings.

During his service as Superior General he gave a notable impetus to the renewal that followed Vatican Council II through the authorship of important documents and incisive speeches which profoundly marked the life of the Order and the world of health and health care.

2. The Leading Facts of his Period of Office as Superior General (1976-1988)

From this biographical sketch one observes how many offices were held by P. Marchesi within his Order. In human terms one would say that he rapidly reached a high and prestigious level, although in the religious life the yardstick of a 'position' is not based upon human and social criteria but upon the criteria of faith. For this reason, who is 'higher up' must be a servant, as Jesus teaches in the Gospel, and he himself gave an example to us of service.

And if it is true that one knows a tree by its fruits, then one can say that P. Marchesi, in all the offices that obedience entrusted to him, manifested an impassioned service to man, to man afflicted by illness; to him he dedicated time, intelligence, words and facts.

And it was specifically when he occupied the highest office in his Order (twelve years as Superior General) that he placed all his energies at the service of the charism and mission of hospitality. These energies were directed in a particular way to the renewal of his Order, to pastoral work, to formation, to humanisation, to alliance with the laity, to looking towards 2000, and also to a strong awareness of, and openness to, the universal Church, as was indicated in a special way by his appointment by the Holy Father to be Auditor of the Synod on Reconciliation in 1983, and the leading role he played in the creation of the Pontifical Council for Pastoral Assistance for Health Care Workers.

I would like to dwell briefly on these central facts of his period of office as Superior General, which, indeed, formed an important part of the life and work of P. Marchesi. In this I would like to stress the leading aspects, albeit well aware of the fact that each of these would really require greater development than is possible here.

Here, therefore, are the principal moments of action during the period of office as Superior General of P. Marchesi, a man who knew how to take advantage of the strength of such slogans as: 'self-renewal

to humanise'; 'self-humanise to humanise'; and 'the sick person is our master, our school, and our university'.

And thus there began a hard, slow, difficult and 'unpopular' path which was not always an

understood path, as he himself knew and did not conceal. Indeed, he was to write: 'To be a Superior General of a religious Order means to have the duty of prophecy, at the price of being unpopular and making enemies' (cf. 'Premessa', *Per un ospedale più umano*, Ed. Paoline,).

But let us now return to those principal moments of his period of office as Superior General:

1. The international meeting for the 'renewal of hospitality' (held in Rome on 26 October-2 November 1977): two study committees were appointed – committee H on hospitality, and committee R on the organisation of renewal courses.

2. The meeting of the general and provincial defining body and the chairmen of the two committees (held in Granata on 7-15 March 1978), when the process to be followed for this renewal was approved.

3. Renewal courses: the Order experienced in an intense way a period of renewal which with regard to the 'courses' took place between November 1978 – the month when the international meeting for the 'animators' of these courses was celebrated – and November 1979, the month when the Extraordinary Chapter began its deliberations. This was an exciting and involving moment which undoubtedly produced good results. It was a strong moment for the whole of the Order, and this I myself experienced when following a course and then teaching it in the Spanish, Italian and Portuguese provinces. This was an unforgettable experience. It was a moment when the Spirit breathed upon the whole of the Order.

4. The meeting of the instructors (held on Rome on 9-20 April 1979): those responsible for formation drew up a formation plan for the Order which the General Chapter then approved. This was the point of departure for the General Formation Secretariat which since that moment has accomplished a long journey, at times slow and laborious, but which is producing significant fruits. The publication of the book *The Formation of the Fatabenefratello* was the point of departure and the reference point for the application of the 'principles, objectives and criteria' that every province or vice-province has adapted within its own concrete context. Today, formation within our Order is guaranteed by communion in unity and respect for special local features.

5. The international committee on pastoral care in health. This committee was established almost by a mandate from the General Chapter of 1976 and had the aim of engaging in deep reflection about pastoral work throughout the whole of the Order. It was a further instrument of the Curia of the Superior General at the service of renewal. And we set to work, to do things, and this I say with healthy pride. The engine was P. Marchesi, and I, as chairman of the committee, and its first members, began our duties in the matter with responsibility. The first meeting was chaired by P. Marchesi in Rome: there the committee and its organisation and its work were organised: its objectives, its structure, and its methodology. Reflection and animation were the strong points, the tasks of this committee.

Here are some dates, some places where meetings took place:

The First Stage of the Committee (1978-1983)

Barcelona (28 April 1979 to 2 May 1979): a historic date; new pathways for pastoral care in health were opened up; and pastoral care in health became a subject for history. This was the first international meeting and the Superior General was present (cf. information provided in the journal *Información y Noticias*, n. 62/1979).

Afterwards, the committee began to go almost everywhere:

Dublin, 27-29 August 1979, for English-speaking agents.

Salzburg (Austria), 18-19 October 1979.

Paris, March 1981.

Los Molinos (Madrid), 5-9 April 1981.

Monguzzo (Milan) 21-26 March 1981.

Latin America (Mexico, Ecuador, Colombia, Peru), 26 July 1981-6 September 1981.

This strong journey, which was intense during the first part of the life of the committee, was a moment that involved gaining knowledge about realities and constituted a great stimulus for the provinces.

The Second Stage of the Committee or International Secretariat (1984-1988)

In the minutes of the first meeting the following phrases are encountered:

– This stage is a motivating stage because the secretariat is aware of its role as an 'agent of change'. The basic work has already been carried out, with all that this has involved in efforts made and objectives reached – the new constitutions as a doctrinal synthesis, the new team, the recent course in November for the provincial co-ordinators – seeks to be an expression of a new impulse.

– So that progress can be made in a real and practical way, we intend to work according to a line that allows the achievement of what we

want. The work for the objectives that we propose for ourselves primarily defines the important fields of our work – realities such as sensitisation and the formation of agents, integration, and pastoral practice.

The fruits of this were, amongst other things:

– The first meeting, Rome April 1984;

– the appointment in every province of a brother for pastoral encouragement and stimulation;

– the course in pastoral work in Rome for the provincial coordinators, November 1984;

– this was followed by activity involving encouragement and stimulation, illustrated with programmes, diagrams, and linguistic meetings: Frankfurt, 30 May 1985 to 1 May 1985; Los Molinos (Madrid), January 1986; and England, March 1987.

At the General Chapter of 1988 a paper on this second stage of activity was presented. Weighing up all that is positive and negative we realise that the result is very positive. A giant step forward has been taken in relation to pastoral care in health throughout the whole Order and the influence exerted on the local Churches has also been strong.

The conclusions and the priorities also stressed these ideas: the strengthening of coordination; the creation of a specific style of the Order in relation to pastoral work; the training of agents; the integration and motivation of the laity; and the encouragement and stimulation of pastoral care in health in the local Churches.

As you can see, we are face to face to the utmost with a challenge. We have reached a very positive destination but there is still much to be done. This is a contribution, the seed that pastoral work has placed at the service of renewal.

The following publications by the committee were also the fruit of this pastoral work: 'What is Pastoral Care in Health'; 'The Pastoral Care on the Sick in Hospitals and Parishes'; and 'The Apostolic Dimension of the Hospital Order of St. John of God'.

6. Humanisation (1981)

The theme of humanisation was a passion for P. Marchesi. This idea was first directed towards his religious brothers and then intended as a great message for those who work in health care structures.

'Humanise yourselves to humanise: every real humanisation presupposes an alliance of love for the man who suffers, a role of service which becomes stronger by rediscovering in daily life what it is to be full-time Christians.' The following were also his thoughts: '...a humanised hospital must be opened wide, open, transparent; it must believe in group work, it must implement ongoing training, it must be a family home...'; and 'For the sick person, the hospital is not a bar, a cinema or a stadium; it is the place in which one may not be treated well, in which one can be neglected, in which one can die...'. With how much vibration, passion and courage he said these things! How much did he stimulate reflection and alliance!

7. The Alliance with the Laity

Another theme in which he was passionately interested, but which seemed taboo, especially when one had to pass from words to deeds, was, for example, that of appointing lay people to positions of high responsibility of a managerial or administrative character. P. Marchesi in this area was ahead of his time. Meetings and conferences were the cornerstone by which to begin gradually to form this alliance.

I would like to emphasise some of his thoughts taken from his paper to the international conference of lay collaborators, which was celebrated in Rome on 17-19 May 1988.

'We must make our forty thousand *collaborators* participants at a level of responsibility that is much deeper than the distribution of burdens and tasks. Those who are co-responsible must be recognised for their autonomous ability to take part in a project and not only to carry out, subordinated to us, orders that we believe to be absolutely valid and which we believe ought to be implemented'.

'We, too, the Fatabenefratelli Order, must recognise that we are behindhand, together with certain parts of the Catholic hierarchy; insensitive to the emerging requests of the world of the laity for a deeper sharing in the apostolic mission. We are often still presumptuous, closed like the medical doctor who believes that it is he who heals, forgetting that his task is to look after a patient, to activate the 'inner healer' that is present in every human being. We are presumptuous when we believe that we are better, more orientated than others towards hospitality, forgetting that everybody can and must be welcoming. And this becomes more possible the more we admit our wounds, our limits, our shadows. Sharing is possible only after we have admitted that we are partly powerful, that we are 'wounded', incomplete healers, on the unapproachable model of he, Jesus, who healed not only physical illness but also existential illness'.

To this alliance with coworkers, in a shared mission, we find numerous references in his book 'The Hospitality of the Fatabenefratelli towards 2000'. In particular numbers sixty-six to seventy-two may be mentioned where three fundamental ideas are proposed: the integration and creation of a laity with a mind and a heart able to ensure the presence of the spirit in our centres; the living out of being a Church with a plurality of gifts; and openness to dialogue with the laity.

This was an approach that P. Marchesi took up again subsequently in his brief booklet entitled 'Humanisation, Encouragement, Formation'. I believe that this was his last initiative and took place three months before he died. He was in Genzano in November 2001. He said with great tenacity: 'The alliance must be based upon real and effective participation with responsibility and not simply upon timid and timorous delegations of services and functions'. 'The future of the Fatabenefratelli (Orders and Works), he said, 'will be possible with the integration of collaborators or there will be no such future'.

8. The Hospitality of the Fatebenefratelli Towards 2000

Here P. Marchesi really appears as a prophet who sees beyond; who reads history and new and complex problems; and who seeks to send a message that centres around the role and charism of the Order, and of hospitality for the third millennium. For this reason, the basic question posed to the religious of his Order is 'how are we planning our future?'

This document, together with 'The Bases of Renewal' and 'Humanisation', make up a trilogy of great courage and prophecy. They are the three arms, the mediations of the Spirit who wants to change our hearts, our attitudes, in order to make them more ready and more suited to the service of hospitality, of the new hospitality. It is certainly the case that P. Marchesi put this idea too high, and made it too demanding, above all for his religious brothers. 'Hospitality 2000' is a book of prophecy, of courage, which is directed in particular to those within the Order, clarifying the role and the mission of the 'fatabenefratello': not to be afraid, the courage to be a witness; the courage to be a moral leader; the courage to be a critical conscience; the courage to be ahead of the times; and the courage to be a researcher. This is the style of the new presence of the new hospitality. A reading of this document proposes a great freshness of spirit and fills your soul with hope.

9. An Auditor at the Synod on 'Reconciliation' (1983)

After being appointed by the Pope, P. Marchesi set to work to make a contribution on behalf of the sick. I can still hear his voice on the telephone from Barcelona. It was evening and he wanted help, or rather he wanted to make the Fatabenefratelli share in, be a chorus with, his speech. And soon there came into his mind what had to be done: a short, real, incisive document on 'reconciliation in the world of health care'. I had the honour to be a leading figure in the document that P. Marchesi sent to each Father of the Synod, a document that was printed by the Curia of the Superior General (*Documenti* n. 4).

And then there was his speech. Can you imagine P. Marchesi in front of the Pope, the Cardinals, the Bishops…? He made a brief but incisive speech, centred around the sick, illness, and pastoral work that should, so he said, be organised, planned, and vital. And he spoke as follows to the Fathers of the Synod: 'It is always edifying to bring the sick into the sanctuaries, or at least those who can be brought there, even though such people are not always those that are most in need of this: today the Church should above all undertake a pilgrimage to hospitals, which, in many countries, are visited by more people than go to our parishes, and where the presence of Christ who wants reconciliation is alive'. And he ended his speech in the following way: '…let us not forget that all of us will set aside a day for the people of the sick and the dying, all of us: this will be an unavoidable way of meeting Christ, who reconciles us and invites us to his Passion'. I can still hear the applause in the hall of the Synod, and also the expressions of good wishes in the corridors.

10. The Creation of the Pontifical Council for Pastoral Assistance to Health Care Workers

All this ideological and animating force prepared the climate and the environment to make a reality of the welcome creation of an institution dedicated to an improved co-ordination of health care bodies at a worldwide level and to the stimulation, promotion and diffusion of the teachings of the Church in relation to health care, as the Pope himself said in his Motu Proprio, *Dolentium Hominum*. In order to bring this institution into existence, the Pope, who had arranged for it to be set up, proclaimed that he had been 'supported by the opinion of experts, priests, religious and members of the laity'. And here we find in the front line Cardinal Angelini and P. Marchesi – two great supporters and promoters of this Pontifical Council.

3. Padre Marchesi: the Values of the Man and the Religious. An Inseparable Tandem

In the previous section of this paper, I indicated many of the values that appeared in his life, in his service as Superior General of the whole of the Order. They come out in, and can be deduced from, his writings. But I wanted to have further confirmation of these values and thus I carried out a survey amongst the people who knew him from close at hand. From a total of nineteen people with whom I made contact, I received written replies from fourteen, which I will now summarise. For help in carrying out this work of synthesis I must thank in particular Dr. Fiorenza Deriu Bagnato. Dr. Bagnato is a Consultor of the Pontifical Council for Health Pastoral Care and a co-worker as a social researcher in some of the programmes of this Pontifical Council.

Here in synthesis is what we learnt:

It is difficult to speak about P. Marchesi isolating the human dimension from the religious dimension: in him these two dimensions co-existed in a very special harmony. It is not possible to understand his life and his thought as a man without considering at the same time his life and his thought as a religious, and *vice versa*.

1. His Charism

An innate sense of history and a prophetic vision; commitment and passion; courage in his ideas and hope in the future; trust in his neighbour and care for the person; practicality and a deep religious sense; charism and communication; a 'man of the frontier' and not a 'man of the barricades'; detached from power; generous and participating – these were all aspects that came together in him and thereby restored to his religious family, the Hospital Order of St. John of God, illuminated, wise and innovative leadership.

2. Farsightedness and a Sense of History

The farsightedness of Padre P. Marchesi was his strong point but also the beginning of a journey marked by obstacles and difficulties: his firmness and conviction, accompanied by a deep humility, allowed him to persevere in the search for what was specifically Catholic in the health care field, based upon a new alliance between the laity and the religious. What always led him to look beyond a narrow horizon was the wish to understand history and interpret the signs of the times in order to innovate the religious presence in health care, with the hope and wish that this could help to improve the quality of care. He was a religious who 'recognised' the essence of *being a Church* in health care not only as having hospitals to manage but above all as taking on in a concrete way the constitutive ministerial character of material and spiritual care for the sick.

3. A Prophet of the Humanisation of Health Care

His sensitivity enabled him to be ahead of the times as regards the introduction of the concept of 'humanisation' into the health care world in order to achieve a full sharing and realisation of the charism of hospitality. Expressions of his such as '*the sick person is the centre of our lives…he is our university…we must humanise ourselves in order to humanise...*' have left their mark. Within the Order he was a strenuous promoter of an alliance with lay co-workers, with whom he shared the values of the charism of the Order. With vehemence he challenged lay members and religious with the words: '*…if we do not have the courage to measure ourselves against men as men we cannot speak about the humanisation of services but rather of their rationalisation…*', and in his trust in being next to God.

His insights about the future development of the health care world were expressed at a practical level, with the passing of time, in the actual reality of facts: history has proved him right.

4. His Passion for St. John of God

It remains to us to ask ourselves whether enough has been done to realise his 'utopia': to return the Order, renewed in his way, to being in history in the footsteps of St. John of God. Padre Marchesi was 'in love with' St. John of God; he was a man able to listen; he was patient; he was understanding and open to dialogue and to interchange; he was endowed with a natural curiosity for 'the other in himself'. He was loving towards the sick and the suffering, caring and respectful towards his neighbour, in a strenuous attempt to draw increasingly near to the example of his founding saint.

5. The Project of Hospitality

He called on the laity and religious to implement the imperative according to which it is good '*to welcome the human need for care and understanding*'. And he added, once again being ahead of his time, that '*the society we live in increasingly sees itself as a society of needs, as a network of supply and demand, a system of consumption. But where health care and social interests are characterised in an exclusive way by this structure of needs, our charism has a more transcendent meaning because in hospitality is shaped a yearning which rises above all needs*'.

When illness entered the life of Padre P. Marchesi he faced up to this experience, which at the side of patients welcomed by the Order he had so often lived through in an active way. However, he did so in the knowledge of the unequal struggle to which he had been called. And with great courage and sense of responsibility he continued to meet the very many commitments to which the Order called him, without ever stepping backwards: when he passed away his diary was still full of appointments.

To remember Padre P. Marchesi cannot but be done with a recognition of his prophetic dimension and with reference to the greatness and nobility of his ideal for the Order: the courage and strength of ideas, the courage and strength of faith.

H.E.Msgr. JOSÉ L. REDRADO, O.H.,
Secretary of the Pontifical Council for Health Pastoral Care, the Holy See.

The Marathon Against AIDS

Given the success of the marathon against leprosy of two years ago, the bishops of the four dioceses of northern Mozambique decided a few months ago to organise another marathon, this time against AIDS. This decision was prompted by the publication of the national strategic plan for the fight against this scourge of humanity, and the Catholic Church wanted to make its own contribution to this plan on the basis of its own approaches.

The wish of our bishops is to sensitise the Christian communities and in general the whole of the population about the real presence of this disease because there are people who do not believe it exists, to make people learn about how it is transmitted, and to spread methods of prevention.

Given the simplistic approach to solving this problem which advocates the use of condoms, the Catholic Church thinks that it is more useful and more deeply effective to stress to young people and the whole of the population the need for a radical change in forms of behaviour as regards sexual behaviour, where sex is not seen as an entertainment but where the sexual and reproductive faculty is given its due importance and behaviour is adapted to this reality. The civil authorities have also realised the ineffectiveness of solely proposing the use of the condom because in many cases this leads to an indiscriminate and frequent engagement in sexual relations. They have also begun to insist on the need for a sensible control of sexuality and as regards its manifestations they have laid stress on the advisability of having only one sexual partner and of practicing loyalty to that partner.

They argue that the use of the condom is a good thing but they do not argue that it is the only method. It is said to be suitable when loyalty is not possible or when one of the partners is infected. This change in attitude is already a step forward, and it is one that has certainly been brought about by the anxiety that is experienced in African countries, and above all in southern Africa where the incidence rate of seropositive people reaches levels that oscillate between 20% and 30% of the population. At a practical level, it is calculated that in Mozambique this incidence rate is roundabout 17%. There are statistics which show that it is necessary to correct the estimates of population growth that were drawn up for the period up to 2010. In some areas such rates are less than zero because the growth rates cannot compensate for the number of deaths, most of which, indeed, are caused by HIV.

In order to achieve real cooperation in this campaign, the initiative of the marathon has been launched, and this involves passing a 'flame or torch' from parish to parish and engaging, while this flame is in the parish, in a series of actions designed to inform young people and adults, men and women, about the reality of AIDS and the best way of protecting oneself. These actions are made up of discussions, theatre performances, songs on the subject and so forth.

Last Sunday, on 25 November, a special song competition was held on the fight against AIDS. This was organised by the various parishes of the city of Nampula and sponsored by the diocesan commission for pastoral care in health, of which I am a member together with other religious and members of the laity. The prizes were: 1. an electric piano; 2. football clothes for fifteen players and a goalkeeper and a regulation football; 3. basketball clothes for ten players. All this cost ten million meticais and was paid for by our commission.

The idea is that these songs, and in particular those songs that won prizes, should be broadcast on the Catholic radio channel 'Radio Encounter' so that people will then learn them and spread them.

We should use all the means

available to warn people about the gravity and seriousness of this disease. One of these instruments is get into people's heads the importance of prevention because a cure does not exist.

On 1 December, the World Day of the Fight Against AIDS, solemn ceremonies took place throughout the country and were marked by the participation of the civil and health care authorities. These ceremonies also took place in the province of Nampula and we took part in them in a practical and very active way. The civil and health care authorities organised the official ceremony, at which the governor of the province was present, in the coastal city of Nacala. The message warning about the dangers of this scourge was read out. In the city of Nampula we organised, beginning at seven in the morning, a march of young people, with placards and songs on the subject, through the main streets of the city. When they reached the park, cultural and artistic performances took place which contained various messages on the fight against AIDS. The Archbishop of Nampula made a speech to everyone present and at the end of his speech he lit the marathon torch which then began its journey towards the parish of St. Joseph where it remained for a week before being taken for a week each time to the fifty parishes of the diocese. The mayor of the city (the chairman of the municipal council) made a speech to those present and attended the celebration for the whole of the morning.

A large number of associations involved in the struggle against AIDS or similar activities designed to support young people or the population in general were also present. Amongst these was our diocesan commission for pastoral care in health and hygiene, which this year will dedicate the Day of the Sick to this problem as well. Our slogan is the following: 'Choose Life, Avoid AIDS'.

On 26 November there was also a religious-ecumenical ceremony in the sports palace of Nampula. The Catholic and Anglican Churches, as well as a number of reformed Churches, took part. The representative of the Islamic community, who had said that he would take part, did not actually do so.

During the ceremony another ecumenical celebration was announced for the World Day of the Fight Against AIDS in one of the reformed churches of the city, which took place at the same time as the official ceremonies to which reference has already been made in this paper.

From our observatory, the commission for pastoral care in health, we will continue to follow and to support the parishes that keep the marathon torch in order to ensure that the message about the prevention of this disease, and the message of support for those people who are already contaminated, will reach everyone.

Fra RAMON FERRERÓ, O.H.

The Episcopal Department for Pastoral Care in Health of the Bishops' Conference of Peru

'Do you not understand that you are God's temple, and that God's Spirit has his dwelling in you? If anybody desecrates the temple of God, God will bring him to ruin. It is a holy thing, this temple of God which is nothing other than yourselves' (1 Cor 3:16.17).

1. Organisation

The Presidency – the Vice-Presidency – Community Health Agents – Assessors – Diocesan Delegates – Seven Health Care Regions (DEPAS) – Work Groups – the DEPAS Group – the Executive Secretariat

2. Aims

Like every other organisation, we have an aim: to develop, defend and promote a new culture and a new education of health; to conserve the health and the overall health of all people and of the community; to foster the prevention of illness and provide primary care to the poor and the excluded, beginning with public health care policies.

3. The Dimensions of Pastoral Care in Health

The dimension of solidarity: giving priority to care for the sick person and his family and to the organisation of all those who suffer, whom we recognise as fundamental actors in addressing their own realities and finding solutions.

The dimension of community: through education and a new culture of overall health which leads the community to recognise social problems and to become involved in providing solutions to them.

Institutional political health care: reminding the state of its ethical and political duty to guarantee the health of the population, and encouraging necessary and urgent complementariness, beginning with civil society, in order to obtain overall health in justice and fairness for all.

4. Lines of Action

Co-ordination and fostering: to achieve greater contact and communication between the various experiences of the community health care agents and health care workers.

On-going ethical, theological and pastoral reflection: to nourish our faith and foster our commitment towards life, especially the life of the weakest and the most excluded.

Training and education in relation to overall health: this should embrace technical, professional, ethical, pastoral, economic and socio-political aspects, thereby moving towards a culture of overall pastoral care in health as well as social participation.

Diffusion and communication: in order to be the voice of forms of experience concerning overall health undergone in all places, and especially those most distant from Peru.

The promotion or organic presences beginning with civil society: this should bring about, through dialogue and common agreement, the drawing up of public health care policies as a response to the various needs of the population of Peru. (An example of this is the present-day work group for overall health which arose from the experience and fusion of three work groups on pastoral care in health: the group on the right to health, the group of community health agents, and the group on bioethics).

5. The National Plan for Pastoral Care in Health

Priorities for 2002

a) The encouragement, training and accompanying of pastoral workers.

b) Impetus towards overall and solidarity-inspired action and overall pastoral care in the face of the following social realities.

1. Patients with tuberculosis and resistant to TBC.
2. People afflicted by HIV/AIDS – 2002.
3. Drug-addiction: rehabilitation through work.
4. Helping the elderly: enabling families and the community to care for the third age, which is the depository of the tradition and the various cultures of our country.
5. The promotion of health care services for the poor and for those who live in acute poverty.

c) The promotion of the strengthening of the work group for overall health.

1. As the carrier out of pastoral, political and institutional action with an active presence aimed at achieving an indispensable dialogue between the state and civil society.
2. As a collective expression and voice of civil society with a clear work option in favour of those excluded from overall health.

d) The overall training of workers in the field of pastoral care in health.

The training and accompanying of the worker in pastoral care in health so that he or she is effective in his or her evangelising and socio-cultural mission in his or her own locality. An attempt will be made to make of him or her a committed Christian, an efficient pastoral worker and an authentic socio-cultural promoter who will give an impulse to the full development of the person, beginning with the commitment of faith. This training must be overall training and embrace, at the least, three aspects: theological training, human training, and academic training.

Theological training *teaches that the theology of health is the theology of life, which includes but does not end with a theology of illness. Illness is a dimension*

of life that imposes on us a dependent humility: the humanity of the child who awaits his mother, the humanity of the thirsty servant who needs the spring of the water of life. 'God, the spring of living water' (Psalm 36:10). The theology of health has as its reference point the experience of being healed and the experience of being saved by the Lord of life on the one hand, and the puzzled and loving contemplation of his suffering on the other. The theology of health sees the healthy and living body as a Maraviglia Dei*, as a manifestation of the shining God, and sees the experience of pain as a demonstration of the vulnerability of man and his need for God.*

A very important theological element in relation to pain and the mystery of death is provided by the Book of Job. Job's detachment is total detachment, a detachment which recognises that God gives and leaves, and Job praises Him for this. This is an experience of the fidelity of God and the free nature of His love, despite the most profound suffering. It is the prayer of somebody who knows how to be a friend of God.

This dimension is essential for pastoral care in health: the recognition of one's own nullity and one's being ready to act in response to God, who can heal and can also teach through illness. This is total dedication to the will of the Lord. In this theological context, the worker in the field of pastoral care in health knows how to accept that pain and death, as passion and as mourning, are difficult and that acceptance is not only an intellectual operation.

Human training helps to apply the best of oneself on behalf of others and to remember once again that 'Charity is patient, is kind; charity feels no envy; charity is never perverse or proud, never insolent; does not claim its rights, cannot be provoked, does not brood over an injury; takes no pleasure in wrongdoing, but rejoices at the victory of truth; sustains, believes, hopes, endures, to the last' (I Cor 13:4:7).

The worker in the field of pastoral care in health knows that he or she never comes to heal but to accompany and aid every person as a subject of his or her own process of overall health.

One learns to bring about and direct an authentic social participation on the part of citizens.

Academic training will help to avoid causing harm to the patient and at the same time to give everybody the information that is required to exercise their right to gain from basic knowledge in the health filed. Here primary importance is to be attributed to the spread of preventive techniques and to techniques for the improvement of health; to the basic identification of cases that could cause epidemics; and to the spread of technologies that are suited to the maintenance of a healthy environment, the survival of infants, and improvement in quality of life.

a) On-going training with the interdisciplinary support of the specialist professionals, health care agents, directors and teams of pastoral care in health; traditional midwives and obstetricians; meetings, days, courses, laboratories, educational material.

b) The continuation of training through regional and zone meetings.

c) A national meeting of diocesan heads.

d) Health care instruction at many levels,

c) Membership of the work group for overall health (reflection-action).

Often consultants hold local refresher courses for the promoters of health, many of whom are in dialogue with, and co-ordinated by, the Ministry of Health and other institutions.

Evangelisation and liturgy form a part of the training courses.

6. Towards a Strategic Plan

A strategic plan will be an instrument for the direction and encouragement of the network of pastoral care in health at a national level. To this end, we are beginning to establish such a plan. The first headings of that plan may be reproduced here:

6.1. The Mission and Vision of Pastoral Care in Health

1. In the light of the orientations of *The Church in Latin America,* of the social Magisterium, and of the social contemporary pastoral guidelines of the Church in Peru, we will try to gather and to bring elements that will allow an evangelisation, and thus a humanisation, of the world of health and health care from the perspective of overall health, proclaiming the Good News and implementing to the benefit of all, and principally of the poor, the promise made by Jesus: 'I have come so that they may have life, and have it more abundantly' (Jn 10:10)

2. The Episcopal Department for Pastoral Care in Health continually provides – beginning with faith and the experiences of the community health care agents of the country – precious elements that illuminate the drawing up of public policies in the sphere of health by the state. These are policies that place the person at the centre of things, respecting his dignity, his capacity for creative contribution, and the right to participate in the promotion of the overall development of the person and the community.

3. Pastoral care in health, which is organised in seven health care regions of the whole of the country, is carried out in a decentralised and democratic form which gathers together the experience, the feelings, and the needs of every diocese and nourishes an action of dialogue, involving and inviting all the sectors of society to search for solutions to the questions and issues connected with the overall health of all, beginning with training and education in overall health which embrace the pastoral, technical, professional, ethical, economic and socio-economic aspects of the field, in order to achieve a culture of

overall pastoral care in health.

4. Pastoral care in health is an instrument to implement the orientations of the Church as regards care for the sick, the commitment of the community to overall health, and political-institutional care, promoting a leadership of participation by citizens in the field of health and health care. This is open to every form of civil and economic participation.

5. Pastoral care in health works to foster and ensure that every local health care reality expresses its own voice and provides solutions. Every ecclesiastical jurisdiction has a diocesan delegate appointed by the relevant local bishop. The diocesan delegates organise a team of pastoral workers from their diocese with whom they promote, defend and conserve live and health in the parishes and the dioceses, and for this reason they relate to society as a whole.

6. They have an impact on political and economic decision-making spheres at an international and national level with projects designed to remove the conditions of poverty and social exclusion which afflict millions of Peruvians.

7. To summarise, our mission can be expressed in the following way:

The Episcopal Department for Pastoral Care in Health, from the perspective of overall health to the impulse of the Spirit, unites and encourages the development of pastoral care in health through its vast national network with the forty-six dioceses which go to make up the seven regions of pastoral care in health in the country. It promotes evangelisation by humanising this reality, bringing together experiences and strengthening the tasks of the Church and of society as a whole in favour of the health and full human development of the whole of the population of our country. Beginning with the liberation, and the appreciation of the dignity, of the person, it seeks to promote the overall human development of everybody, and in a special way that of the poor.

8. In line with our mission, our shared vision of the future is as follows:

The Episcopal Department for Pastoral Care in Health, together with the pastoral and diocesan network, during 2010 will continue to:

Gather together elements from the positive and negative experiences of the community health care agents which can shape public policies;

promote – on behalf of the poor and the excluded – organised research into solutions in every local reality in dialogue and co-operation between the authorities, civil society, and both these parties taken as a whole;

promote the human-Christian training in the sphere of overall health of pastoral workers, community agents in general, and health care agents and professionals, and encourage them to be the protagonists of their own growth and development;

promote pastoral care as a whole and different forms of multidisciplinary, inter-sectorial, and inter-confessional interaction in favour of the right of the poor to overall health.

6.2. Goals

a) To encourage and accompany the work of pastoral care in health in the ecclesial world, promoting the specific and ongoing training of pastoral workers in order to deepen the commitment, the mystic aspect and the spirituality of pastoral care in health.

b) To humanise the world of health and health care by reassessing it as a space of evangelisation and a place of encounter with God, through one's brethren.

c) To contribute to theological-pastoral reflection on the subjects connected with the ministry of life: the technological challenges and their ethical implications, health care legislation, and so forth.

d) To promote organic forms of the presence of civil society to achieve a contribution to the drawing up of public health care policies that meet the real needs of the people of Peru.

e) To promote the social participation of community agents (and not only pastoral agents) and other health care agents, principally through the adoption of political decisions on health and health care in a climate of dialogue and co-operation.

f) To accompany, strengthen and encourage experiences involving supervision and monitoring by citizens themselves of the right to health.

6.3. Strategic Objectives and Specific Objectives

1. To reinforce our identity as pastoral care in health in the social area of the Church, open to joint work with other Churches, with civil society, and with society as a whole, in favour of overall health as an indispensable element in the full human development of our population:

1.1. The dioceses and pastoral workers should become aware of the importance of reinforcing local forms of pastoral care in health.

1.2. The values and transversal principles of the strategic plan for pastoral care in health – the fruits of a process of formation and commitment over the previous thirteen years – should be fully adopted.

1.3. The actions of pastoral care in health at a national and local level should strive to complement and strengthen the action of other Episcopal commissions in line with the Pastoral Plan of the Bishops' Conference of Peru.

1.4. The state and society in general should recognise pastoral care in health as being an evangelising and effective presence in the humanisation of the world of health and health care.

1.5. Pastoral care in health should support and work with those who fight against poverty in our country and abroad, showing the human face of poverty and seeing poor people as subjects of their own processes of overall growth and development.

2. To take part in the promotion of an authentic culture of overall health which transcends the geographical limits of Peru.

2.1. Civil society should see health as a right of the citizen, as a social and political question, and as the ethical and political responsibility of the state.

2.2. The concept of overall health should be a general goal of the population.

2.3. There should be an ongoing production of popular materials which can be distributed.

2.4. There should be a gener-

ation of different points of dialogue and reflection on overall health, its forms of progress, the challenges involved, and the joint search for solutions.

2.5. A culture of the prevention and promotion of overall health, including the elements of an adequate management of natural resources and the protection of the environment, should be created.

2.6. Joint dialogue and work for overall health should have an international frame. Priority should be given to those channels which allow the direct expression of the views of the poor and the excluded.

2.7. Peruvian society should become sensitive to the importance of overall health and become committed to concrete actions to the benefit of the poor and the excluded at a local and national level.

2.8. The experiences and the forces of pastoral care in health should be shared and reproduced as a whole by the network

3. Pastoral care in health is a place of encounter, analysis, condemnation, and proposals in relation to the principal social problems in our country in order to achieve a healthy country.

3.1. The strengthening and organisation of examples of supervision and monitoring by citizens in the sphere of health and health care.

3.2 Civil society should have an impact on the formulation of health care policies which meet the needs of the population.

3.3. Civil society should watch over the implementation of policies of overall health.

3.4. Civil society should see health as a right and should be motivated to perform its own role as a political actor by having an impact on the debate, by creating feasible proposals for health care policy, and by watching over their implementation.

3.5. Pastoral care for health should continue to open itself and to strengthen spaces for supervision and monitoring by citizens, and for dialogue and co-operation in relation to the problems, and especially health care problems, that are faced by the poor and the excluded of our country.

3.6. Civil society should draw up proposals on the priorities of health care and investment in health which are based upon drawing resources from the external debt.

4. To promote processes of overall training and new forms of leadership that retrieve the value of the human person and are directed towards social participation on the part of citizens, a participation which is real and which brings about dignified and fair conditions of life for everybody.

4.1. The people and the communities who are the objects of programmes of pastoral care in health should obtain a growth in their own self-esteem and become protagonists in the taking of political decisions regarding health and health care.

4.2. The pastoral workers of the network of pastoral care in health in most of the poor and excluded sectors should engage in leadership as evangelisers and socio-cultural agents at the service of the full human development and growth of everybody.

5. To contribute to improving the conditions of the health care services of the poorest by organising our mission and Church structures in line with the requests of the state and civil society through joint plans of development and the fight against poverty.

5.1. To promote the recognition of the human person as a subject of the processes of the health programmes of the Church which are respectful of his dignity as a child of God.

5.2. To support the strengthening of actions which generate dignified jobs, in particular for the poor, as a first step towards achieving and maintaining health.

5.3. To promote the defence of life and the defence of the environment and to denounce everything that attacks the environment.

5.4. To establish strategic alliances, agreements of mutual co-operation, and conferences which link the various initiatives directed towards care for the sick, community action and institutional commitment in favour of overall health, with public and private, national and international institutions.

5.5. Pastoral care in health as a promoter and member of the work group on overall health should take part in, and encourage, the active incorporation of its community agents and basic social organisations in every process directed towards obtaining social development and promoting the fight against poverty.

6. To put into practice the promise made by Jesus: 'I have come so that they may have life, and have it more abundantly' (Jn 10:10).

6.1. The Episcopal Department for Pastoral Care in Health develops a democratic, participatory, demanding and quality organisational structure which allows the performance of the institutional vision and mission of the department and allows it to bring to public health care policies the impulse of faith and social commitment.

6.2. The Episcopal Department for Pastoral Care in Health develops and implements within its network an approach of solidarity-inspired love which for three years has contributed to its sustainability and permanence, overcoming economic limitations, to provide service to all and in a special way to the excluded.

6.3. The encouragement of a commitment to pay the social debt in the field of health for all through the work of inter-sectorial and multidisciplinary work groups; and the promotion of the conversion of the payment of the external debt into social investments.

7. Goals Reached

1. In moving towards effective overall pastoral care, we have managed to organise our actions more closely with:

a) the Campaign for Shared Solidarity 2001 (the whole of the country).

b) CEAS: laboratories continuing on from the Sixth Peruvian Social Week (Huancayp e Puno).

c) Various kinds of support for other commissions and listening to their worries and concerns.

d) Joint work with the Commissions for Education and for Young People of the Bishops' Conference of Peru.

The drawing up of shared objectives; the reduction of

costs and serving the poorest with quality and professional expertise beginning with team work strengthened by faith.

Encouraging our pastoral workers to engage in associative work that promotes the coordination and union of forces, thereby strengthening the presence of the Church in the heart of society.

Gathering together the contributions of the experience of civil society in the field of health, and strengthening them.

An on-going sharing of work teams and spaces with initiatives connected with catechism, liturgy, youth and childhood.

2. The promotion both of pastoral workers and health care personnel, especially female nurses, nursing technicians, young people and communities in general, through the organisation of, and/or participation in, courses on pastoral work, education in values, specific forms of instruction (bio-health, cardiac support, traditional medicine), in addition to permanent support; co-operating in the planning and drawing up of the contents of the educational material for pastoral care in health and of the Group for Overall Health and the Sharing Campaign; articles in reviews, daily newspapers, and various organs; and radio and television interviews (the Commission for Young People, Radio and TV Maria etc.).

3. The strengthening of the Lima-Calloa Region for Pastoral Care in Health through accompanying and permanent acceptance, beginning with pastoral care in health and the unqualified support of Msgr. Miguel Irizar.

4. Growth in the openness of pastoral workers to team work with other social actors in a climate of mutual co-operation and collaboration, in order to achieve shared objectives.

5. Recognition of the fact that in the dioceses pastoral care in health is moving towards a form of planning that is more in accord with the realities of the local zones, in many of which it is seen as an area of social pastoral work and can count on the strong and growing support of the pastors.

6. The strengthening of the identity of the community health care agent from our holistic perspective, whose aim is the human person and his propelling axis – the Incarnation. He or she should be:

An evangeliser and humaniser of the world of health and health care.

The builder of an effective solidarity-inspired love within the community.

A socio-cultural agent: an educator working for social participation.

7. To keep the subject of overall health on the public agenda by taking part in national platforms of civil society, such as the Sixth National Conference of Social Development, and relying upon the possibility of direct dialogue with the Ministry for Health and other organs of the state such as:

The Department for Funding, Investment and Foreign Co-operation of the Ministry for Health.

The High Level Commission for the Organisation of the National Health Service of the Ministry of Heath.

The National Conference for the Education of Young People and Adults of the Ministry of Education.

The National Institute for the Development of Human Resources of the Ministry for Health (consultancy and training-instruction meetings for community health agents).

8. The drawing up and diffusion at a national level of the pastoral letter on those afflicted by HIV/AIDS.

Challenges

1. To consolidate the identity of workers in pastoral care in health and community health agents and to ensure that their recognition by the state and society has concrete expressions based upon their dignity as persons and as servants of life who are active within the community. This recognition should be applied to all the community agents of the country and not only to those of the Church.

2. To reinforce our actions with a spirit of overall pastoral care that always begins with the real needs and the experience of people and achieves solutions through an inter-confessional, interdisciplinary and multi-sectorial dynamic based upon dialogue within a climate of tolerance and co-operation, emphasising what unites us and encouraging a complementary approach.

3. To support the impetus towards Church policies for the overall health of everyone and to continue to advance elements useful to public health care policies.

4. The promotion of examples of associative work, and for the year 2002 the consolidation and dedication to civil society of the Work Group for Overall Health which should work seriously and tenaciously to obtain state public policies

by capitalising on the concrete experiences of the community, especially those of the poor. At the present time, this Group has received the recognition of being the only group that systematically studies the subject of health beginning with the approach of overall health.

5. To overcome the lack of material resources which impede our concrete actions through a direct invitation to our friends and those who work with us in order to increase a contemporary and real communion of goods with pastoral care in health, and to give an impulse to the conception and implementation of joint projects with the various commissions and departments of the CEP and others in order to achieve overall health for everyone using resources in a creative and austere way.

The Twenty-First World Congress of Catholic Doctors in Seoul

Cardinal Angelo Sodano's Letter to Msgr. Lozano Barragán

5 AUGUST 2002

To His Most Reverend Excellency, Msgr. Javier Lozano Barragán, President of the Pontifical Council for Health Care Workers (for Health Pastoral Care), the Vatican City.

Most Reverend Excellency,

The Holy Father has learnt with great pleasure that the International Federation of Associations of Catholic Doctors will celebrate its Twenty-first World Congress in Seoul, South Korea, from 1 to 4 September 2002. This important appointment, which this year will witness the meeting of the representatives of the fifty-four national associations of Catholic doctors that are affiliated to the FIAMC, will offer medical doctors a propitious opportunity for study and the exchange of thoughts and experiences on different questions and issues that ask for our reflection in the field of medical ethics and pastoral care in health.

From the point of view of its contemporary relevance, the subject chosen is worthy of appreciation. Indeed, today, with the advent of experimental medicine, the identity of the individual health care worker is relegated to the individual and private sphere. Hence the need and urgency for the medical doctor in general, and the Catholic medical doctor in particular, to regain to the full his or her personal identity as a person who loves life, which should be loved and defended always and in every context.

On this point, referring to the specific identity and responsibility of health care workers, the Holy Father writes: 'In today's cultural and social context, in which science and the practice of medicine risk losing sight of their inherent ethical dimension, health-care professionals can be strongly tempted to become manipulators of

life, or even agents of death. In the face of this temptation their responsibility today is greatly increased. Its deepest inspiration and strongest support lie in the intrinsic and undeniable ethical dimension of the health-care profession, something already recognized by the ancient and still relevant *Hippocratic Oath*, which requires every doctor to commit himself to absolute respect for human life and its sacredness' (*Evangelium vitae*, 89).

In addition to addressing questions that have an obvious bioethical and pastoral relevance connected with the value of life – stem cell therapies, forms of pain-killing treatment, AIDS, forms of dementia, the ethical training of future medical doctors, natural methods – the Seoul Congress will also award – out of acknowledgement and esteem for the Billingses – the FIAMC prize for 2002, seeking thereby to emphasise their important contribution to centres for the application of natural methods for the regulation of fertility, centres that are still 'a valuable help to responsible parenthood, in which all individuals, and in the first place the child, are recognized and respected in their own right, and where every decision is guided by the ideal of the sincere gift of self' (*ibid.*, 88).

The moment has now come when Catholic medical doctors are called to special gospel-based witness in the world of suffering and health. The good intentions and the wise reflections of the Congress must be followed by concrete actions of charity and solidarity taking Jesus, the Good Samaritan, who during his earthly life dedicated himself to healing men and women in the body and the spirit, as an example.

The Holy Father invites all those taking part in this Congress to return to their respective countries more convinced of their high mission at the service of health and the life of man from its beginning to its natural end. Their task is to do

what is possible for the promotion of the culture of life, achieving an incisive presence in the debates that permeate the medical profession, with faithful adherence to the Magisterium of the Church. In this way, the Congress of Seoul will go down in history not as one of so many study meetings, but as a Congress in which was matured an operational commitment to coherent gospel-based witness at the service of those who suffer.

In the face of a secularised world, which with the pretext of 'understanding' and 'compassion' in relation to man tends to conceal or to weaken moral truth, the Holy Father invites Catholic medical doctors to repropose such truth 'in its most profound meaning as an outpouring of God's eternal Wisdom, which we have received from Christ, and as a service to man, to the growth of his freedom, and to the attainment of his happiness' (*Veritatis splendor*, 95).

The hospital context, in which the Catholic medical doctor exercises his profession-mission, needs to be renewed in the light of the Gospel of suffering and life, so that through the actions and daily work of the medical doctor the compassion and the mercy of Christ are always alive and operating in that context. On this point John Paul II writes: 'They {health care institutions} should not merely be institutions where care is provided for the sick or dying. Above all they should be places where suffering, pain and death are acknowledged and understood in their human and specifically Christian meaning, This must be especially evident and effective in institutes staffed by Religious or in any way connected with the Church' (*Evangelium vitae*, 88).

The Holy Father encourages Catholic medical doctors to pursue their solidarity-inspired commitment with new impetus, basing themselves on the wise social doctrine of the Church. They should not tire of sharing their learning and medical culture with those Churches which are in need, and they should always seek to promote within the FIAMC the universal diffusion of the good of 'health'. In this way, Catholic medical doctors will make a notable contribution to the pertinent and topical debate on values, on which the phenomenon of globalisation must be based if it does not want to lose sight of its purpose – man.

The Supreme Pontiff urges Catholic medical doctors, following the example of the martyrs who founded the Korean Church, to be courageous and credible witnesses to Christ, the physician of the body and the soul, recognising in sick people his suffering face. He can illuminate and transfigure their gaze and their profession, revealing his face of light and joy, the pledge of hope for those who believe in him.

In hoping and wishing those taking part in the twenty-first FIAMC Congress fruitful work, the Holy Father wishes to express to you, Most Reverend Excellency, and the other high officeholders of the FIAMC, his keenly-felt and grateful appreciation of the commitment expended in this form of apostolate. With these feelings, he sends you, and to those who work with you and to all those taking part in the Congress, a special Apostolic Blessing, a pledge of abundant outpourings of heavenly favours.

I take this opportunity to confirm my feelings of high regard,

Yours most devoted in the Lord,

H.E.Card. ANGELO SODANO
Secretary of State,
the Holy See

An Account of the Congress

The World Federation of Catholic Medical Associations (FIAMC) celebrated its twenty-first world congress in Seoul, Korea, on 1-4 September 2002.

The inaugural ceremony began with a solemn celebration of the Eucharist presided over by the Archbishop of Seoul, H.E. Msgr, Nicholas Cheong Jinsul. At the end of this religious ceremony, accompanied by very evocative music, the congress was opened by the President of the FIAMC, Gian Luigi Gigli. Numerous authorities then followed one another on the podium, including the Minister for Health of Korea, Sung Ho Kim. The message sent by the Holy Father through his Secretary of State (see the accompanying text in this issue) was read by H. E. Msgr. Javier Lozano Barragán, the President of the Pontifical Council for Health Pastoral Care. Also of special significance was the message sent by the President of the Republic of Korea. At the end of the ceremony the 'John XXI' Prize for Medical Deontology was awarded to Dr. Salvino Leone. John XXI is the only medical doctor in history to have been elected Pope.

The inaugural ceremony ended with a reception of welcome offered by the Korean hosts to all the countries taking part, whose delegations entered the hall accompanied by their national flags.

The days of the congress, for the Catholic medical doctors who belong to the FIAMC, were an important occasion to discuss subjects that call on the reflection of the Church in the field of medical ethics and pastoral care in health.

The scientific proceedings were opened by a conference

held by H.E. Msgr. Lozano who proposed detailed and authoritative reflections on the identity of the Catholic medical doctor. This was followed by other papers which examined the influences to which the identity of the Catholic medical doctor is exposed in pluralistic societies; the need for, and the limitations of, dialogue with secularised ethics; the ethical challenges posed by the unfair distribution of resources; the inspiration and the ethics of the presence of Catholic medical doctors in health care institutions.

After reflecting on the identity of the Catholic medical doctor, those taking part in the congress were able to listen to very interesting reports on the very diverse conditions in which Catholic medical doctors live out their mission and bear witness. It was thus possible to listen to the voice of those who find themselves fighting the processes of anti-Catholic secularisation working within countries of ancient Christian traditions; the mission of those who work in developing countries with a Christian majority; the problems of preaching Christianity in Africa; the situation of those who live in countries where Christians are a respected minority; the difficulties of Catholic medical doctors in countries with an Islamic majority; and the witness of those who, as is the case in Vietnam, had to pay the price of persecution for their loyalty to the Gospel and the Church.

An entire session was dedicated to the challenges that new circumstances are raising for Catholic health care institutions, and more in general for the pastoral care in health of the Church.

On this point emphasis was placed on the urgent need to have more specific relationships between local bishops and Catholic hospitals, which in some countries run the risk of losing their identity under the impact of the fall in religious vocations and the processes of fusion with partners from different cultural backgrounds. Exposed to the disintegrating pressures of a secularism that even penetrates the management councils and the consultants in bioethics, Catholic hospitals run the risk of finding themselves in situations of great ambiguity, with a grave disorientation of ecclesial communities. Inversely, in a description of the experience of the Church in Taiwan emphasis was placed on the social role that evangelisation can perform through the care and treatment of the sick.

The session on health care co-operation with developing countries also aroused great interest, during the course of which those attending the congress had their attention called to seven health care projects of co-operation in different countries: from Myanmar to Mongolia, and from Eastern Timor to Mozambique. In these reports the national associations found encouragement to engage in new and more incisive experiences of co-operation in health care in a spirit of solidarity and gospel-based witness.

The session on stem cells, which was held in memory of the much lamented Professor Lejeune, was the highest scientific point of the congress, thanks first and foremost to the contribution of Prof. Angelo Vescovi, one of the most important researchers in the world in this field of inquiry. This scientist from the Istituto San Raffaele of Milan demonstrated the clinical potential of the studies on adult stem cells, brought out their feasibility and utility, and stressed their positive aspects at an ethical level compared with the risks involved in research that is directed towards finding forms of treatment with embryonic stem cells. The scientific contribution of the session was expressed in the final motion of the congress and the pressing invitation to Catholic universities and hospitals to invest funds in research on adult stem cells so as to avoid the risk of being overwhelmed by scientific and business pressure in favour of the use of embryonic stem cells.

In addition to the papers that were given, during the course of the congress there was space for many free communications and for some workshops, during which those taking part in the congress had an opportunity to discuss some of the most significant and topical bioethical questions, such as palliative forms of treatment, AIDS, forms of dementia, the ethical training of future medical doctors, and natural birth control methods.

Every day holy mass was the spiritual summit of the day. The celebrations were carefully organised from a liturgical point of view, thanks, as well, to the contribution of the Korean choirs who combined very beautiful holy compositions of their country with music from the universal tradition of the Church.

The Holy Mass celebrated in the Sanctuary of the Korean Martyrs of Jeoldosun was especially moving and evocative. This sanctuary is one of the many places where for 120 years, until the end of the nineteenth century, Korean Catholics paid for their loyalty to Christ in blood. In Jeoldu-

san alone about 10,000 faithful were tortured and persecuted, and their sacrifice is remembered in the museum attached to the sanctuary. During the holy mass, celebrated by the Auxiliary Bishop of Kuala Lumpur (Malaysia), prayers were said so that, following the example of the martyrs who founded the Church of Korea, whose witness gave rise to a vital and fertile presence of the Church in Asia, Catholic medical doctors may become in their own spheres credible witnesses to Christ the Physician and able to see his suffering and glorious face in the face of every human being, above all of those whose dignity is not recognised, such as unborn children, elderly people afflicted by mental deterioration, and the terminally ill.

Following tradition, during the course of the congress the FIAMC held a general assembly and elections for its chief posts. The following were some of the most important decisions: a revision of the membership of the executive committee was approved with the inclusion of the representatives of three new committees as a sign of the interest of the FIAMC in certain emerging subjects: international health care co-operation, bioethics, and information and training through information technology. In addition to discussing other problems of organisation and its programmes, the general assembly engaged in a long journey of reflection, begun in 1994, about the bases and the aims of Catholic medical associations. To this end there were included in the statutes of the Federation the 'Promise of the Catholic Medical Doctor', approved in 1997 by the Pontifical Council for Pastoral Assistance to Health Care Workers, and the 'Doctor's Prayer' composed by Pope John Paul II and given to the FIAMC during its XX world congress held in Rome during the Great Jubilee of 2000.

As a result of the elections that were held, Gian Luigi Gigli (Italy) and François Blin (France) were reappointed as, respectively, President and General secretary of the FIAMC, and Joon Ki Kang (Korea) and George Isajiw were elected Vice-President and Treasurer.

Lastly, the general assembly approved the candidacy of Barcelona for the location of the twenty-second world congress of the FIAMC of 2006 and unanimously approved the final motion of the congress (see the accompanying text in this issue).

Meticulously organised in every detail by the Korean Association, the congress was also characterised by very special hospitality and by the climate of friendship and brotherhood. The convivial moments and the performances involving entertainment and folklore allowed those attending to appreciate certain aspects of Korean culture. The farewell dinner was especially moving, during the course of which, in addition to the presentation of those who had been elected, the following were given prizes for their long service to the medical profession and the Church in their countries; Prof. Agostino Maltarello (Italy), Prof, José Maria Massons Esplugues (Catalonia), and Prof. Francisco Kyu-Sang Cho (Korea). During the farewell dinner the third edition of the prestigious 'FIAMC Award of Honour for

Science and Faith' was given to the Billingses for their studies on the regulation of fertility and their work in favour of the spread of natural birth control methods, which respect the teaching of the Church.

Lastly, emphasis should be given to the announcement made by the Association of Catholic Doctors of Korea that it will propose to the Archbishop pf Nagasaki the opening of the cause of beatification of Prof. Paolo Nagai, a Japanese convert and lecturer at the University of Nagasaki who died from the radioactive fall-out caused by the atomic bomb that was dropped by the USA on the Catholic district of Nagasaki. Prof. Nagai died after years of suffering, giving a heroic witness to charity which moved very many faithful all over the world, as well as Pope Pius XII and the Emperor of Japan. His history also inspired a famous film ('The Bells of Nagasaki') and a number of books. The FIAMC hopes that this distinguished colleague will be proposed by the Church as a model for medical doctors throughout the world.

The twenty-first world congress, for the FIAMC and the associations federated to it, was an important stimulus for a renewed and more incisive presence in the cultural debates that the medical profession is now experiencing, in a faithful and cordial adherence to the Magisterium of the Church and with special reference to the promotion and defence of life in line with what is outlined in *Evangelium Vitae.* Over the next four-year period, while looking forward to meeting again in Barcelona in 2006, the FIAMC intends to continue to increase its collaboration with the dicasteries of the Holy See and in particular with the Pontifical Council for Health Pastoral Care, which was present at Seoul with its President H.E. Msgr. Javier Lozano. Similar collaboration on the part of the individual national associations is assured for their respective bishops' conferences.

The programme of the congress and most of the texts of the papers can be visited on the website of the FIAMC: www.fiamc.org.

Prof. GIAN LUIGI GIGLI,
President of the FIAMC.

Conclusions of the XXI World Congress of the FIAMC

1. The lifetime vocation of the Catholic doctor is the same throughout the world. It is based on love for the patient, shared with God, and with respect for all human life from conception to death. Patients are treated in the overtly shared spirit of faith and hope of the resurrection, towards healing in body and spirit.

2. With the advent of experimental medicine and advanced technology, the identity of the doctor cannot be relegated in the individual and private sphere. The role of the Catholic doctor in particular must be restored, so that the patient is treated with the love and full recognition of the patient's medical, social and spiritual status, and protected from all possible harm.

3. Catholic doctors reinforce again their faithful adherence to the Magisterium of the Church, in collaboration with the Pontifical Council of Health Care Pastoral. They promote the defence of that position, wherever it is under attack.

4. Suffering, pain, and death are experiences of life that should not be rejected, but rather seen in the light of the "Gospel of Life", considering them joined to Christ's Death and Resurrection. Understanding compassion, and the alleviation of suffering until the point of natural death, must be the hallmark of Catholic health care.

5. In our pluralistic world, Catholic doctors will adapt management of the patient's illness, in sympathy with the patient's culture, religious belief, and respecting the patient's own identity.

6. The rights of all patients to basic medical care, transcend all religious cultures, but will be assisted, where possible, by dialogue and collaboration, across the boundaries that characterize non-Christian cultures.

7. Catholic doctors propose more intensified investigation of the possible benefits of all types of stem cell therapy, except of human embryonic stem cells. Doctors and the public require reliable information on the benefits and adverse side affects on the use of stem cells, so that legislators can be accurately informed. Catholic doctors oppose the freezing of human embryos, which are to be treated with the same respect and rights that apply to all living human beings. Catholic universities and Catholic hospitals should fund and support research on stem cells, alternative to the use of embryonic stem cells.

8. Catholic doctors need to find ways and means of bringing basic health care to all people, who have little or no medical services, by advocacy [NGO/UN] and personal effort, especially with obstetrical and gynaecological services. One thousand million people lack running water and live on less than $1.00 a day.

9. Catholic doctors are concerned for the welfare of Catholic health institutions/hospitals and their Catholic identity or ethos. Catholic doctors are urged to give direct assistance through committee activities in the areas of ethics and other advisory committees. They encourage Catholic health institutions to welcome the support of committed Catholic professionals to share their mission.

10. Catholic doctors recommend that, as bishops take responsibility for the Catholic identity of Catholic health institutions, they be represented on ethics committees, and receive regular reports on matters that involve ethical difficulties, or affect Catholic identity. Bishops will give leadership to institutions when required to do so.

11. Elaboration of basic Catholic bioethics and evolving bioethical problems remains a concern for Catholic doctors. In the age of "information overload", it will become a function of the executive committee to collate, condense, and distribute advice from authentic Catholic bioethical centres. Proposed alterations in laws affecting bioethical matters [euthanasia etc.] will also be collated and distributed for advocacy and political action.