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The Identity of Catholic Health Care Institutions

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Contents

friday 8 november

II Section
Illumination of the Contemporary Reality of Catholic Hospitals by the Faith

III Section
What Should Be Done to Improve the Identity of Catholic Hospitals

Saturday 9 november

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25° anno del Pontificato
25th year of the Pontificate

ADDRESS OF HOMAGE TO THE HOLY FATHER

Most Blessed Father,

We are truly very happy and we deeply thank Your Holiness for having wanted to receive us at the beginning of our seventeenth international conference. This year the subject that we chose, in agreement with Your Holiness, was: 'the identity of Catholic health care institutions'. After a reflection on the word of God, we will study the present-day situation of Catholic hospitals, then illuminate that situation through theology and inter-religious dialogue, and conclude by studying the most suitable guidelines for pastoral practice.

Holy Father, I would like to present to you all the scholars who are here, who have come from the five continents of the world and are taking part so intensely in this seventeenth international conference. But first of all I would like to point out to you the thirty-three speakers and moderators who will throw light on the subject of the conference with their deep reflections and contributions.

One of the programmes of the Dicastery that Your Holiness entrusted to us is specifically the world union of Catholic hospitals, in order to foster their mutual help. The circumstances in which the 6,038 Catholic hospitals of the world work are very diverse. These hospitals are tangible proof of charity within the Church, who carries out her mandate received from Christ, the divine physician, who told us: 'heal the sick'. This international conference will also reflect on the new problems, responses and prospects of Catholic health care centres. Immediately after our conference we will have a meeting with the continental representatives of the Catholic hospitals of the whole of the Church so that our conclusions can be translated into practice.

Your Holiness, as the root of the unity and the resoluteness of the Church, is the only possibility that we have to achieve an authentic communion in the world of the Catholic health care institutions so that in them there shines forth the charity of the Good Samaritan, through a deeper faith and as witnesses to a resolute hope in resurrection. For this reason, Holy Father, all of us wish to hear your venerated words so that from the outset they will guide our study and lead us to turn it into life and communion in the 108,000 health care institutions in which the Church carries out her pastoral ministry.

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

ADDRESS OF HOMAGE TO THE HOLY FATHER

I hope that Catholic health care institutions and public health care institutions may be able to collaborate effectively, united by the common desire to serve the human person, especially, the weakest and those who, in fact, are not socially insured.

Venerable Brothers in the Episcopate and the Priesthood,

Dear Brothers and Sisters,

1. I am glad to meet you on the occasion of the 17th International Conference organized by the Pontifical Council for Health Pastoral Care.

I cordially greet each of you. I extend a special greeting to Archbishop Javier Lozano Barragán, President of the Pontifical Council for Health Pastoral Care whom I thank for the kind words of respect he spoke in your name and for his overview of the goals of your conference. I am pleased that your Dicastery promotes this annual initiative which is an important chance for reflection, debate and dialogue between the ecclesial and the civil world on such a priority goal as health.

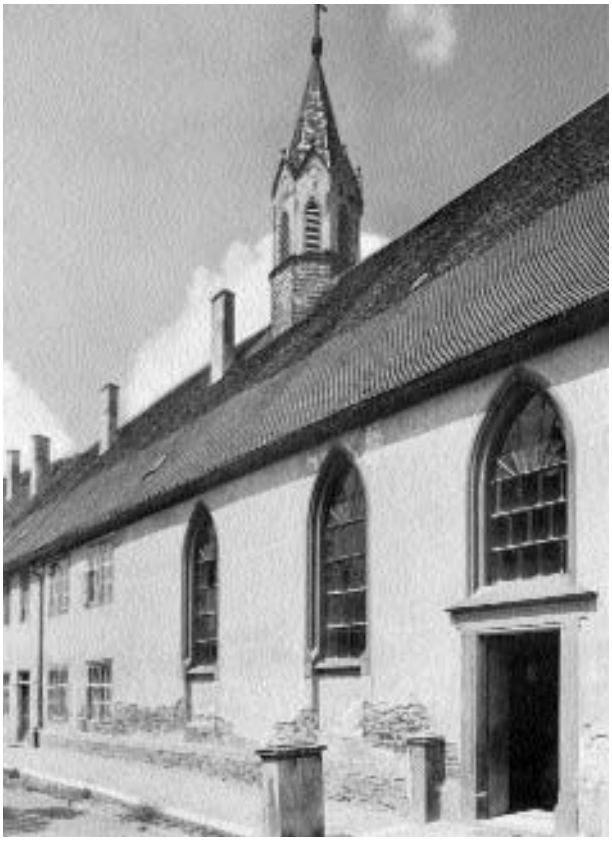
Care for the sick and evangelization

The theme of the present Conference – "The Identity of Catholic Health Care Institutions" – has great relevance for the life and mission of the Church. In fact, in carrying out the work of evangelization, in the course of the centuries, the Church has always associated assistance and care for the sick with the preaching of the Good News (cf. Motu *proprio Dolentium hominum*, n. 1).

Gospel requires care for the sick who are uninsured

2. Following closely the teaching of Christ, *the divine Physician*, several saints of charity and of hospitality, such as St. Camillus of Lellis, St John of God and St Vincent de Paul established hospices for the recovery and care of the sick, anticipating what would later become modern hospitals. The network of Catholic social and health care institutions was gradually created as a response of solidarity and charity by the Church to the mandate of the Lord, who sent the Twelve *to proclaim the Kingdom of God and heal the sick* (cf. Lk 9,6).

In this perspective, I thank you for the steps you are taking to put fresh life into che *Confederatio in-*



ternationalis catholicorum hospitalium (International Confederation of Catholic hospitals), a valid organism for responding better to the many questions that arise in the minds of those who are involved on many fronts in the world of health care. For this reason, I encourage the Pontifical Council for Health Pastoral Care to sustain the work realized by the Confederation so that the service of charity that is carried out in Catholic hospitals will be constantly inspired by the Gospel.

Express the charity of the Good Samaritan, affirm the Christian meaning of suffering and death

3. To understand *the identity of such health care institutions* fully, one must go to the heart of what the Church is, whose supreme law is love. Catholic health care institutions thus become powerful witnesses to the charity of the Good Samaritan because, in caring for the sick, we fulfill the Lord's will and contribute to realizing the Kingdom of God. In this way they express their true ecclesial identity.

It is right to review from this point of view "the role *of hospitals, clinics* and *convalescent homes*... These should not merely be institutions where care is provided for the sick or the 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"* (Encyclical Letter *Evangelium vitae*, n. 88).

Creativity in charity towards those who lack even the most basic medical care

4. In the Apostolic Letter *Novo Millennio ineunte*, referring to so many needs in our time that challenge Christian sensitivity, I recalled those *who lack even the most basic medical care* (cf. n. 50). The Church looks with particular concern to these brothers and sisters allowing herself to be inspired by a new 'creativity in charity' (cf. *ibid*.).

I hope that Catholic health care institutions and public health care institutions may be able to collaborate effectively, united by the common desire to serve the human person, especially, the weakest and those who, in fact, are not socially insured.

Dearly beloved, with such good wishes, I entrust all of you to the motherly protection of the Blessed Virgin Mary, Health of the Sick, while, with every best wish for the fruitfulness of your ecclesial service and your professional activity, I wholeheartedly impart to you, to your families and to those who are dear to you, a special Apostolic Blessing.

The Identity of Catholic Health Care Institutions

thursday
7
november

JAVIER LOZANO BARRAGÁN

Inaugural Speech

We are now inaugurating this seventeenth international conference whose subject is 'the identity of Catholic health care institutions'. This is a subject that is often addressed and on which the Bishops' Conferences have issued many documents. We must now investigate what has been said hitherto and perhaps look for new aspects that so far have not been taken into consideration.

We know that a Catholic health care institution is based upon the Gospel message of Christian charity, as practised, taught and lived out in the Catholic Church. In fact, the Catholic health care institution bases its own identity on the mission received from Christ in the Church, namely to heal the sick (Lk 9:12). And the Church has founded, and founds, Catholic health care institutions not only out of simple humanitarianism towards the sick person but because of her love towards him. The Church has animated, and animates, service to the sick with the love of God that is infused by the Holy Spirit. It is natural that this love brings with it love for one's neighbour, but only at a second stage: first of all there is always love for God, the Holy Spirit himself. The Holy Spirit has inspired the Church in the past and inspires her in the present in founding and maintaining Catholic health care institutions. Now, the action of charity rests on the same essence of the Church. Indeed, the motivation for it is inscribed in the ecclesial call that brings the Church together and makes her such. The Holy Spirit makes the Church understand that Christ is found in particular amongst the sick, and within them, amongst the poorest and most abandoned in particular, and calls the ecclesial community to extend its range of action and increase the ties of communion with the sick themselves. In this way, the ecclesial mission is realised in particular amongst the poor, who are reached powerfully by the word of God, and whom the word of God unites and saves because it offers them the overall health of the body and the soul, a health that includes the whole person. This word of God that brings together is the essence of the Church. The founding and maintenance of Catholic health care institutions is inscribed in the permanent constitution of the Church, especially if marked by the sacrament of the Eucharist, the foundation, in its turn, of the Church.

Catholic health care institutions are included in what constitutes the Church. She realises herself in the call that establishes her. As this call is completely fulfilled by the bishop of the Eucharist, it is not possible to understand a Catholic health care institution without reference to its connection with the bishop and at a practical level with the celebration of the Eucharist. This is because it is there that the Spirit projects into the present the unrepeatable action of Christ of healing the sick, a present where the sick are treated and cared for as a sign of the coming of the kingdom of God. The bishop, the Eucharist and the Catholic health care institution form a fundamental unity. It was for this reason that in ancient times the hospital of the bishop was located next to the cathedral. It has the function of amplifying the invitation made by the bishop through the Eucharist to summon in Christ all men of all times constantly and thus to constitute the Church.

The bishop as a pastor is in a unique position to encourage the faithful as regards the real responsibility of the healing ministry of the Church: as a teacher he ensures the moral and religious identity of her apostolic action, and as a priest he realises this identity in the very mystery that he celebrates. In this way, the bishops places himself in the apostolic tradition of the minister who heals the sick; with his alive personality he realises the apostolic tradition, makes Christ (the sole call to salvation) present in the sick person, and constitutes the Catholic health care institution.

The forms and ways in which this tradition is realised have many variants that flow out from the mystery of the Eucharist made contemporary

by the Spirit and his gifts. Amongst these gifts now emerges the wonder of the advances of medical science and technology and the efficacy of organisation and administration.

This pastoral theological study that we have now begun has been organised by us into three parts. Beginning, therefore, with the Word of God on Catholic health care institutions, the first part will investigate the contemporary situation of Catholic hospitals in all the continents of the world, examining them from the economic, social, political, cultural and religious angles as well. The second part, through faith, will throw theological light on this reality in relation to history by employing theological, moral and pastoral reflection and also by means of inter-religious dialogue with Judaism, Islam, Hinduism and Buddhism. In the third part of our conference we will bring the threads together by answering the question of how Catholic hospitals can be improved as regards their identity, their mission, their formation, their economics, their administration, their membership of international associations, and their religious character. Thirty-four speakers and moderators will speak at this conference, all of whom are highly qualified and who come from the five continents of the world. Everybody will have an opportunity to make a contribution to the dialogues that are envisaged. I would like to express to everyone my great gratitude and thanks. These people are really honouring us with their high-quality contributions and their presence is the highest guarantee of the high level of this international conference. The proceedings will be terminated with the venerable words of the Holy Father: words which will guide us in an effective way in the difficult world of pastoral care in health. Many, many thanks.

H.E. Msgr. JAVIER LOZANO BARRAGÁN,
Archishop/Bishop Emeritus of Zacatecas, Mexico, President of the Pontifical Council for Health Pastoral Care, the Holy See.

FIORENZO ANGELINI

A First Approach to Catholic Hospitals

The subject that I have been asked to address can be seen from a dual point of view. This is because the approach to Catholic hospitals today can be dual in nature.

This approach can be considered in a, so to speak, *subjective* sense, and responds to the question of how Catholic hospitals are seen by those who draw near to them, by those who use them, or by those who work in them. It can also be considered in an *objective* sense, and responds to the question of how hospitals that boast of the attribute or qualification of being Catholic should present themselves to society.

The distinction is not of marginal importance because whereas the subjective meaning can give rise to personal and debatable evaluations, behind the objective meaning are to be found centuries, indeed, thousands, of years of the history of pastoral care in health, a salient expression of evangelisation. Moreover, given that we are dealing with a *first* approach it is of primary prior importance that a Catholic hospital, objectively considered, is called to offer an image that is suited and adequate to its definition.

I would, however, like to free the scene immediately from a misunderstanding. As I have always argued, a hospital as a Catholic hospital does not have the duty to be different from other hospitals or similar health care structures. It is simply called to be, or at least to strive to be, better than others. This is because to follow Christ in helping those who suffer is to place at the service of the sick the highest level of one's professional skills and expertise with generous dedication, although, as John Paul II has written, however important and indispensable 'no institution can by itself replace the human heart, human compassion, human love or human initiative, when it is a question of dealing with the sufferings of another'.[1]

Nor is it my task to dwell upon the technical aspects of Catholic hospitals, on their structure and the organisation of departments, on the hierarchy of tasks, on the equipment that is needed and on everything else that can – as indeed is often the case – make many Catholic health care structures leaders in the field.

I would like, rather, to dwell upon certain premises which I think are inescapable for a Catholic hospital. These are premises, let us say ideals, because they represent the foundations of a real and exemplary Catholic hospital. These premises are many in number, but I think it is enough to confine ourselves to a brief reflection on three of them.

They are as follows. 1) The first is to see hospitals as a privileged place for evangelisation, open to different cultures and situations; 2) the second is summed up in the need for the health care staff to be marked out by a solid moral formation; 3) the third, but the most important, is the duty to work so that the human and spiritual budget of the management of the hospital has priority over the economic and administrative budget.

1. The Hospital as a Privileged Place for Evangelisation Open to Different Cultures and Situations

There is no Catholic-style hospital just as one cannot talk about an identical typology of such hospitals. Of the institutions which belong to the Catholic Church, the hospital or place for the recovery of health is the most widespread in every part of the world where the Church is present. The first census in the history of the Church of Catholic health care institutions carried out immediately after the creation of the Pontifical Commission, later the Pontifical Council, for Pastoral Assistance to Health Care Workers almost surprised even those Catholic circles that were usually well informed about such matters. We did not expect such a massive and direct presence of the Church in the field of health care and health in every part of the world.

However, for Catholic hospitals to be a privileged place of evangelisation we need to ensure that where they arise they know how to insert themselves into the specific local cultures and situations. This is a fundamental point, known also as the need for the inculturation of the Gospel.[2]

The basic reason why the Pontifical Commission for Pastoral Assistance to Health Care Workers, when it was first founded, was concerned about ensuring that every Bishops' Conference had a bishop with the responsibility for pastoral care in health, was precisely this. The directives of the Magisterium of the Church in this area had to be applied by being placed in a suitable way in different cultural, social, political, economic and religious realities.

The special assemblies of the Synods of Bishops which characterised the 1990s and were dedicated to the subject of the Church in the various continents of the world brought out the importance of presenting Gospel values within the framework of the characteristic leading ideas of the cultures of the individual continents.

The Church in *Africa* should be seen as a family of God. For this reason, it is not surprising if in Africa, where Catholics are 14% of the population, the Catholic health care structures make up 17% of all the health care structures of that continent.[3] This is due to the need of the African populations to encounter a family climate, especially in places of care. This is an example to be followed by everyone. Now that today in many African countries the AIDS epidemic is widespread, the most acute and painful social drama is made up of the increasing number of children and young people who lose their parents and do not have a family, coupled with the increasing number of people terminally ill with AIDS who, discharged from hospitals because they cannot be cured, find that they have no family relative who can help them. For this reason, Catholic hospitals in Africa must have the Christian face of the family.

In *Asia*, which is the cradle of the largest religions of the world, Christianity and the Church are seen as *foreigners*. It follows from this that the constant dedication and efficiency of those who work in the not specifically confessional field of health and health care are the most effective channel for Christian values.[4] In these places the Gospel rather than being preached is borne witness to, and in this witness it finds its credibility in cultural contexts that are very far from western contexts. The example of the activity of Mother Teresa of Calcutta in this field is a very high and unmistakable example.

In the *Americas*, and especially in Latin America, a Church which draws near to the weak, the poor, and the sick has affirmed herself to be the most credible,[5] given the condition of the oppression that was experienced with the colonisation of the populations of Latin America.

Obviously enough, the situation in *Europe and countries with an ancient and solid Christian tradition* is different, and this is a situation where the Church's role of substitution in the field of health care and health has come to an end. In these countries, in fact, in a clear and direct fashion, a complete ecclesial community must be achieved in so-named 'Catholic' hospitals. In this field, pastoral care in health becomes the most convincing synonym for evangelisation, precisely because the approach to those who suffer is the same that inspired the teaching of Jesus and above all else because in understanding pain, in working to heal it, in the attempt to give a constructive and redemptive meaning to it, we become witnesses to unity in hope and the bases are built to ensure that the message of Christ and his grace reach all men.

I am personally convinced that European Catholics at all levels do not sufficiently appreciate the unifying factor of the commitment of the Church in the health care field in the various countries of our continent. Starting from that commitment one can prepare the ground for the hoped-for unity of Europe, which will be such only if it is united to service to man and his dignity.

In other words, an evangelisation that lays special emphasis on the questions and issues of the field of health and health care (and their solution) almost inevitably encounters the full concept of civilisation and a form of globalisation that is a globalisation of love and service.

The extraordinary scientific and technical progress that we are witnessing and of which we are also the protagonists, at the level of its original impulse is the child of civilisation. Only man, endowed with intelligence, will and freedom, is able to progress. This is because he feels irresistibly within himself the necessity and the need to broaden his own knowledge and through it to make his life and that of other people increasingly noble and worthy.

Medicine, perhaps more than any other branch of science, reflects the close relationship that exists between progress and civilisation. This is because there cannot be an improvement in the quality of life without the safeguarding, the promotion and the recovery of health. And even where medicine is powerless in the face of a malady, it is able to lighten the weight of that affliction, not to speak of the contribution that preventive medicine can make to the defeat of many of the very many infirmities which threaten his existence.

It is sufficient, however, to glance over the world and the

civilisation in which we live to be aware that although they are the child and the fruit of civilisation, scientific and technological progress run the risk every day, and in an increasingly threatening way, of working *against* civilisation.

This painful truth, unfortunately, is before everyone's eyes.

The discovery of nuclear energy at first created very powerful weapons of destruction rather than providing service to man. We have arrived at the production on a very large scale of 'intelligent' bombs, attributing to the concept of destruction and death an attribute that offends true intelligence, whose target cannot be destruction and death but growth and life. And this has happened because what encouraged research in this field was the need to improve the instruments of war, which, quite apart from considerations of a political and historical character, are instruments of death.

The gigantic steps ahead achieved by data communication run the risk of transforming the dream of globalisation or of the so-called 'global village' into a tyranny of the few over the rest of mankind. One simple observation may suffice: whereas technological progress enables, in any part of the part, every action to be learnt about and carried out, the fragmentation of territories and division amongst peoples is a process that is on the increase.

Wealth, which is traditionally the fruit of work, as a result of the prodigious advances in information technology is daily tempted to take advantage of the resources accumulated as a result of the labour of the weakest, thereby expanding the gap between the poor and the rich both at the level of individual relationships and of the relationships between peoples.

Medicine itself, which has reached the high peaks of organ transplants, genetic engineering, and forms of pharmacology that are able to eradicate very ancient and devastating endemic epidemics, is often transformed into being the arbiter of the lives of other people, introducing concepts and selective techniques that are in fact the disguised face of a new racism. And this happens to a surprisingly increasing extent specifically in countries which have an ancient and consolidated Christian tradition.

The map of Catholic countries in these countries is impressive. They are called to be the pioneers, the outer frontier, of evangelisation. I am therefore happy, here today, to remember that exemplary bishop, Msgr. Javier Osés, the Bishop of Huesca, who passed away on 22 October 2001, who from 1978 until his death was the bishop responsible for pastoral care in health in Spain. He had a full vision of the very close relationship between pastoral care in health and evangelisation. In 1994, in Madrid, he met the diocesan heads of the Association of Christian Health Care Workers (PROSAC) and dictated a decalogue that can be seen as one of the best comments on the sentence

that can be read in the Apostolic Exhortation *Christifideles Laici*, according to which 'the Church today lives a fundamental aspect of her mission in lovingly and generously accepting every human being, especially those who are weak and sick'.[6] It was for me a great grace to have the opportunity to know him personally, and I think that his figure deserves to be held up as an example to be imitated in the world of pastoral care in health.

And now I will come to the second aspect that so much characterises the approach, today, to the Catholic hospital.

2. The Need for the Health Care Staff to be Marked out by a Solid Moral Formation

When, in 1969, I began in Rome, at the National Council for Research, the annual course on 'Medicine and Morality', I was moved in giving rise to this initiative by observing the increasingly marked gap, experienced every day, between the scientific and technical training of health care workers and their moral grounding or formation.

In the medical field, in fact, civilisation is called service to life, and this service to life calls on the moral conscience every day. This is because nothing that is connected with life and its sacredness and inviolability escapes the sphere of conscience and moral law.[7]

The Hippocratic oath itself presupposes a moral vision of human life: a vision of service to life and to its sacredness and inviolability.[8]

What we are called upon to adopt is, in fact, a moral approach: in front of the defence of unborn life and against abortion; in front of responsible motherhood and fatherhood against selfish population control; in front of the medicine of transplants and against genetic biology that threatens the personality of the person at its roots; in front of the safeguarding of the right to die in peace against euthanasia; in front of the humanisation of medicine against every bureaucratic and depersonalising form of medicine; and in front of the right of all to health without any form of discrimination.

What moral formation underlies these inescapable tasks? And I am certainly not referring here only to medical doctors but rather to all health care workers, in line with the full definition given to us by John Paul II who sees such workers as medical doctors, chemists, nurses, chaplains, male and female religious, administrators, and voluntary workers.[9]

In truth, as I have just said, for some time pastoral and health care workers had felt the need for an authoritative document, a clear and concise document that 'offers an overall and exhaustive synthesis of the position of the Church on everything that is connected with the upholding in the health care

field of the primary and absolute value of life – all life and the life of all'.[10]

We thus arrived, thanks to the most valuable help of those working with us, at the drawing up of the 'Charter for Health Care Workers', the first edition of which was published in 1994.

In the title of this 'Charter' the adjective 'Catholic' was deliberately not placed before the phrase 'Health Care Workers', specifically because, as I said at the beginning of this paper, being a Catholic health care worker or a Catholic hospital does not mean that either of these categories must be different from their non-Catholic counterparts. It means, rather, that those that are Catholic must have the quality that all of them, irrespective of their faith or religious approach, should have.

The 'Charter', in fact, is made up of 150 articles or sections organised, after an introduction 'sections 1-10), into three parts whose titles are: 'Procreation' (the first part, sections 11-34); 'Life' (the second part, sections 35-113); and 'Death' (the third part, sections 114-150).[11]

A glance at the contents page of the 'Charter' suffices to bring out that, especially today, the close relationship between medicine and morality is even more evident than in the past, in the sense that most of the great questions regarding medical theory and practice have an evident moral or ethical dimension.

It follows from this, in my view, that despite the continued distinction between health care and pastoral care in health there exists between the two a rigorous interdependence.

Just as a Catholic medical doctor and a Catholic paramedic cannot ignore the moral aspects of the decisions that they are called upon to take in relation to their patient, so the worker in pastoral care in health has to have a non-approximate knowledge of strictly medical questions. Priests or pastoral workers in places of care or in home assistance to sick people do not take the place of the health care worker but are called to operate at his or her side, albeit with great sensitivity and discretion.

A lack of incumbent awareness of the integration of the tasks of the health care worker and the worker in pastoral care in health is at the root of the difficulties in the action of this latter, who is taken for the person who is supposed to take note of the failure of medicine, when even non-believing scientists acknowledge the even therapeutic value, for example, of prayer.

The presence of ethical committees in hospital structures requires members who are trained in relation to the moral aspects of the problems that have to be addressed. Needless to say, this training can be indispensable in situations which do not allow time for experts to be consulted.

The moral training of Catholic health care workers cannot be delegated given that it is an integral part of their professional training.

This is why it is of fundamental importance for the great Catholic health care structures as individual units but first and foremost as associations to be endowed with suitable instruments for the moral formation of the staff that work inside them. We need an initial ethical formation which is always supported by on-going training given the complexity of the increasingly sensitive problems that present themselves today in the health care field. This moral training should be closely linked to the medical profession but should also be able to make the Catholic health care worker a citizen who observes laws and who is foreign to forms of exploitation and careerism that damage the rights of those who are cared for and treated on the one hand, and the sound and balanced provision of health care on the other.

I will now come to the third premise, which must be seen as being of primary importance in relation to the other two.

3. Working to Ensure that the Human and Spiritual Budget of the Management of a Hospital has Priority over its Economic and Administrative Budget

It is not unusual, even in the case of responsible Catholics and of people who belong to religious orders, for them to say that a hospital or a place of care is going well because in a difficult and complex time such as that now prevailing the budgets are balanced.

Where a society is advanced and organised in its various expressions, hospitals and places of care are certainly also concerns which must be administered with honesty, transparency and correctness with respect to the law, although also with the necessary administrative ability. It is not always easy to move within what is often clumsy legislation which exposes the administration of a hospital structure to even serious economic risks. Given this premise, however, the administration of a Catholic health care institution goes completely and really well only if its spiritual balance is also in the black - a spiritual balance connected with caring for the sick, the involvement of the families of the patients, the professional skill and expertise of the health care workers as authentic Good Samaritans in relation to the physical maladies to be treated but also as regards the spiritual needs that should be cultivated.

A Catholic hospital must not only be involved in scientific research – it should also excel in scientific research, in improving the techniques of treatment and care. But at the same time it should not neglect elderly patients, the chronically ill, the terminally ill, all those who rebel against suffering and need a spiritual therapy which educates them to appreciate the very condition of pain.

A Catholic hospital can become a centre for the spiritual reconstruction of man and our experience tells us that treatment and healing can, and must, also involve the inner man.

The humanisation of care is the channel for the efficacy of the spiritual action and above all the supernatural action that must characterise a Catholic hospital.

Perhaps because we live in a time that does not implement such humanisation, much reference is made to the humanisation of medicine and the humanisation of care. And yet it is precisely humanisation which prepares the ground for spiritual and pastoral action. This is because unimplemented Christian values are first and foremost unimplemented human values.

The humanity to which the

Church gives her service above all in places of care is humanity in its entirety: the ecclesial community itself, present in a nascent way within Catholic hospitals, expresses itself in communion with man, with the whole man: not communion between Christians alone, not even communion that privileges Christians, because man, especially if he is a Christian, is able to accept values that are shared by everyone, independently of their faith, their race, their culture, and their social origins.

Teacher and prophet of the humanisation of medicine – such was the very dear and much lamented Fra Pierluigi Marchesi, the former Superior General of the Hospital Order of St. John of God.

His works, *Per humanizzare l'ospedale* ('To Humanise Hospitals') and *L'Ospitalità dei Fatabenefratelli verso il 2000* ('The Hospitality of the Fatabenefratelli towards 2000'), immediately achieved a wider circulation.[12] I will confine myself to remembering one episode of which I was the witness and which was also an opportunity for me to appreciate in a particular away the vision that Fra Pierluigi Marchesi had of the humanisation of health care.

In 1983 the Ordinary Assembly of the Synod of Bishops was held on the subject 'Reconciliation and Penitence in the Mission of the Church'. Fra Pierluigi Marchesi took part in this assembly as a simple 'listener invited to speak'. He was then the Superior General of his religious order, a position that he held for two six-year periods from 1976 to 1988.

When he spoke to the Synod it should be remembered that of the 197 Fathers of the Synod not one of them, and I mean not one of them, had made even a simple reference to sick people and the world of suffering with its very great and urgent problems which require authentic actions of reconciliation by the Church as well.

The speech made by Fra Pierluigi Marchesi was at one and the same time very human and also an authentic magisterial text on humanisation.

After asking himself where Christ would have been placed if the Assembly of the Synod had been celebrated during his time, he stated that Jesus – as he always did – could not but have placed himself with and amongst the sick, the real biblical place in which to reflect upon human reconciliation. This is because man cannot be reconciled with himself or with others without answering his request for physical and spiritual health. And going to the heart of the question of reconciliation he added: 'This request for healing and salvation directed to Jesus is directed shortly afterwards to the Church of Jesus. Medicine is asked to heal the maladies of the body, psychotherapy is asked to cure mental and emotion-

al disturbances, and perhaps the Eastern religions are asked to fill the void of the spirit. The request has become very fragemented. The offer of the forgiveness of sins by the Church does not seem to touch man as a whole. We can pose ourselves the question: does the Church today, in the world of health and health care, defend and listen to the spirit of the whole man? Modern medicine, with its sub-specialisations, is often accused of engaging in what is almost a distribution of the anatomical parts of the malady: is it not the case that the Church has perhaps taken part in this distribution by being exclusively concerned about the soul of the sick person and not his spiritual experience? We, who by the mandate of the Church and our founders are next to sick people, have to call attention to a feeling of powerlessness and irrelevance as regards what we have to offer. It often seems that it is of no interest to anyone.'[13]

Fra Pierluigi Marchesi had a belief that threaded through the whole of his activity and which recurs as a constant leitmotif in his writings. He wrote: 'To the people of the sick and the dying, all of us, and we as well, will dedicate a day: it will be an inevitable way of encountering the Christ who reconciles us and invites us to his Easter'.[14] In other words: 'to the inevitable way of meeting Christ must correspond pastoral care that is in the same way inevitable, indeed obligatory'.[15]

When two years after the referred to Assembly of the Bishops, the Pontifical Commission for Pastoral Assistance to Health Care Workers was created, I would have really wanted him to take part in its governing organs. However, things turned out differently.

I have wanted to dwell upon this figure because I consider him emblematic of a basic historical fact. The real and historic revolution carried out by Christianity was the taking on in Christ – and only God could carry out such an operation – of the whole man, understood horizontally, that is to say as a contextual sum of values, and vertically, namely as being stretched towards a higher reality in which to realise himself.

As Christians, therefore, we are called upon to defend, to propound, and save all the supreme values of the human condition: faith offers us the guarantee that we will be able to perform this task.

Unfortunately, the influence of a mentality and also of an inescapable need of our time weighs upon the complex organisation of a hospital: that of operating in sectors, of exasperating the sub-division of tasks. Today, more than ever before, people are unaware of what others are doing and the pretext of necessary professionalism accentuates incommunicability.

Spiritual action within a Catholic hospital involves a communion that is much more than mere co-ordination, a communion that is sharing and participation by everyone.

Humanising a hospital involves readiness to help and participation, and thus no preclusion in relation

to any value, whatever it may be and in whatever situation it may be proposed; readiness to help as the ability to co-operate, to understand, to enter into communion, and thus to share and to participate, in order to uphold in the practical facts of the health care world the values of Christian culture, which is always a deeply human culture.

As a community, the Church does not have barriers that impede an approach to her: in expressing herself in the reality of hospitals as communion she is present wherever man is present because she is communion with men and with man.

This special vision of man 'also raises sensitive and ineluctable questions concerning not only the social and organisational aspect but also that which is quintessentially ethical and religious. This is because fundamental *human* events are involved such as suffering, illness and death with their connected questions about the function of medicine and the mission of the medical doctor in relation to the sick person'.[16]

It follows from this that the spiritual activity within a Catholic hospital must once again find, without pseudo-forms of modesty, the courage of personal and community prayer, of contact with the Word of God; the courage to take advantage of those spiritual guides that really make Catholic hospitals a full ecclesial reality.

And it is this human and spiritual, scientific and supernatural reality that the first approach to the Catholic hospital must allow us to see, so that the Catholic hospital is really, in line with a terminology that belonged to it, the home of man, because it is a *Home of God*.

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Notes

[1] JOHN PAUL II, Apostolic Letter *Salvifici doloris*, 29.

[2] Referring to inculturation, John Paul II says that it 'means the intimate transformation of authentic cultural values through their integration in Christianity and the insertion of Christianity in the various human cultures. This process is thus a profound and all-embracing one, which involves the Christian message and also the Church's reflection and practice. But at the same time it is a difficult process, for it must in no way compromise the distinctiveness and integrity of the Christian faith', Encyclical Letter *Redemptoris missio*, n. 52.

[3] 'Although Catholics constitute only fourteen per cent of the population of Africa, Catholic health facilities make up seventeen per cent of the health-care institutions of the entire Continent', JOHN PAUL II Apostolic Exhortation *Ecclesia in Africa*, 14.09.1995, n. 38.

[4] 'Many Catholic medical institutions in Asia are facing pressures from public health care policies not based on Christian principles, and many of them are burdened by ever increasing financial difficulties. In spite of these problems, it is the exemplary self-giving love and dedicated professionalism of those involved that make these facilities an admirable and appreciated service to the community, and a particularly visible and effective sign of God's unfailing love. These health care workers must be encouraged and supported in the good that they do. Their continuing commitment and effectiveness is the best way to ensure that Christian values and ethics enter deeply into the health care systems of the continent and transform them from within', JOHN PAUL II, Apostolic Exhortation *Ecclesia in Asia*, 6.11.1999, n. 36.

[5] 'The miracle of which Bartolomé de Las Casas spoke – that the Indios of Latin America came to accept and believe in the God of their oppressors – was nourished by the attention that so many men of the Church and missionaries paid to the suffering. A miracle, for that matter, that has continued to our days, when the Church the Church is called specifically in the field of health care and health in Latin America, to give force and credibility to the new evangelisation', F. ANGELINI, *La prima evangelizzazione in America Latina e l'attenzione della Chiesa per gli infermi* (Rome, 1992, p. 39.

[6] *Christifideles Laici*, 38. Cf. Boletín PROSAC (Asociación de Profesionales Sanitarios Cristianos), n. 21 Octubre-Diciembre 2001, p. 3.

[7] 'It is clear that the person of the medical doctor, as is the case with all his activity, constantly move within the sphere of the moral order and under the law of its laws. In no declaration, in no advice, in no measure. In no action, can the medical doctor be outside the terrain of morality, unbound by, and independent of, the fundamental principles of ethics and religion, nor is there is there any act or word for which he is not responsible before God and his own conscience', PIUS XI in F. ANGELINI (ed.) *Discorsi ai Medici* (Rome, 1961), p. 49.

[8] 'What most amazes one about, and makes great, the *oath* of Hippocrates is the close relationship between personal ethics and professional ethics, between honesty and the practice of the art of medicine. This relationship in Hippocrates does not have the force of a simple philosophical principle but refers to a religious vision of life': F. ANGELINI, *Quel soffio sulla creta* (Rome, 1990), p. 378.

[9] Cf. JOHN PAUL II, Encyclical Letter *Evangelium vitae*, 25.03.1995, n. 89.

[10] Pontificio Consiglio della Pastorale per gli Operatori Sanitari, *Carta degli Operatori Sanitari* (Rome, 1994), prefazione, p. 5.

[11] The first part (*procreation*) addresses the questions and issues of genetic manipulation, fertility control, and artificial procreation; the second part (*life*) deals with the beginning of life and death, the value of life: unity of body and soul, the indisposability and inviolability of life, the right to life, prevention, sickness, diagnosis, prenatal diagnosis, therapy and rehabilitation, analgesia and anesthesia, the informed consent of the patient, research and experimentation, the donation and transplanting of organs, dependency (drugs, alcoholism, smoking, psychopharmaceuticals), psychology and psychotherapy, and pastoral care and the sacrament of anointing the sick; the third part (*death*) is concerned with terminal illnesses, death with dignity, the use of painkillers for the terminally ill, telling the truth to a dying person, religious assistance for the dying, and the suppression of life (abortion and euthanasia).

[12] P. MARCHESI, O.H., *Per umanizzare l'ospedale* (Centro Stampa Fatebenefratelli, Rome, 1983); *Ospitalità dei Fatebenefratelli verso il 2000*. (Curia generalizia dei Fatebenefratelli, Rome, 1987).

[13] P. MARCHESI O.H., *La riconciliazione nel mondo della Sanità* (Intervento al Sinodo dei Vescovi, Rome, 29 settembre-29 ottobre 1983).

[14] *Ibidem*, p. 21.

[15] P. Marchesi, *Per umanizzare l'ospedale*, p. 84.

[16] John Paul II, Motu proprio *Dolentium hominum*, 11.02.1985, n. 3.

PROLUSION

KARL LEHMANN

The Essence of Identity: Catholic Health Care Institutions in the Contemporary World

The marked mutation of contemporary society has involved health care institutions as well, even though we are dealing here with rather constant human phenomena. It is advisable, therefore, to ask ourselves what the long-lasting substance and the inalienable essence of these institutions is within this worrying and very rapid process of transformation. I would like to engage in this task by first of all considering the impact of, and the damage caused by, the condition of being a sick person on the life of man, then by illustrating the biblical bases for such an assessment, and, finally, by considering first and foremost the example of the hospital – the reasons for its historical emergence, the criteria for working within it, and certain specific problems of today. This, of course, implies that I would like to give concrete form to the very general formula in the title of this paper – 'Catholic health care institutions' – by referring above all else to the hospital as an institution and in particular to a hospital of Catholic ownership. I will try to speak in a general way in so much as this is possible, not least because the deliberations of the next three days will be dedicated to an analysis of the various countries and continents of the world. I would like, however, not to ignore the fact that in my practical exposition my background of the Federal Republic of Germany will be noticed, even though I would like to avoid such specific perspectives.[1]

Hospitals managed by the Church are face to face from many points of view with the same problems of secular institutions, and for them, as well, the situation is no longer easy. An appropriate, efficient and competent form of medicine, which includes accompanying the patient in the provision of the many services supplied by a hospital, is a yardstick and a criterion for everyone. But specifically in giving to the sick person, one must not forget, in religious hospitals, with which spirit Christians and the Church take care of sick people. The survival of religious hospitals, as well, is today faced with enormous challenges, a subject to which I will refer at the end of this paper.

1. Health and Illness as an Anthropological Situation

Health usually appears to us as something obvious, even though it should never actually be considered as such. Yet in our normal consciousness health is rather hidden and is not directly accessible. We really discover it only when it is threatened, that is to say when we do not feel well or when we are really ill. Then everything becomes a matter of recovering our health. This is the miracle of convalescence and the mystery of health.

The sick person is in a special situation.[2] He relies upon various kinds of help. This is so not only in the sense that he needs external help, for example to walk or to get up: in many cases he relies upon across the board support, that is to say in relation to his body and his spirit. Specifically today, this is not an easy situation. We often have an exaggerated or even mistaken idea of human autonomy, we are educated at all levels in self-determination, and by no means rarely we are ashamed when we need other people to conserve our conditions of life. We easily take on illness with a regressive sense of being outside it, together with a kind of infantilism. We fear above all that the sick person will for the most part lose his freedom, his dignity and his intimacy. This feeling of fear, aggression and powerlessness is for many people a part of the experience of illness. The person who is sick is limited as regards his autonomy and his freedom of decision. It would be an expression of a mistaken human image if against this we did nothing else but engage in protection, perhaps, thereby, even becoming disappointed and embittered. The fact of being faced with many limitations, and even to barriers to his physical existence, is specific to man as a creature.

As men, in this finite being of ours, we rely in fundamental terms on each other and we need each other when we are in difficulty. We are always and at every moment solicited by others who ask for our help either with words or tacitly. This shows that solidarity between men is deeply rooted in human nature. From this there springs being a fellow man in a double sense; we belong to mankind and because of the

dignity of every man the respect and support of others is required. This being fellow men in the sense of concrete humanity and Christian love for one's neighbour should, by its nature but also and above all else by its ethics, unite men together.

For all those involved, this situation is not merely a challenge in a general sense but must be concretely accepted and addressed in the spirit of being a fellow man. The sick person must understand his limitations and his powerlessness, even though they are of a transitory nature. It is by no means easy to allow oneself really to be helped. At the beginning, we do not want in the least to admit that we need help. For this reason, many people also rebel against medical help and care, at least to a certain point. The acceptance of illness places man in a position of weakness and powerlessness, which we should accept with an approach of humility. For modern man, who is used to autonomy, this can be very painful and lead him specifically to rebellion against his finitude and his mortality.

But this is also a challenge for those who give help, and I am not referring here only to a challenge for the medical doctor. When another person finds himself in a situation of powerlessness it is easy to establish dominion over him. Almost automatically a kind of discretional power over the other person is installed. For this reason, there can be the impression that the person who provides help can in underlying terms rapidly become dominant. Indeed, in the relationship between the medical doctor and the therapeutic staff, on the one side, and the sick patients, on the other, there is often a risk that this relationship of domination will arise. In daily routine, where direction and authority are certainly necessary specifically for suitable care and treatment as well, this risk can be easily underestimated. It is a good idea, therefore, for all the workers involved to see the sick people as their peers and to bear in mind that they themselves, one day, may be in need of help. For this reason, all of them should strive as far as this is possible to fully accept the patients in their dignity and make them participants, as far as possible, in the decisions that are taken.

A situation such as that experience by the sick person can easily lead to isolation and loneliness. For this reason, visiting patients is an elementary imperative of humanity. They must not be excluded from the human community and must live 'normally' where this is possible. The trajectory of hospitalisation seeks this relationship with the patient until the final process: it is surprising how the most recent work on relationships with handicapped people has been able to breach a certain kind of isolation in many cases and has in some cases achieved something akin to 'normality'. In any case, the sick person needs in a very elementary way both communication and to be accompanied. This is especially necessary in an epoch (such as ours) that has high technical capacities and knowledge available for the sick person. The sick person, specifically in the conditions of a form of medicine of a high technical level, should not be seen solely as an 'object' of care: we must place ourselves at the side of the sick person, accompany him during a stage of his life, and be near to him above all when there is a dark moment in his life. Accompanying is an element of lasting and continual assistance that must be ready to accompany all the stages and crises. 'Accompanying' guarantees in addition a certain distance that defends the integrity and the personality of the sick person and protects the worker against an over stressing identification with him. Professional distance can, therefore, be salutary for the patient as well. When, however, professional distance is excessive, all forms of sensitivity easily become lost.

Expert care, even in simple human help, which may appear very ordinary and modest, is the realisation of love. Real 'accompanying' is an irreplaceable gift to the sick person. For this reason, many sick people are deeply grateful when they experience a human giving of this kind. The visible appearance and lasting presence of a concrete human aspect is of decisive importance when there are many technical forms of equipment and treatment, whether one is dealing with a medical doctor, a nun or a nurse.

The volunteer services and workers within hospitals can at times provide this reality as well. The 'Green Ladies', that is to say women who as volunteers visit the sick and provide small services, and all the visiting services, play a particularly important role because they are not directly involved in the stress of professional care and assistance – they have a special opportunity to accompany sick people without having a specific goal in view. This is expressed in the fact that a person has time for somebody else. In a very concrete form this applies to spiritual and hospital assistance for sick people.[3] It would be wrong if it was otherwise.

2. The Biblical Bases for a Relationship with Illness

These are the very general human premises for the relationship between patients and the whole of the medical staff. Biblical care for man, however, makes us more acutely and deeply concerned. I would like to briefly illustrate this concept by referring to the example of the Good Samaritan (Lk 10:25-37).[4]

At the outset, in a clear way, almost as though one was dealing with the minutes of a meeting, we have a description of a man who was going down from Jerusalem to Jericho and fell in with thieves 'who stripped him and beat him, and went off leaving him half dead'. By chance a priest and a Levite passed by but they did not pay any attention to the wounded man. This certainly should be read as an indication of the fact that membership of a religion and having a position or post do not in themselves guarantee giving to human need. The Christian hospital as such, as well, is not a guarantee of humanitarianism. To this end, the overall conditions are also important but concrete humanitarianism springs above all else from the people who work within institutions.

Faced with the sick person, perceptive capacities are especially important. Specifically today, however, this capacity can rapidly fall into a kind of torpor. There are many reasons for this, not least the flood of stimuli from the mass media which in this case have a negative effect. Indeed, in order to perceive suffering, a certain sensitivity is required. We willingly look beyond

impotence and weakness. Origen, the Father of the Church, once said that the original sin of man is 'anaesthesia', that is to say the insensitivity of man towards pain and suffering. In such a situation we behave like people with the insensitivity of narcosis. One can really hear how the biblical tale laconically describes the behaviour of the priest, and then the Levite, with the same words: they 'saw him there and passed by on the other side' (Lk 10:31-2)

Matters are completely different with the Samaritan, who, in the first place, does not belong to the chosen people and from whom, therefore, no special help could be expected. Instead, it is he who has a very special 'feel', that is to say he really sees another person who is in need and is powerless. This is possible only when one looks with the eyes of one's heart. The person who sees in this way does not arrive at a fundamental distance that will soon be marked by indifference. Instead, he remains close to the wounded man. The becoming aware of suffering becomes com-passion; it means taking part in suffering. This is why this parable says that he 'saw him and took pity at the sight' (Lk 10:33). The fact that a person is ill should also lead us to feel wounded and in need of help as regards our bodies. Then, from compassion is born real pity.

But the description of the Samaritan does not stop here. This is because the parable deals with help and remedies. From the sight of the man and compassion something concrete has to spring. The Gospel is very precise in its description of what then happens: 'a certain Samaritan… saw him and took pity at the sight: he went up to him and bound up his wounds, pouring oil and wine into them' (Lk 10:34). With insuperable simplicity this person who sees with the eyes of compassion goes on to provide help. He does not pass by in the sense that he carries on with his own business. Instead, he stops and interrupts his own activity because he is moved by the poor state of his brother. It is very important to observe this series and succession of moments which dominate the whole story, and without any rhetoric and without religious maxims: he sees him, he feels pity for him, he binds up his wounds and he takes him – post-assistance, we could call it – to the nearest inn, where he can be looked after. Sight, when it really wants to perceive and gives rise to pity, brings about the initiative, just as in medicine it is the case that on the basis of a diagnosis one engages in an operation that can save the life of a sick person.

The biblical concept of help, however, goes well beyond this. It reminds us all above all else of the fragility and limits of life and also raises questions about guilt and meaning. Often, being ill brings out or involves a crisis in human life. In such a situation the existing models of life have to be reconsidered. Possibilities are opened up for the making of decisions about reorganising one's own life. In the case of the individual, illness can be integrated into an entire biography, where it is seen as a key moment, and can give a 'meaning' – which is often only perceived later – by which one can redirect one's own life. But one must proceed with the utmost care because this 'working out' of illness is not automatic. It is always a gift and giving it forms that are generally valid is difficult. It remains above all pain and suffering. This fact should never be overlooked.

The Christian image of man knows that man must live with his limits, but also that he must live with his destiny. This certainly includes that we must treat what is treatable. We must eliminate the malady. Where this is not possible, we should at least alleviate suffering.[5] Avoidable suffering is a bad thing. However, there is pain that we cannot completely avoid by this route. It is no accident that we talk about incurable illnesses. Christ also simply takes into consideration that there are forms of suffering and illness in which he cannot perceive any 'meaning'. In such cases what is needed above all else is patience so as to be able to bear such situations. One should not give a meaning to something that does not have a meaning in order to calm and comfort somebody. First of all, the Cross of Jesus Christ reminds us that our lives are a constant absurdity and a nonsense that often cannot be clarified. But specifically in these situations Christ does not leave those who suffer, and those who are sick, alone, but accompanies them in the last journey as well, and he is especially near to them in this powerlessness and even really supports the sick person.

An understanding of illness and pain in the New Testament comes from the address given by Christ on the last judgement at its high point (Matthew 25:31-46). Jesus Christ declares: 'sick, and you cared for me' (Mt 25:36). When the men listening to him are amazed and ask him 'When was it that we saw thee sick or in prison and visited thee?'

(Mt 25:39), they receive the unprecedented reply: 'when you did it to one of the least of my brethren here, you did it to me' (Mt 25:40). Jesus thus identifies directly with the sick. He establishes, therefore, a special criterion and reason for taking care of the sick, and by no means least, for visiting the sick. This belongs profoundly to the gospel of Jesus Christ. In the promises of the Old Testament about how the Messiah will come it is said that he will restore sight to the blind and make the oppressed free (Luke 4:18 and John 6:1ss). For this reason, Jesus from the outset addresses his work to the sick. His healings fundamentally strengthen this aspect. In these healings, Jesus breaks the destructive dimensions. There are healings where the sick people open to Jesus the physician (Mark 6:54). Lastly, Jesus himself becomes a 'sick person' and takes infirmities on himself and heals them (Matthew 8:17). Thus substitutive suffering becomes a means for the redemption of the world. The overcoming, and above all the healing, of illness are some of the signs by which the advent of the Kingdom of God is announced, even though death remains undefeated.

The first Christian community saw this behaviour of Jesus as its own task and established the first steps for the spiritual care of sick people. As the letter of James reads: 'Is one of you unhappy? Let him fall to prayer. Is one of you cheerful? For him, a psalm. Is one of you sick? Let him send for the presbyters of the church, and let them pray over him, anointing him with oil in the Lord's name'. Prayer offered in faith will restore the sick man, and the Lord will give him relief; if he is guilty of sins, they will be pardoned' (5:13ss). Here we very clearly see how early Christianity responded to the behaviour of Christ and began with a general 'therapy' for sick people. Here we are very clearly dealing with a form of care for people that refers to both their bodies and their souls, and thus also prayer which involves total healing. Blessing (Mark 5:23; Luke 4:40; Mark 16:18) is also a sign of this giving and belongs to visiting the sick. After Vatican Council II members of the laity have also been able to bestow this blessing.[6]

3. The Birth of Hospitals from the Spirit of Christianity

We cannot illustrate here in an exhaustive way how as a result of this healing activity of Christ and the care of the Church for the sick something similar was formed relatively quickly in hospitals.[7] It is understandable that these first steps were still within the framework of general care for the sick, poor and elderly. Only subsequently would there be specific differentiations as regards the various institutions. We should, in addition, not locate hospitals solely in the modern age, even though it is true that in relation to other institutions during this period they became specialised, marked themselves out, and were broadened. Until the modern age hospitals were places of refuge for all kinds of people in need, of these the sick were only one group among many. But there was, naturally, a vast provision of care to the sick that should not be neglected.

About 140 AD the Christian philosopher Aristedes of Athens wrote: 'They (the Christians) love each other. They do not neglect widows; they free orphans from those who maltreat them. Those who have, give without envy to those who do not. When they see a stranger they take them under their roofs and are joyful with him as though he were their brother'.[8] It was widows and deaconess, whose work we can follow in the East until the beginning of the century, who took care of the sick. Not unusually, rich women transformed their homes into hospitals so as to be able to take care of the sick in them.

It was above all else the development of the eighteenth century which led to the differentiation of institutions in the direction of the hospital in the strict sense: people were received solely for the period of the illness; there was medical and nursing care for the patients; hospitals also became buildings built specifically for the stationary care of patients; and there was medical control of the general care provided to the sick. Soon there were also maternity wards, wards for infectious diseases, military lazar houses, and wards for internal and surgical medicine. An important differentiation took place in the German speaking lands as a result of the action of the Austrian emperor, Joseph II, who divided health care institutions into four categories: hospitals for the sick, maternity institutes, institutes for the mentally ill, and homes for the elderly. At the same time a decisive step forward took place in the secularisation of hospital care in Middle Europe.

In Germany, it was in the nineteenth century that there arose many religious hospitals, primarily concomitantly with the birth of a large number of female religious orders. Often at the outset there were only poor people in the hospitals. There was not even any equipment or any chances of treatment and care, as was the case with private homes to which medical doctors were called. After the revolutionary movements of 1848 which involved many countries in Europe, the initiatives of federations and associations, civil-religious foundations and congregations, increased in an almost explosive way: many hospitals arose within the framework of freedom that had been reacquired by the Church. A very strong impulse in this direction was given by the well-known social bishop, Wilhelm Emmanuel von Ketteler, in the diocese of Monganza, after his appointment in 1850. It was, therefore, no accident that some of the religious hospitals as well owed their creation to initiatives taken during this period.

There were many religious foundations that were concerned in a new way with the social needs and difficult living conditions of many people following an illness. The

strong commitment with which specifically the active female orders and communities took care of the poor and those in need forms a part of the glorious actions of social history. Many social professions, which today we naturally encounter in our society, were created and developed by religious communities. The female religious provided qualified workers in suitable numbers, worked without pay, and thereby made specialised hospitals possible. We should think in a special way of the nuns involved in looking after the sick, but also of those involved in education, and of the female religious who served the sick in the parishes and provided assistance to specific groups within the population, such as, for example, domestic servants, serving boys of various kinds, workers, wage earners. Collections, donations and foundations financed these houses.

Much was also done from a pastoral and socio-pedagogic point of view, at least at a general level. It is particularly important to see, above all else, how nuns moved towards helping those sick people who often were not sufficiently mobile. At that time there already existed a 'mobile structure' and the scene was not occupied solely by those who waited for the interested parties to come to them. The following was said in an exemplary way within the Foundation of the Sisters of the Divine Redeemer in Alsace and in the dioceses of Magonza in Giessen a hundred years ago: 'The primary intention of the community of female religious concerns the poor who have become poor because of illness. The community goes to them, will search for them in their poor hovels, in their lost villages or the attics of the industrial outskirts. From this primary turning to others is born the driving strength, the readiness to help and the resourcefulness to fight all the possible forms of acute poverty that obstruct the real happiness of man and his encounter with Jesus Christ, the Redeemer'.[9]

The fact that specifically the female orders which arose in the nineteenth century and were dedicated to the needs of people, not least in hospitals, and helped to shape many social and charitable professions, have in recent decades experienced a notable decrease in vocations amounts to a tragically striking fact. Such orders, because of this decrease in vocations, have no longer been able to provide nuns from their communities to the usual extent to work in their institutions. It is, however, to be observed that in many cases it has been possible to keep these hospitals running and, with the support of communities of female religious, to administer them in a convincing way with secular staff and to expand them.

These hospitals share today in a broad way the problems faced by many institutions of our health care system. This paper will address itself to this subject in its last past.

4. The Challenge for the 'Christian Hospital' Today

I would like first of all to make certain observations about the concept of a Christian hospital. This concept is completely defined first and foremost by the hospital vocation. It is therefore obvious that to begin with we may expect that everything that forms a hospital is also to be found in a so-denominated Christian hospital. In no case can there be, so to speak, a purely Christian hospital. The specific 'Christian' difference does not eliminate the fact that it shares in the essence of a hospital. For this reason, in many areas there cannot be great differences. The same is true at an essential level as regards the concept of a 'Catholic hospital'. This will be seen in the observations that now follow.

The phrase 'Christian hospital' can mean many things. The term refers to the many origins of the Christian understanding of faith that converged into the birth, the history and the development of hospitals. But this is not only a historical concept. The owner of a hospital also determines today from many points of view the direction and the character of an institution. Many 'guidelines' and 'model creators' have arisen recently to guarantee this direction. These programmatic declarations have often arisen in cooperation with medical doctors, nuns, nurses and hospital staff, and for this reason they also have a binding character. The working communities of Christian or Catholic hospitals have in part adopted for themselves these model creators and guidelines and have developed them at their own level.

In this the image of man has a constitutive role. Generally, in a given hospital there is to be found the intention and the history of a concrete owner. For example, in the case of communities of female religious there is a connection with a constitutive task that has to be implemented. Specifically in the nineteenth century, many communities of female religious were founded with the precise mission of caring for the sick. Great saints played an important role in providing direction and an example to be followed. For example: Vincenzo de Paola, Camillo de Lellis, Elisabetta di Turingia, and Rocco.

Naturally, the concrete image of a hospital depends on the approach and kind of work of all those who work together within it, both men and women. This of course applies not only in the sphere of hospitals within the framework of the Churches. Many municipal and other structures have an evident history with which many of their workers identify. A Christian hospital also needs people in the front line who are committed to carrying out a task within a structure. The owner must, therefore, be concerned to ensure that a Christian hospital is recognisable at the level of its concrete image and its orientation as well. We refer in this context to 'the evolution of a community of services for the good of all' as an objective.[10] This also applies to the training and constant development and specialisation of the men and women who work in the hospital. Spiritual care within a hospital has an important role in this task because it is created not only for the patients but must be understood also as being a partner of the various services within that hospital.

In the achievement of this 'Christian community of services for the good of everyone' the connection of the hospital with its context plays an important role. In the already referred to directives of Assia, the following is said in a brief and meaningful way: 'In our professional daily life we feel that we are a community of staff formed by patients, collaborators, friends and those near to the Home. We are tied to the places that surround the religious life, in particular to the parish com-

munity, and as a result we feel that we are a sign of an orientation of Christian life that is directed towards action. We do not live out our tie to the Catholic faith and the Catholic Church as something that is marginalizing but as an invitation to others and as a suggestion to collaborate'.[11] In this sense the co-operation of the principal and volunteer collaborators is seen as a special opportunity 'to transmit to patients in the context of the hospital, which to them is foreign, the experience of being accepted in the spirit of Christian love for one's neighbour'.[12]

Without doubt, such a shared orientation and effort on the part of all groups is an advantage that is not negligible. If this common orientation is continually motivated and activated, the Christian hospital will be able to face up to many external changes in the health care and hospital system and to continue to be highly efficient. So-called human capital will remain the constant strength of Christian hospitals if it is looked after and developed. Today, this is more necessary than ever before. If we are successful in this direction, we should also be more courageous and confident that we can solve the contemporary problems faced by hospitals. We should not count too much on other advantages, which I would not like to neglect or even underestimate, such as the solidarity expressed by many families over many generations towards a specific hospital. There are also very major changes taking place, not least as regards responsibilities and efficiency, nearness to the patient, and perhaps also the emergence of small units, which undoubtedly are of great importance.

However, the leading goal is the Christian image of man.[13] In addition to what has already been said in this paper, we can describe it with reference to following three dimensions.

The foundation is our belief that the dignity of every man, independently of his physical or mental make-up, his religion or his view of the world, his race or his social background, is determined by God Himself. The belief that every man is a creation of God and made in His image confers on him *a priori* an unassailable human dignity, as is upheld as a supreme principle in many constitutions and some declarations on human rights. No man can do as he wishes with this human dignity. This is because such dignity does not depend on recognition by other men but is given by God Himself, prior to all other differences between rich and poor, the healthy and the sick, and as regards race and class. Such dignity cannot be traded and it cannot be alienated.

This foundation is respected and developed depending upon how we see the sick person. In the already referred to guidelines, the following is said: 'The promise and loving nearness of God makes us see our neighbour in need in the sick person and in him we discover the face of God. In this way we can draw near to the people for whom we work in an adequate and confident way'.[14] We must constantly look for and defend this dignity of man. At this point we should speak at greater length about the fact that this dignity is applicable in a special way to the beginning and the end of life. For this reason, the Holy Father rightly established a key point of his mission as the successor to Peter in his encyclical *Evangelium vitae* of 25 March 1995. The debate about abortion and euthanasia here encounters its correct context. A Christian hospital must never be open to these ways of thinking, these practices.[15]

A third element is the complete human care and treatment of sick people. The individual is more than the sum of his medical data and results. He brings with him his history and his beliefs, his destiny and his life. We should try to bear in mind all these human factors with a view to providing help to achieve recovery and healing. We know, however, that with limited health, as well, it is possible to conduct a dignified life and a life full of meaning, and that we should accompany and offer help to those people who have to live with these limitations and perhaps impediments as well. We also want to ensure that those people who have to finish their earthly journey are not left alone. We want to be near to them until the arrival of a dignified death and strengthen in them the hope of faith or communicate to them that death does not mean the end of everything.

A Christian hospital can also be recognised from the fact that this complete service provided to man for his body and soul has a special role and that these beliefs are transmitted through training, which is an especially valuable good, improvement and specialisation in a competent and reliable way. Often I have had to convince myself that we are still exploiting and utilising these opportunities too little. We should not complain about this but we must actively mobilise our forces to perform this task specifically today.

Only in this way will it be possible to maintain and defend our profile within the context of multiple changes and challenges.

This human profile gives its direction to the work carried out in the Christian hospital. We understand the suffering of the patient not only as a 'defect' but also as a need linked to suffering. This is not mere repairing but healing in a sense that includes the whole of man, as has been repeatedly observed. Even though there exist calculation models that schematise and quantify (a forfeit treatment of cases), and other systems of medical and bureaucratic assessment of illnesses and sick people, nobody should be a 'case'. In the bed there is not only 'appendicitis' but a whole man. In this, it seems to me, lies the greatest danger for the future. The various systems of remuneration must not cancel out the concrete face of the individual man with his origins and his history.

Even if we have great understanding when it comes to economic aspects, we try not to bow before the diktat of economic criteria alone. Treatment should not be limited solely to what is 'medically necessary'. I have here a certain worry about a kind of competition that I do not fear as such. I fear it because the person who does not see the man as a whole but classifies him as a 'case' with specific 'defects' comes to prevail. Here there is a very fine line of demarcation that can lead to sharp changes: necessary economic limitations ('covering the budget'), staff reductions and reductions of periods of work etc.) should not go beyond the human limit. Bureaucratic requirements must continue to be controlled with reference to their actual necessity. They must not increase to such an extent that human encounters, time for conversation etc., become too short or even provoke a dirty conscience.

Health care in a hospital is highly vulnerable and delicate. There are many components and factors that must be harmonised with each other. To this end, intelligence and experience, patience and touch, are required. It is not impossible – indeed, this is something to be totally welcomed – that the social services offered and the medical work carried out in hospitals are controlled and recognised as a criterion of quality so that in this field as well there is more competition. But the market does not regulate everything, as some people want to believe in relation to the health care field as well. For me, it is not reasonable that one wants, on the one hand, to increase this segment of the market in hospitals and, on the other, at the centre of the so-called social market economy[16] to prescribe rigorous planning and a limitation, for example, of services, which in basic terms ruin real competition and are rather similar to a prescribed planned economy.

There are conflicts of aims whose repercussions cannot today be taken into consideration by Christian hospitals. The level of unemployment is very difficult to reduce. The consequences of population trends involve many problems for the safety of social insurance systems and illness funds. The contribution of many people to the social and health care system is disappearing or decreasing. This is in contrast with growing life expectancy, medical advance and expensive technology. We must increasingly recognise that our means our limited as regards existing possibilities. We do not have before us only an explosion in costs but even more an explosion in services. It is very difficult to reform this phenomenon and this 'system' which, taken as a whole, is ambivalent, indeed almost contradictory. Many reforms of recent years have not resolved these conflicts of aims, which nobody in basic terms can doubt. Yet at times new such conflicts have been created. I am thinking here of budget limitations (coverage), the separation of forms of treatment, the division of responsibilities, the movement of sectors of responsibility, and many other individual initiatives.

As president of the council of administration of the hospital of St. Vincent and Elizabeth of Magonza, for almost two decades I have seen what the consequences are of all this for hospitals. It irritates me to constantly see that these conflicts of aims between people and professional groups, which already, for the most part, involve a major expenditure of energy, generate tensions and clashes that have a negative impact on the climate of a Home, and many other things. However, I am strongly convinced that specifically religious hospitals, which in the main in this situation are neither worse nor better than other hospitals, have many internal forces which can be used to transform these conflicts in a productive direction. We should complain less and try, instead, to strive together to mobilise the creative resources that certainly exist.

To tell the truth, something is increasingly torturing me: the daily clashes, and the strategies that constantly change in relation to health care policy, take away our strength to look for and to find new pathways which could eliminate, on the one hand, the gaps that are actually present, and on the other, face up in a creative way, and also in a convincing way, to the new needs of people who are sick. For this reason, I am happy that specifically in the sphere of co-operation with the national health funds it is possible to engage in targeted experiments, such as integrated assistance for elderly people through more than one institution.

I have not been able to speak in this paper about many things that are a part of this subject, as indeed I have already observed, even though this would be necessary. I am thinking in particular of certain measures within the health care field that are in contrast with our image of man, for example the interruption of pregnancies and actively helping people to die. But on this subject we express our views more often through the Magisterium of the Pope, through congregations and Roman councils and bishops' conferences, and perhaps we are less conscious of this shared task of service to the sick. In any case, I rejoice at every form of co-operation and union, both in communities of work and in other different forms of co-operation.

I would like at this point, and certainly on your behalf, to thank all those who dedicate themselves, in large numbers and with great commitment, to this task and thus ultimately to the sick. For the Church as well this is not any kind of task along with many others: it has a central position in service for the faith and for the imitation of Jesus Christ. Service to the sick and hospitals are, and remain, for Chris-

tians of our time as well, and perhaps also in the future, excellent and irreplaceable places of solidarity, of deaconate, and thus also of love for one's neighbour, even though today this is not uncommonly given in a more hidden way.

The reform of health care policy over the next years will in many countries be one of the most important and difficult projects to be faced. The Churches, in their responsibility towards this sector, should not put themselves to one side.[17] Here, as well, the changed words of a letter to Diognetus from a little before 200 BC apply to Christians: 'The Lord has placed them at a very high post; it is not for them to leave that post'.[18]

His Eminence Cardinal
KARL LEHMANN,
President of the German Bishops' Conference

Note

[1] I will only use a part of the rich literature on the subject. Indeed, I will confine myself to supporting the testimony presented. A description of the abundant literary output on this subject will be added in a later published version.

[2] Cf. H.G. GADAMER, *Über der Verborgenheit der Gesundhei*, (Frankfurt 1993), pp. 133-149; Kranheit, Heilkunst and Heilung, *Présentation par H. Schipperger et autre* (Fribourg 1978); C. HERZLICH and J. PIERRET, *Kranke gestern, Kranke heute. Die Gesellschaft und das Leide* (Munich, 1991); cf. on the health question: *Lexicon für Theologie und Kirche*, Vol. 3 (3rd. edn., Fribourg-en-Brisgau., 1997), pp. 426-430.

[3] Cf. E. WEIHER, *Mehr als begleiten: ein neues Profil für die Seelsorge im Raum der Medizin und Pflege* (Mayence, 1999); and: *Die Religion, die Trauer und der Trost: Seelsorge an den Grenzen des Lebens* (Mayence, 1999).

[4] In addition to the specialised comments of Lk 10:25-37, see above all W. JENGS, *Der barmherzige Samariter* (Stuttgart, 1973) (a work that also appeared under the title 'Vom Nächsten', in the small paperback n. 10338, Stuttgart, 1984).

[5] Cf. K. LEHMANN, *Glauben bezeugen - Gesellschaft gestalte* (Fribourg-en Brisgau, 1993), pp. 281-291.

[6] Cf. Constitution on the Liturgy 'Sacrosanctum Concilium', art 79; *Benedictionale* (Fribourg-en-Brisgau, 1978), n. 19, 53, 56; *Die Feier der Kankensakramente* (2nd. edn., Fribourg-en-Brisgau, 1994); see also the pastoral introduction, 23 ss, 33 ss and above all 28 (*Krankenbesuch und Krenkensegen*), 245 ss (prayer of blessing); see also all the popular publications on the subject.

[7] See E. SEIDLER, ,Krankenpflege und Krankenhaus aus dem Geist des Christentums', in *Zwischen Profit und Profil: Herausfroderungen und Perspektiven für das christliche Krankenhaus, -Mainzer Perspektiven. Orientierung 5* (Mayence, 2002), (cf. Lit.: 32 ss); H.W. GAERTNER, *Zwischen Management und Nächstenliebe. Zur Identität des kirchlichen Krankenhauses* (Mayence, 1994).

[8] *Die ältesten Apologeten*, ed. by E.J. Goodspeed, re-edition Göttingen 1984, 21 (15,7); German tranlsation: *Bibliothek des Kirchenväter: Frühchristliche Apologeten und Märtyrerakten* I (Munich, 1913, p. 50. For the history and anointing of the sick see R. KACZINSKI, *Die Feier des Krankensalbung dans Gottesdienst der Kirche VII*, 2 (Ratisbonne, 1992), pp. 241-343 (and other extensive literature).

[9] *Aux sources du Rédempteur* (Paris, 1991), p. 22.

[10] Directives of the Association of the Employees of the Catholic Hospitals of Hesse: *Leitlinien der Hessische Arbeitersgemeinschaft der katholischen Kankenhäuser vom 15.11.2001*, 6 (special edition). Henceforth I will refer to this text . Even though it is regional in its origins it is instructive in relation to identical questions.

[11] *Ibid*. p. 10.

[12] *Ibid*. p. 8.

[13] Cf. M. PROBST and KL. RICHTER, *Heilsorge für die Kranken* (Fribourg, 1975); H. Sapemann, *Stärker als Not, Krankheit und Tod* (3rd. edn., 1984); A. HELLER and H.M. SENGER, *Den Kranken verpflichtet* (Innsbruck, 1997); B. HÄRING, *Ich habe deine Tränen gesehen* (Fribourg, 1998). For the theological studies on the subject see my broad contribution: *"Aus Gottes Hand in Gottes Hand". Kreatürlichkeit als Grundpfeiler des christlischen Menschenbildes, dans Was ist der Mensch? "Akademie der Wissenschaften zu Göttingen"*, ed. by N. ELSNER and H.-L. SCHREIBER (Göttingen 2002), pp. 249-269 (bibliography p. 269).

[14] Directives, p. 3.

[15] Cf. R. SCHOLZ, *Die diskusion um die Euthanasie. Per i problemi annessi di question etica= Studien der Moraltheologie 26* (Munster, 2002) (see the extensive bibliography).

[16] Voir LEHMANN, *Notwendiger Wandel der sozialen Marktwirtschaft* (Ludwig Erhard Lectures, Berlin, 2002).

[17] Cf. on this point the important document of the Pontifical council for Health Pastoral Care: *Carta degli Operatori Sanitari* (Vatican City, 1995), published in many languages and in English under the tile *Charter for Health Care Workers*.

[18] Letter to Diognetus, n. 22 in the German version presented by B. Lorenz (Einsiedeln, 1982).

I Section

The Contemporary State of Catholic Hospitals

I. Identifying the Economic, Socio-Political, Cultural and Religious Challenges that Face Catholic Health Care Institutions

JACQUES SIMPORÉ

1. Francophone Africa

Introduction

Francophone Africa is an immense zone of over twelve million square kilometres. For this reason, its surface size is greater than that of Europe, whose surface covers ten million square kilometres. The health care problems vary from country to country, from one geographical constellation to another in this old continent, the cradle of mankind. My paper is entitled 'Identifying the Economic, Socio-Political, Cultural and Religious Challenges that Face Catholic Health Care Institutions in Francophone Africa'. In identifying these multiple challenges that francophone Africa now faces, I will address in summarising form the following component subjects:

I. The socio-health care background of the countries of francophone Africa.

II. The economic, socio-political, cultural and religious challenges of the Catholic health care structures in francophone Africa.

III. In conclusion, what is the identity of Catholic health care institutions in francophone Africa?

1. The Socio-Health Care Background of the Countries of Francophone Africa

On the threshold of the third millennium there are a series of challenges that the states of francophone Africa have to face up to. We should make clear at the outset that most of these states are in Sub-Sahara Africa. Poverty is the common denominator of all these countries. Most of the people who live in this region have less than a dollar a day to live on.[1] Its rapid rate of population growth is 2.3% compared to 0.1% in Western countries.[2] In Africa, malnutrition scythes down 5,000,000 children every year[3] and malaria kills over a million people a year. In the West there is a medical doctor for every four hundred sick people but in these zones there is only one for every 3,125 patients.[4] During the 1980s, according to the data provided by the World Health Organisation, in Sub-Sahara Africa there were 8.5 million people afflicted by the HIV/AIDS virus, that is to say 59% of all seropositive people in the world. In a very short period, by 2001, Sub-Sahara Africa had 71% of all the seropositive people in the world (that is to say 28.5 million victims). AIDS strikes blindly and everywhere in this part of Africa and produces numerous difficulties: the problem of widows, of orphans, of marriages, of sexuality, and of human growth and development. It is within this context of problems specific to francophone Africa that Catholic health care structures work, like Good Samaritans, to give more health, more life and more hope to these peoples who are afflicted by a thousand and one pathologies.

2. The Economic, Socio-Political, Cultural and Religious Challenges of the Catholic Health Care Structures in Francophone Africa.

a. The economic challenges are immense

– The poverty of the states of Sub-Sahara Africa: how can people clothe themselves, feed themselves, house themselves and look after themselves on only a dollar a day?

– The difficulties encountered in maintaining the health care struc-

tures that were built by the first missionaries: clinics, maternity clinics, hospitals, SMI.

– The difficulties encountered in paying staff, in obtaining medicines and drugs, and in renewing diagnostic equipment that is now obsolete.

– Western benefactors, who were zealous at the beginning of the creation of health care structures in the missions, today intervene increasingly less. This is due to diverse factors: the appearance of numerous socio-cultural problems, the economic crisis, and the deChristianisation and secularisation of the West. The ageing and the death of some benefactors who supported the heart and soul of the work of missionaries. In this way, the management of certain Catholic health care structures in Africa has become increasingly difficult. Luckily, some organisations such as the CEI, Missio, Secours Catholique, the Christians of the Sahel, the John Paul II Foundation, Cafod, Sainte Enfrance, Caritas etc., continue to support health care projects and some of the initiatives begun by the first missionaries.

b. The social challenges

In all the countries of francophone Africa the pioneers in care for the sick were the missionaries, who built health care structures. Today, these structures receive above all else the poor sections of society, while the rich go to receive care and treatment in private clinics.

The philosophy that governs the work of Catholic health care structures is this: to offer care and treatment of quality to the poor, asking from them in return only a modest financial contribution. The great question, however, poses itself: what should be done with the poor, the abjectly poor, the orphans, and the widows who cannot pay the modest visiting fee and the fee for biomedical examinations?

In a large number of centres there are special fees for poor people, while for those who are in a state of suffering consultations and biomedical analyses are free. The economic challenge is interpreted by the following two questions: how can a balanced budget be achieved without running the risk of bankruptcy, but at the same time in a way that ensures free services for the poor? And how can the Catholic health care structures have financial autonomy?

c. The political challenges

– The contrasting health care approaches of Catholic health care structures and those of the state in the secular francophone countries. In these countries there are people of traditional, Muslim and Christian religions and denominations. Each religion has it own vision of sexuality, human fertilisation, and abortion. For these reasons, the governments of the states of francophone Africa propose family planning in the form of the use of contraceptive pills, condoms, and the coil, whereas the Catholic Church speaks about birth control through the use of natural methods. As regards the prevention of AIDS, the Catholic Church preaches within its health care structures fidelity and abstinence, whereas the health care governmental ministries of the francophone countries propose the use of condoms as an effective means by which to combat infection by, and the transmission of, the HIV virus.

– Tense relationships between regional health care directors, health care directors, district medical heads and the male and female religious who work in Catholic health care structures because of questions relating to organisation, supervision, service or the government staff in those structures.

– Difficulties in managing the large number of sick people and births during political strikes or civil wars.

d. The cultural challenges

– The construction of health care structures that do not take into account the mentality and the culture of the local region. The building, for example, of multi-storeyed health care centres in an area of huts, and which are equipped with lifts that no longer work.

– According to WHO/AFRO, because of a lack of economic means for the purchase of modern drugs and medicines, about 80% of Africans use physiotherapy in one way or another during their illnesses. There are two challenges here: how can a practical harmonisation be achieved between modern forms of treatment in our health care structures and the use of the traditional pharmacopoeia? And how can the principles of Alma Acta on preventive medicine and community health, which is more accessible to poor populations, be developed in our Catholic health care structures?

e. Religious problems

On the one hand, there are difficulties as regards collaboration and agreement between the religious who work in diocesan health care structures and their local Ordinary. Often there is a lack of clear agreements between the dioceses and the religious who work in the diocesan health care structures. On the other hand, problems of co-operation may arise between religious who are responsible for health care structures and the local Church hierarchy: often conflicts arise because of the creation of health care institutions that belong to religious congregations in the area of the local dioceses and because of misunderstandings caused by the large number of pastoral organisations.

Oral agreements which are not written down on paper between bishops and superior generals concerning a health care institution or otherwise can strengthen their friendship of the time but lead to great contestations between their successors in the future. By now, in order to avoid useless diatribes before creating a health care institution in a diocese, clear and renewable agreements should be signed between the partners.

Conclusion

We have identified the different challenges that face Catholic health care structures in the French-speaking part of Africa, but there remains the great basic question. What should be the identity of Catholic health care structures in francophone Africa? What should be the level of Christian witness in our Catholic health care structures? What are the criteria and the principles that are required for us to be able to affirm that a health care institution, belonging to a diocese or the members of a religious order, is a Catholic health care structure? In other words, how can we make our Catholic health care structures privileged places for evangelisation? Catholic health care institutions are based upon the message and the example of the merciful Jesus Christ, and adhere to his missionary mandate: to go all over the world and preach the Good News of salvation;[5] his disciples set out, preached the Good News, cast out demons, and anointed the sick and healed them.[6] The central point of every health care structure that wants to be Catholic is Christ, the Good Samaritan,[7] who pours the oil of love and compassion over health and who protects human life from its conception until its end.

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Notes

[1] United Nations Development Programme, *Human Development Report* (Oxford University Press, New York, 1997).
[2] Rapport mondial sur le développement humain, *Droits de l'homme et développement humain* (PNUD, De Boeck & Lancier, Burssels, 2000).
[3] S. PIGNATELLI, J. SIMPORE, and S. MUSAMECI, 'Effectiveness of forced rehydration and early re-feeding in the treatment of acute diarrhoea in a tropical area', *Minerva Pediatri.*, 2000 July-August, 52 (7-8), 357-66.
[4] Rapport mondial sur le développement humain, *Droits de l'homme et développement humain* (PUUD, De Boeck & Lancier, Brussels, 2000).
[5] Mt 28:19.
[6] Mk 6:12.
[7] Lk 10:25-37.

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P. ZOUNGRANA, 'Salute ed organizzazione sanitaria nei paesi in vis de sviluppo', *Dolentium Hominum*, n. 14, V 1990, n. 2, p. 2.

EDWARD PHILLIPS

2. English Speaking Africa

To better understand the reality of the health care system in English-speaking Africa, we must understand the developmental pattern that took place on the continent. We can break down the developmental components of the health care to colonial rule, the time of independence, early post-independence and present reality.

During the colonial regime, minimal health and other social service assistance was offered to the black African population. There were hospitals and dispensaries run by the colonial powers, but the Churches reached out into the hinterland to offer health services to the black African population who were not accessing health care. Thus Church-run dispensaries, health units, hospitals, mobile clinics etc. were the major health providers for people. These health units were basically dependent on overseas funding for their operations. People would pay something for the services, but the operations were basically dependent on three sources:

1 – Personal fund raising capacity of the religious involved.

2 – Religious Congregations' commitment of their funds to health care.

3 – Seeking out external donors for the health care operations.

As political leaders like Nkrumah, Nyerere, Kaunda and Kenyatta struggled for the independence of their countries from colonial rule, they all had as part of their political platforms free health care for their people. Thus as countries like Ghana, Tanzania, Zambia and Kenya became independent from colonial rule, the expectation of the citizens as well as the political philosophies of the founding fathers were that health care was to be free.

Thus after independence one finds two highly subsidized health care systems in operation. A developing government system of free health care that was dependent on taxes as well as foreign aid as the way to offer health services and Church-run health services that were charging something for their services but were also dependent on the personal resources and Congregational ability to raise funds for health care.

In both the government and Church operations there was an expectation that there would be an economic development of the countries that would facilitate the continual growth of the public and private health care systems. Unfortunately, this has not come to pass.

The reasons for the failure of the economic systems to develop are both internal and external. On the internal side, most of English-speaking Africa, except for South Africa, were and still are agricultural economies with a minimal industrial base. The sale of agricultural items like coffee, tea and cotton faced the realities of the global market of agricultural items being sold cheaply and finished products being purchased at a high price. The main employer in these countries was not the private sector but the government and where was the tax base to meet all the demands?

In response to the economic dilemma that many of the countries were in, the World Bank and the International Monetary Fund came in with the now infamous policy called SAP (Structural Adjustment Programs). As part of SAP, governments were to cut back the costs of their social services like health care and education and a new concept of cost sharing was introduced. Who was to absorb the deficit in the government social service system? Was the hidden agenda, the Churches, to absorb this deficit? The World Bank has now seen that SAP by itself will not answer all the problems around poverty and basic social services and is now speaking about a new policy called

Poverty Eradication Programs

Even though there can be criticisms of certain international policies, there must also be honesty on the role of good governance in African countries. Unfortunately, in sections of English-speaking Africa, corruption, addiction to power and wars seem to be having a major impact on the life of the people and the basic development of the country. If national leaders are corrupt, how do we stop bribery in the health care system? If good governance is not in place there is no impetus for the investing of funds in economic development. In point of fact, the economies stagnate and one of the implications of deteriorating economies is decreasing health care resources.

On the Church side we also see both positive and negative developments that have directly impacted health care. In the pre-independence and early independence days the mission of the Church as expressed in English speaking Africa was to work towards the development of local Churches. Two key aspects of this development of the local Church were local vocations to religious life and extension of health services to people.

Diocesan Congregations of Religious Sisters were being strengthened and within their communities Sisters were trained to be health care professionals. As priests and religious Brothers and Sisters continued to increase within the local Churches, international Religious Congregations began to recruit candidates for their congregations.

In health care, hospitals and dispensaries continued to be built as well as training institutions for health care workers. At many large hospitals, there were Nursing Schools attached to them. This provided a continual source of staff for the hospitals and dispensaries.

In the 1990's Missionary and Religious Congregations began to face the reality of aging personnel with few if any new personnel coming from Europe or the USA. For those groups that could no longer staff their health services, they were faced with the delemma of either closing down their health services or turning them over to the local Church. In most cases the health services were turned over to the local Churches with the supposition that the local Religious Congregations would run these operations. Unfortunately there was a flaw in their basic supposition. The local Religious did have the medical training to offer health services but did not have the financial and managerial resources to keep many of these facilities running. The European Religious could write to their Motherhouse or friends in Europe for assistance for their health ministries but to where could the local Religious write for assistance?

Thus the local Church has faced the same issue as the government health system of not having a solid financial base for running its health services. In the Church's case, with poor national economic development the economic resources are not there within the local community to meet the expenses of health care. Add on the additional stress put on the health system because of HIV/AIDS, which is a pandemic in Africa, and you have health systems that are basically in cardiac arrest or in intensive care.

The dream of health care for all becomes the harsh reality of access to care for those who are economically empowered. For the poor, health care is on an emergency basis. Illnesses that could have been treated early on are not treated until they become chronic or acute. This actually increases medical costs for the patient and the health system.

A key factor in health care that has not been clearly addressed and acknowledged by the donor community in funding is the percentage of national health care that is being offered by the Churches, mosques and other NGO's.

The following table shows the comparison of public/private health expenditures in some of English speaking Africa as reported in the WHO 2001 Report. The figures are 1998 figures

Table 1. Public/Private Expenditures as % of Total Health Expenditures

Country	% Govt. Expenditure	% Private Expenditure
Nigeria	39,4%	60,6%
Ghana	54,0%	46,0%
South Africa	43,6%	64,4%
Tanzania	48,5%	51,5%
Uganda	38,2%	61,8%
Kenya	28,1%	71,9%

The question to be asked of the international donor community is why there appears to be resistance to investing in the private sector health systems when they are assuming a large percent of the health services in these countries? Is the underlying issue the tension between secular society and Church? The new policy of the United States Government to work with Faith Based Organizations (FBO) seems to imply that there was a previous policy of not working with FBO's.

Besides the very basic issues of the economic sustainability of Church health services, the Church is now facing an additional moral

and ethical challenge in the struggle between what his Holiness Pope John Paul II calls the *culture of life* and the *culture of death*. The ethical and moral issues around propagating a culture of life can be seen more clearly through the problems of HIV/AIDS. Two key components that directly interrelate to the integrity of life and HIV/AIDS are abortion and access to care.

Abortion in much of English speaking Africa is illegal. South Africa to the contrary has a very strong pro-abortion law. In the countries where abortion is illegal, abortion can legally be performed to save the life of the mother. The new avenue to try to increase the acceptance of abortions is through advising pregnant mothers who are HIV/AIDS to have an abortion. In South Africa it is government protocol that any woman who is HIV Positive should be advised that she has an abortion before the twentieth week of pregnancy. The South African Bishops have campaigned strongly against this protocol but their voice has not been heard by the government.

It is the failure of access to care that diminishes the basic life of the mother, child or other persons who are infected with HIV/AIDS. In the South Africa situation at the same time as the government is strongly advising HIV positive women to have abortions, the same government has been resisting the use of the anti-retroviral drug Niveropine administered to mothers to prevent maternal/child transmission of the HIV virus. The resistance of the South African government on this issue is in complete contradiction with the other African countries that are trying to develop programs for Prevention of Mother to Child Transmission (PMTCT)

Besides the issue of saving the life of the mother, the other unspoken concept is that if we save the child of a HIV/Positive mother then we will just be ultimately increasing the amount of orphans and they will become a burden on the society. Therefore, why save the child?

These new developments of the culture of death leads us to ask a very frightening question: are we moving into a new phase of economic social engineering where people, and particular HIV Positive pregnant mothers, have no value because they are poor! The life of the child is terminated within the mother and the mother is left to deal with her own HIV/AIDS illness without any real medical support from her government. Even without the use of any anti-retroviral drugs, 60% to 70% of the children will become HIV Negative.

Where then do we go as a Church in response to the serious dilemma of health care in Africa? Pope John Paul II in his Encyclical *Gospel of Life* gives us clear directions. If we take his explanation of the culture of death, it gives us clear guidance for an appropriate Social Justice response.

"This culture is actively fostered by powerful cultural,economic and political currents which encourage an idea of society excessively concerned with efficiency... it is possible to speak in a certain sense of a *war of the powerful against the weak*... A person who, because of illness, handicap or, more simply by just existing, compromises the well being or life-style of those who are more favoured tends to be looked upon as an enemy to be resisted or eliminated" *(The Gospel of Life* section 12)

Our response to the *war of the powerful against the weak* should be the following:

1 – The Local Churches in Africa should become even more involved in identifying and speaking out against the culture of death within their reality. The issues are there with poor governance, war, corruption, violence and abortion and destroyed economic systems. These are not political issues but Gospel issues.

2 – The Church of the North must be more supportive emotionally of the local Churches in Africa since the Local Church is taking the role of the weak against the powerful.

3 – The Church of the North must take a more pro-active stand with the international donor agencies and national government for access to funds for health care for appropriate Catholic health services.

4 – European and American Religious Congregations should review their policies and procedures for turning over health services to the local religious congregations and dioceses.

In conclusion, Church health services in English speaking Africa are now at a crossroads where they must assume a much more prophetic role in identifying those structures in their environment that are imposing a culture of death

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3. North America

1. The Catholic Health Care Ministry in Canada

Founders of Catholic Health Care in Canada

From the founding of the Hôtel-Dieu Hospital in Quebec, in 1639, by the Augustines Hospitalières de Dieppe, members of 64 religious congregations of sisters and three religious orders of men have dedicated their lives to the service of those who are sick, suffering and dying in Canada. They are responsible for founding the health care organizations that have formed the basis and tradition of the Catholic health care ministry in Canada. They have also laid the foundation for Canada's health care system.

Currently, 73 Catholic hospitals and 38 long-term care institutions serve those who are sick and dying, in nine provinces and one territory across Canada. There are currently thirty-two sponsors of Catholic health care institutions, eight of these are public juridic persons and 24 are congregations of sisters.

Medicare - Canada's Publicly-Funded Health Insurance Plan

Catholic hospitals and long-term care institutions operate within Canada's publicly-funded medicare system.

The principles of the Canada Health Act include: Public Administration on a non-profit basis; Comprehensiveness: all medically-necessary services provided by hospitals and medical practitioners are insured; Universality: all Canadian residents are insured; Portability: residents are covered when they are temporarily in other provinces; and Accessibility: there must be reasonable access to insured services without financial or other barriers.

Medicare is currently under review by the federally-appointed Romanow Commission.

Visions/Goals Inspiring the Catholic Health Care Ministry

The following visions/goals, rooted in the gospels, give direction to the Catholic health care ministry in Canada.

– Respect for human life at all stages
– Church health ministry transformation
– Vibrant Catholic health care organizations
– Just health and social policy

Activities include education, advocacy, networking and policy development in the areas of ethics, spirituality and justice related to health and health care.

Challenges and Opportunities

The ministry faces many challenges and opportunities:

1. Many religious congregations of sisters, that have founded and sponsored Catholic health care institutions, have left, or are in the process of leaving, the institutional health care ministry.
2. New sponsor organizations, public juridic persons with lay leadership, have been founded to continue Catholic governance of Catholic health care institutions. These new sponsors are struggling with issues of financial viability, authority, roles and relationships.
3. New leaders within Catholic health care sponsor organizations and institutions are needed and require education in the values and history of the church's healing ministry.
4. Greater education is needed in the Church – for bishops, priests, and laity – about the Church's health and healing ministry.
5. The future existence of some Catholic health care organizations is in jeopardy, in the face of ethical pressures that threaten Catholic identity and government decisions that affect governance structures.
6. Catholic health care also advocates with respect to public policy ethical and justice issues such as biotechnology and genetic research, reproductive technologies, care for the dying, the needs of the poor, and ecological/environmental issues linked to health.

National Dialogue on a Preferred Future for the Ministry

The Catholic Health Association of Canada (CHAC) is sponsoring this year a national dialogue on a preferred future for the Catholic health care ministry in Canada. This dialogue is being organized in collaboration with the Canadian Conference of Catholic Bishops (CCCB), sponsors, member provincial associations, Catholic social service agencies, diocesan representatives, and other interested parties,

This national project includes dialogue among those engaged in the ministry, from October 2002 to April 2003, about the characteristics and essentials of the Catholic health care ministry. This dialogue will lead to a National Forum in May 2003 that will develop a vision and action plans for the future of the Catholic health care ministry in Canada.

The Catholic Health Ministry in Canada is guided by the motto, "The Love of Christ Impels Us." Those engaged in this ministry seek to be witnesses of Christ's healing presence in service to those who are sick and dying, advocates for a just health care system, and promoters of a healthy society.

2. Health Care in Mexico

Health Trends and Problems

Mexico has a population of over 81,000,000 inhabitants. The proportion of the population under 15 is over 30% while that of persons 65 and over is approximately 5%. Life expectancy at birth has risen to approximately 69 years for the population as a whole. Infant mortality rates fell 50% between 1960 and 1989. Mortality from communicable diseases has decreased between 60% and 87% for all age groups during the last three decades.

The most pressing health problems include heart disease, intestinal disorders, cirrhosis, diabetes and malnutrition. Infectious diseases such as AIDS and TB are rising daily. Poverty is widespread, especially in rural areas.

Health Care Services

The National Health System is composed of public and private sector institutions. In 2001 there were approximately 974 public (government) hospitals and approximately 1621 private hospitals in Mexico.

The public sector includes social security institutions and institutions that provide health care and social services to population groups not covered by any health care scheme. The Secretariat of Health is the sector's lead agency, and it operates institutions at all levels of complexity, including ten national health institutes. The social security system institutions in the public sector serve both government and private sector workers and their family members. In 1991, the social security system covered 54% of the population.

The private sector includes professionals and institutions that provide outpatient and hospital care, health insurance companies, and practitioners of traditional and alternative medicine.

Economic Environment for Private Hospitals

The events of September 11, 2002, and the war against terrorism, have seriously affected Mexico's economy, particularly in those states and cities near to the United States. The aviation industry, transportation and tourism have been particularly affected. The globalization of the economy, controlled by multinational corporations, has led to depressed prices, little margin of growth and deflation. These economic conditions have led to job losses and business closings.

Other important aspects of the political and economic environment include: the election of Presidente Vincente Fox Quesada, the federal government's plan for fiscal reform, new negotiations with the World Bank, a strong peso, American financial support, and economic activity that continues to benefit the rich and not the poor. There is an expectation of economic stability for the next 12 months.

Because of these economic realities, consumers of medical services are using public hospitals, clinics and civil hospitals, in increased numbers. There is less use of private hospitals, especially those hospitals on the border with the United States.

3. Catholic Health and Social Services in the United States

Catholic health care and social service can trace its heritage to New Orleans in 1727 when 12 French Ursuline sisters arrived in the city to become nurses, teachers and servants of the poor and orphans – a 275 year legacy!

Current Profile

Catholic health systems range in size from a few to more than 100 facilities. Catholic hospitals and other organizations minister through shelters, food programs, and other community outreach efforts to people of all ages, races and religious beliefs. The broad continuum of ministry includes:

– 62 Health Care Systems, 136 Home Health Agencies

– 634 Hospitals, 36 Hospice Organizations

– 522 Long-Term Care, 700 + Other - Continuum of Nursing Facilities Care Services (*assisted living, adult day care, senior housing*)

Catholic health care institutions are present in almost all dioceses nationwide. There is at least one Catholic health facility in 173 of 176 dioceses. Forty-nine dioceses "sponsor" Catholic health care and nine dioceses sponsor their "own" health care system. There are hospitals in 153 dioceses and Long-term care facilities in 166 dioceses.

Catholic hospitals constitute 11% of all hospitals in the United States – the largest single group of the nation's not-for-profit hospitals. One in five not-for-profit hospitals is a Catholic hospital.

Twenty-eight per cent of Catholic hospitals are classified as rural health providers and often are sole providers.

Hospital Ministry in the United States

The Catholic hospital ministry serves one in six persons needing hospital care. Catholic hospitals provide:

– vital care for the poor, sick and needy;

– vital witness for social change;

– a vital part of United States health care;

– a vital ministry of the Church.

This ministry carries out the healing mission of Jesus Christ through *service* and *transformation.* In a very special way, it supports the Pro-Life agenda of the

United States Conference of Catholic Bishops with the rest of the Church to advance a culture of life, in particular, the life of the unborn and the aged.

Ten Opportunities to Serve and Transform

The challenges to providing health care in the United States are real and numerous.

They include challenges for health care and challenges unique to the ministry.

Challenges for Health Care

– *The uninsured* - The latest figures are showing 42 million citizens of the United States without health care insurance coverage; 6 million of those are children.

– Adding to the challenge of the uninsured is an *unjust payment system.* Catholic hospitals are increasingly called upon to serve those without means to pay for care. Without adequate reimbursement, many of these hospitals have been forced to close or sell their assets to for-profit systems.

– The health care *delivery system* is in a great state of fluctuation resulting in an uncoordinated system and poor care for patients.

– *Technology advances* such as the human genome, biomedical devices, expensive pharmaceuticals and commerce over the Internet add to the economic and social challenges to providing health care.

Challenges Unique to the Ministry

– The *transition to lay leadership* raises questions as to what model of sponsorship and what types of leadership development for lay people will best keep alive the legacy of care and compassion so carefully nurtured by the sisters, brothers and priests.

– Public debate about the *role of religious health care organizations* in society has produced threats to the freedom to serve as faith-based providers of health care.

A visible symbol of this controversy has been whether participation in publicly funded health care programs, such as Medicare and Medicaid, should obligate religious health care institutions to provide abortions. The argument has been extended to other services, from contraception to assisted suicide, and beyond health care providers to religious employers and health insurance plans.

Elements of a Preferred Future

Over 1,000 members of the Catholic health care ministry have participated in articulating a preferred future for the provision of health care in the United States. The resulting ministry-wide strategic plan is designed to give the elements of a vision for the future.

A ministry that is characterized by:

– Strong mission and values foundation emphasizing compassion and quality.

– Collaboration with other providers and Church ministries.

– Effective advocacy.

A *health care ministry* characterized by:

– Better coordination of care and utilization at the right level.

– A strong sense of community.

– Care for the whole person.

– Universal coverage/availability of insurance.

Health care *for the patient and community* characterized by:

– Improved quality of life.

– Patient satisfaction.

– Effective use of technology with a human touch.

– Empowerment of patients, families, communities.

A *workplace* environment characterized by:

– Committed/effective staff.

– Sponsors/boards as effective stewards.

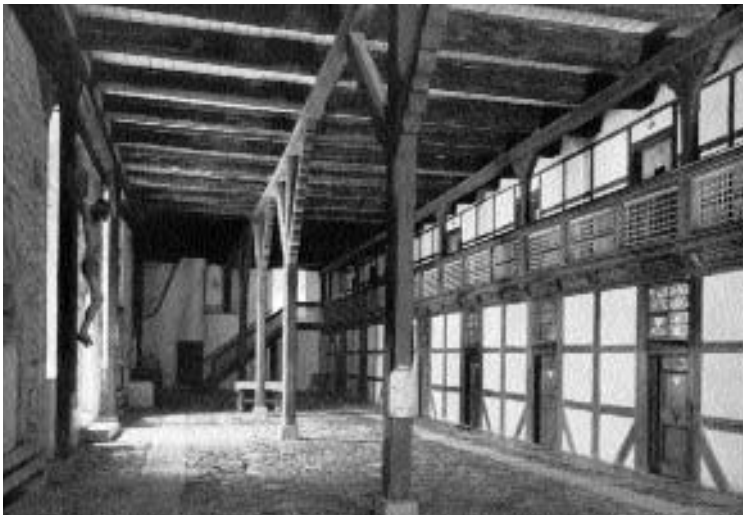
– Adequate staffing levels.

– Good working environments.

– Effective leadership for multiple groups.

The Catholic Health Ministry of the United States, recognizing the challenges of the environment, remains committed to the mission of Jesus *to serve and to transform.*

Dr. RICHARD M. HAUGHIAN
President,
Catholic Health Association of Canada



CARLOS AGUIAR RETES

4. South America

A Look at the Past

The presence of the Church in the health care institutions of South America is very significant. One can without doubt state that from the beginnings of this region's history as a colonial territory in the sixteenth century, it was the Church that began and managed the first hospitals, extending their benefits, in addition to the conquerors to the native population in general. It is worthwhile mentioning the 'doctrine hospitals' managed by the religious orders, in which, in addition to the medical-curative dimension, evangelisation through teaching, catechesis, the administration of the sacraments and other missionary activities that were promoted in the hotel context were also engaged in.

In this way the Church perpetuated the Spirit of Christ, who in his ministry had compassion for the sick and restored to them not only their physical health but also their spiritual health (Mt 1:32; 2:1-2; 6:53-56).

The historic witness of the first evangelisers, in the defence of the natives in all the dimensions of their lives, is recognised and appreciated (*DP* 8). The various religious orders that continued the evangelising process, such as the Franciscans, the Dominicans, the Augustinians and the hospital religious orders, conserved down the centuries the work of concern and health care as an evangelising work.

From the beginnings of our evangelisation there arose an infinity of hospitals whose reason for existing was to express Christian mercy, in addition to ancient brotherhoods which founded, paid for and administered hospitals in conjunction with the hospitals of Rome.

In the villages that they established, the evangelisers felt the need to build churches for the spiritual congregation of the new Christians, and to create and build hospital institutions that functioned with staff, rules and structures that were totally Christian.

This was the reason for the existence of the brotherhoods of the Holy Spirit, of the 'Vow of Hospitality', of the 'convent-hospitals', and of the 'doctrine-hospitals'. Many hospitals of the Catholic Church were known by the name of 'doctrine hospitals' because they had the following objective: to be places of evangelisation which was projected outside the hospital structure itself.

We should also remember the existence of the martyrs of hospitality of the various nations of Latin America, just as it is important to recall the building of the first hospital in the new world in the Dominican Republic, the beginnings and the development of hospitals in Mexico, the presence in Cartegena de Indias of the Hospital Brothers of St. John of God (the Fatebenefratelli), and in general the hospital orders in the continent of Latin America.

We can state that the health care institutions were born in this continent as a result of the work of the Church: dioceses and religious communities established hospitals throughout the territory. Still today, many public hospitals which maintain and appreciate the fact of being under the patronage of one of our Christian saints, exist in all the countries of our continent.

Statistics

In South America, the Church plays an important role in the provision of health care services, whether in the form of hospitals, health care centres or charitable institutions, orphanages, rest homes, centres for teenage mothers, and so forth.

The statistics supplied by the Pontifical Council for Health Pastoral Care are very significant: the Church manages a total of 1,678 centres, 61% of which are hospitals. As regards the ownership of centres, 60% of these are owned by the dioceses or religious orders, and the remaining 40% are administered by the Church with the support of governments and non-religious private bodies.

In Latin America, Catholic hospitals make up a high percentage of the supply of health care institutions, which ranges from 15% to 50% according to the country involved. These percentage figures increase in some specialised sectors, such as, for example, psychiatric hospitals, centres for elderly people, and centres for the chronically or terminally ill.

Trends

In South America, processes involving the modernisation of the state and the health care sector are underway. The principal changes, which involve the working and the structure of the sector, are the following:

– the privatisation and commercialisation of the sector;
– decentralisation;
– administrative autonomy;
– new forms of funding and finance;
– emphasis on the control and the covering of costs;
– the inclusion of basic packets in the health care supply.

All this is directed towards broadening the funding and the supply of health care services. The state is withdrawing from the direct provision of health care services but is also creating a framework law for a specific set of norms, and carries out essential functions in the field of public health such as drawing up

health care policies and controlling the effective provision of a service. Over the last decade, the sector of social insurance has been the sector that has registered a growth in public expenditure.

The present-day reforms are directed towards redefining the role of governments in the management of health care services, and to guaranteeing fair access for all the population to such services. Our new health care systems lay emphasis upon the following:

– the influence of the market economy;

– self-management;

– institutional pluralism in the funding and provision of services;

– the incorporation of new technologies;

– the efficiency, the control and the covering of costs.

Ecclesial institutions have to enter these new dynamics, both as administrators of state centres and as private operators in the field of health care services. According to the new models, the patient is seen as a customer, the services are analysed from the perspective of costs and benefits, and the public hospitals and the charity hospitals are subjected to pressure to maintain themselves financially and if they do not do so they are forced to close.

Today much emphasis is placed on the promotion of health and on the prevention and control of illness. This assumes intervention by the state directed towards producing changes in the standards of life of the marginalised sections of the population and eliminating unjust inequalities at the level of health and collective well-being. Here, as well, the Church plays an important role as an agent of change that promotes in a number of ways an increase in the standards of life of the marginalised sections of the population, something that in turn has a favourable impact on health.

One trend that can be pointed out as regards the presence of the Church in this sector is the preference for small works, accompanying, and providing service in primary health to the poor sectors of society: dispensaries, health care centres, initiatives dedicated to prevention and the health care education of a population that has few resources, rehabilitation centres for drug-addicts, etc. A presence in major hospitals is not the dominant kind of presence of the Church, especially as regards the management and ownership of hospital centres. Those that do exist are maintained, but it is rare for new hospitals to be opened by the Church because of the complexity of this kind of initiative and the existing sets of norms, marked by market criteria and strong competition between health insurance companies. This situation requires the presence of evangelising groups (religious service) in the major hospitals, whether they are public or private in character. This requires training as regards pastoral care in health and the organisation and funding of its services.

Challenges

1. The impoverishment of the populations. An economic crisis is being felt in almost all of the countries of this region. At the same time, the prices of health care services and of medicines and drugs are rising.

2. The privatisation of health care services. The state is gradually withdrawing from the responsibility of guaranteeing health to the whole of the population and prefers to encourage private mechanisms.

3. The commercialisation of medicine and medical services. The neo-liberal model sees the health care institution as just another business, where the desire for gain prevails. The view is that it is necessary to reduce costs and increase earnings, The contemporary model has led to the financial crisis of many hospitals because of the conditions imposed by the insurance companies and a failure on the part of these companies themselves or the state to make over payments.

4. The neglect and the abandonment of certain sectors: the elderly, the mentally ill, the chronically ill, the incurably ill, and the handicapped.

5. One difficulty currently being experienced in our countries is the scarcity of men and women religious within health care institutions, The decrease in the number of vocations, the resistance of some religious to living out their mission within the context of great institutions, in which they are seen as ‘the boss’, and the growing difficulty encountered in providing services according to the current neo-liberal model, have all placed many Catholic hospitals of this region in a state of crisis.

6. At the same time, there exists greater participation and training of the lay faithful in pastoral service within the Church’s hospitals and in the public or official sector as well. Pastoral care in health in hospitals has come to be an essential component part of the role of the Church in this sector. It promotes humanisation, looks to personalised care, re-

spects the psychological and spiritual processes of the patient and his or her family, and fosters a transcendent vision. All of this is appreciated by the people who use Catholic hospitals.

7. In public hospitals there exists a scarcity of chaplains and Catholic voluntary workers. Often this is due to a lack of legislation or of an agreement establishing the right to religious assistance (with basic support provided by the state); at other times, it is due to a lack of awareness of the importance of hospital religious service on the part of the dioceses themselves.

It is necessary to point out the following aspects as points to be taken into account, and where they are taken into account, they should be appreciated, conserved and improved.

1. The organisation of hospital pastoral care as a part of the overall pastoral care of the dioceses. The appointment of chaplains.

2. The structuring of hospital religious service. Agreement with public and private bodies.

3. The training of the agents of hospital pastoral care.

4. The promotion of humanisation and overall service for the sick.

5. The promotion of the accompanying of the sick person, his or her family, and the health care agents of the hospital. The sacraments, catechesis, prayer, and liturgy. Becoming aware of the fact that this is a privileged moment for evangelisation.

6. The organisation of, and participation in, hospital ethical committees. The promotion of awareness of bioethics taking the criteria of the Magisterium of the Church as a starting point.

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Bishop of Texcoco and Secretary General of the CELAM

YVON AMBROISE

5. Asia

1. Introduction

Asia houses 60% of the world's population. Asia has a civilization that dates back to two to four thousand years B.C. There are 400 officially known languages spoken. Excepting the Middle East, there are 32 countries in Asia, of which 21 countries have Caritas Organizations. Asia's economy ranges from the richest in the world (Japan) to one of the fast growing (China), to some of the least developed ones like Bangladesh and Nepal.

When we look at health problems, Asia poses several challenges. The health and policy developments in the health sector, Asia's struggles and success can provide lessons to the global health sector particularly in Africa and Latin America.

In this paper we would like to situate the Catholic Health Care Institutions in the context of the general health care situations of Asian society and see the challenges that face the Catholic Health Care system in the economic, social, political and religious areas.

2. The General Context of Asia in Health Care

Health care sector and several reforms have brought about amazing transformations in health policy throughout Asia. In just 12 years South Korea changed fully its financing of health care by introducing a national system of insurance that now provides universal care for all citizens. Japan has made a revolution in health care. Even the other developing nations in South and Southeast Asia have made significant improvement in the last decades.

After World War II, in the 50s and 60s Asia faced serious health problems. Infectious and parasitic diseases such as malaria, tuberculosis, polio, measles, and tetanus were rampant. There was widespread malnutrition that went along with poverty and weakened immune systems and thereby worsened the seriousness of illnesses. Added to this was high fertility rates and poor birth spacing that served as a great threat to the health of both mother and child.

At the national level the Governments have implemented policies over the past four decades and introduced immunization drives, pest control projects and health education campaigns. Large hospitals and village-based primary care health centres have been established to treat emergency and common illnesses. Organizations like WHO and UNICEF have added their own interventions which have helped decrease infectious deceases, increase access health care and reduce infant mortality as well as improving maternal health.

"Almost all the developing countries of Asia are involved in health-sector reform today. These efforts, according to one researcher, now include primary health care, sectoral finance, planning and development management and organizational review, rationalizing the role of the private sector and nongovernmental organizations (NGOs), improving gender staffing mechanisms and reducing gender disparities, health systems research, resource mobilization for health and the social sectors, and making better use of available resources. (See Asian

Development Bank (ADB), 1994a; Ali, 1996.) And that is not all. Recent or current reforms include decentralization in the Philippines, efforts to create a private sector in the central Asian republics and in Mongolia, and the simultaneous introduction of universal health care and cost containment in Taiwan.

This interest in health-sector reform is motivated primarily by the belief that reforms will lead to better health by more efficiently using limited resources. Though health reforms are influenced by many factors, including each country's unique social, economic, medical, political and cultural forces, change can be seen throughout Asia. In Indonesia, social disparities between urban and rural populations and economic development have led to an overhaul in health care financing, which has produced improved access to care through a redistribution of public resources. The explosive AIDS epidemic in Thailand spurred policy initiatives that now focus on changing personal behavior to limit a further spread of the disease. In Cambodia and Laos, as war yields to peace, political energies have turned to health and welfare, and the resources formerly used to wage war are now available to help the sick, the poor, and the disenfranchised. In Sri Lanka and South India, anthropologic research points to social and political influences on health. The combination of a cultural interest in diagnosing and treating diseases, a tradition of open politics and political consensus, and the marked degree of female autonomy associated with a high level of maternal education, translate into early utilization, quick referral, and higher-quality medical care better outcomes.

The health sector reform we have witnessed in Asia has been impressive in scope and has involved a significant amount of policy innovation. However, a fundamental question remains: have the reforms made a difference in improving the health status of the people of Asia?"[1]

This is the key question: namely *what is the improvement in the health status of the people of Asia* that we need to critical look into? We shall particularly take the case of the involvement of the Church to see whether this involvement makes a significant contribution. These health reform trends in each Asian country continued to the 1990s. The globalization process that stepped in as a major force also started affecting the health sector in various ways. Hence the Church was also very much affected by these trends.

Table 1 gives the health status indicators for several Asian countries.

It will be useful to know also what is the pattern of government expenditure for health sector. Table 2 provides information on that.

3. The Involvement of the Church

The involvement of the Church in Asia is to be seen in its presence in Asia. Leaving aside the Middle East, Asia has 32 countries. Among these 32 countries, Caritas organizations exist only in 21 countries. Statistically, except for two countries like East Timor which has the highest percentage of Christians (around 85 – 90%) and the Philippines (around 80%), the Christians form a tiny minority. As a whole, Christians are only 2% of the total population of Asia and if we remove East Timor and the Philippines they come down to 1%.

There are countries in which the freedom of the Church is very much restricted and even denied: China, Vietnam, Laos and North Korea. In addition in the ex-Soviet Union countries of Kazakhstan, Uzbekistan, Kyrgistan, Tajikistan, Turkmenistan and Mongolia the Church is just starting to implant herself. There are some Muslim dominated countries like Afghanistan, the Maldives and Brunei where the Church is hardly present in terms of Catholics. In the military controlled regime of Myanmar, the Church has suffered several setbacks. In a Buddhist country like Bhutan the presence of the Church is hardly tolerated and similarly the Church in Nepal (a Hindu Kingdom) has several restrictions. Besides, there is the rising fundamentalism of Islam, Buddhism and Hinduism in the Asian context that is not only restricting the Church but also hindering the work of the Church and even going to the level of persecuting the Christians. One has to keep this context of the Church very much in mind.

In spite of the minority character of the Church, it is present very strongly in the educational, health and social work sectors. Since we are only dealing with the health sector, we shall concentrate on its functioning. In South Asia, the presence of the health institutions in India, Sri Lanka, Pakistan, Bangladesh and Nepal is quite significant. In Southeast Asia, in Thailand, Malaysia, Singapore, the Philippines, Indonesia, Cambodia and East Timor, there are also significant health institutions run by the Church. In East Asia, since the government takes a major part of the role of the health care like Japan and South Korea, the Catholic Institutions that cater to health needs may not have a major impact. But in Taiwan, Hong Kong and Macau there is a good network of Catholic health institutions within the set-up of the Communist atmosphere. In Central Asia, the Church is now slowly initiating through Caritas these health services.

3.1. The Different Ways of Catering to Health Needs

The Church as a whole in Asia follows different strategies with reference to health care needs. We can broadly divide them into four categories. First, there are hospital institutions of various sizes. Secondly, there are the dispensaries or primary health centres. Thirdly, there are specialized hospitals or institutes for specific diseases like cancer, leprosy, tuberculosis, AIDS patients, etc. Fourthly, there are specific health projects that cater to the village population through extension services, mobile clinics and community health projects.

The first and the third categories concentrate only on the curative aspect. As for the second and fourth categories, depending on the personnel the services are restricted to curative only or extended to preventive and promotive health care. The investments are

Table 1. Health Status Indicators for Selected Asian Countries Sorted by GNP

		Life expectancy at birth			Child mortality rate (per 1,000 live birth)			
Country	GNP per capita 1994 ($)	1960	1994	% change	1960	1994	% change	IMR (1994)
Nepal	200	44	53	20,5	290	118	-59,3	84
Vietnam	200	44	64	47,7	232	46	-80,1	35
Bangladesh	220	46	55	19,6	247	117	-52,6	91
Mongolia	300	47	63	34,0	185	76	-58,9	58
Lao PDR	320	44	51	15,9	233	138	-40,8	94
India	320	47	60	27,7	236	119	-4936	79
Bhutan	400	38	50	32,0	324	193	-40,0	125
Pakistan	430	19	61	24,5	221	137	-38,0	95
China	530	43	68	58,1	209	43	-79,4	35
Sri Lanka	640	58	72	24,1	130	19	-85,4	15
Indonesia	880	46	62	34,8	216	111	-48,6	71
Philippines	950	59	66	11,9	102	57	-44,1	44
Papua N. Guinea	1240	47	56	19,1	248	95	-61,7	67
Fiji	2250	63	71	13,2	98	27	-72,1	22
Malaysia	3480	58	71	22,4	105	15	-85,7	12
Thailand	5410	52	69	32,7	146	32	-78,1	27
Korea, Rep. of	8260	53	71	34,0	124	9	-92,7	8
Singapore	22500	65	75	15,4	40	6	-85,0	5
Japan	34630	68	79	16,2	40	6	-85,0	4

Source: United Nations International Children's Emergency Fund (UNICEF), 1996; World Health Organization (WHO), 1996a; World Bank, 1996a[2]

Tabella 2. Annual Health Care Expenditure for Selected Asian Countries, Using 1990 Data

Country	GDP per capita 1990 (US$)	Total expenditure per capita*	Expenditures as % of GDP	Public Expenditures as % of Total
Nepal	188	8	4,5	48,9
Bangladesh	204	6	3,2	48,8
Vietnam	240	5	2,1	52,3
China	311	11	3,5	60,0
India	353	21	6,0	21,7
Pakistan	354	12	3,4	52,9
Lao PDR	364	9	2,5	40,0
Sri Lanka	473	18	3,4	48,6
Indonesia	596	12	2,0	35,0
Philippines	724	14	2,0	50,0
Papua N. Guinea	839	37	4,4	63,6
Thailand	1558	73	5,0	22,0
Malaysia	2581	78	3,0	43,3
Korea, Rep.	5921	390	6,6	40,9
Taipei, China	11200	515	4,6	52,2
Singapore	13653	546	4,0	57,9

SOURCES: World Bank, 1993a; WHO, 1995c.3
* Expenditures per capita are rounded to nearest whole number.

the highest in the first and third categories, whereas the investments are minimum compared to the second and fourth categories. Therefore, the number of institutions are very small in the first and third and comparatively more in the second and fourth categories. Concerning the personnel, the number of qualified personnel of the Church as well as lay people engaged in the work are higher in the first and third categories rather than in the second and fourth categories. Regarding treatment, it is more hospital based and doctor and medicine based in the first and third categories than in the other categories where it is more people-based. Further more, the latter has several educational inputs and a participation from people in becoming guardians of their own health. From the point of view of the system of medicine used, the first and third are dominated by an allopathic system whereas in the

second and fourth categories there is a mixture of allopathic and traditional medicine, depending on the culture and geographical area.

We do not have statistics of all health services in each country in Asia and thus we will give sample statistics for India. Total population 1 billion, Catholic population 15 million, Hospitals 710, Dispensaries and Health centres 1800, Leprosaria 111, Rehabilitation centres 102. (Catholic Directory of India 1998)

3.2. Problems in the Service in Health Sector

The Catholic Church, because of its network and dedicated personnel like the Religious Sisters and a few priests who have specialized in the health apostolate at various levels, has rendered a great service to the well to do, to the middle class and to a large extent also to the poor, but the methodologies of helping them are different.

Through the big health care institutions like hospitals and centres for specialized diseases which need very specialized care, huge investments have been made financially and with very qualified professionals in the medical field. Hence they demand a high level of maintenance forcing the Church to tax its clients for the services rendered. This very often makes the poor unable to make use of these institutional services, particularly in a context where there is no social security system or health insurance or any other government subsidy. In spite of their goodwill they can serve only a very limited number of the poor, otherwise they could not maintain and develop those institutions.

As for the primary health centres and other initiatives with village based activities, the catering to the health needs was done by Religious Sisters and lay people trained as nurses. They could reach a wider population in several villages by their extension services. Further more, certain projects like community health programmes recruited local personnel and trained them in the basic health care needs and made them attend to the needs of the remote villages. In such an approach there was a study of the disease pattern and attention was particularly given to preventive health care like immunization and a promotive health care by means of health education, hygienic practices, nutritious food and environmental hygiene.

A survey made in India revealed that 60% of the health care needs of the people in villages are very basic ones and do not need hospitalization. Hence they could be treated at the village level itself with the help of nurses and trained community health workers as well as through a health education process. Such services are always people-based and have a capacity to cater to the real poor sections of the people. From the point of view of the medical expenses, since the allopathic medicines cost more and more every year in several countries in Asia, the use of traditional medical interventions provides more effective care at less costs.

The allopathic or Western medicines emphasize hospitalization, drug therapy and surgery. For certain diseases we need that, but for most of the basic diseases that people suffer from in villages there may not be a need for that. Traditional medicine focuses on dietary and lifestyle changes. They also introduce some form of physical exercise, natural plant and herbal treatments and different types of physical treatments like massages. They also introduce some religious practices like meditation, yoga and other such exercises.

Unfortunately in many of the Asian countries the dominance of the allopathic system tries to undermine the practice of traditional medicines. The sole argument used is that they are not scientifically proved. Hence there is no real support for the promotion of traditional medicines by and large.

We give hereby an interesting excerpt on traditional medicine in Asia and how it works.

"Oriental medicine, which originated in China more than 5,000 years age, and *Ayurveda*, which originated in India at about the same time, are two ancient systems of traditional medicine. Despite their independent development, these systems have remarkable similarities and have provided the underpinnings of almost all traditional medicine practiced today in Asia.

How exactly do they work? Two related principles – balance and maintaining energy flow within the mind and body – underlie their approaches to maintaining health. *Ayurveda* views balance in terms of the three primal qualities – *vata, pitta,* and *kapha* – while Oriental medicine describes these three qualities as *qi (*or *chi), yang,* and *yin.*

When *vata, pitta* and *kapha* (or *qi, yang,* and *yin)* are in balance and our bodies are in harmony, we exist in a state of health and vitality. When the balance is broken, the disharmony is expressed as pain or states of disease. Such a framework has one theoretical advantage: It lends itself to using techniques to restore optimal health even if no specific disease state has been diagnosed, for in traditional medicine good health is a state of balance and high energy rather than simply the absence of disease.

In both traditional medicine systems, pain is caused by the blockage of the flow of energy, an example of which is the development of muscular tenderness in areas of overuse. Over time, these blockages can lead to pain, discomfort, or dysfunction of bodily organs. Causes of imbalance include practically every pathogen we can think of in Western medicine

terms, such as stress, toxins, drugs, and physical and emotional injuries.

Balance is restored by using herbs, and the flow of energy is restored by stimulating acupuncture points along the affected channels or by removing bodily impurities. To restore balance, hundreds of herbs have been developed over thousands of years – most of which are relatively free of side effects. The study of herbs affecting the immune system is an interesting topic of modern pharmacological research. For example, two herbs – Echinacea and the Chinese astragalus root Astragalus membranaceus – have been found to have effects on the immune system. An interesting difference between Western medicine and traditional medicine is that the use of herbs in the latter is based not on their chemical composition but on their physical characteristics in terms of *vata/pitta/kapha* or y*in/yang*.

Compared to modern Western medicine, traditional medicine is relatively weak in terms of diagnostic and laboratory tools, but it makes up for this deficiency with an elaborate system of physical and pulse diagnosis. Traditional medicine techniques are most frequently used to provide symptomatic relief and a sense of well-being in treating chronic diseases for which Western medicine has no cure. Although clinical proof of the efficacy of such techniques is often lacking, traditional medicine provides a level of patient satisfaction and acceptance comparable to Western medicine treatments and is highly valued in many Asian cultures."

In several Asian countries, the Church is one of the pioneers in this line.

3.3. Constraints Arise out of Globalization in Asia

The health sector has suffered one of the highest onslaughts of globalization. The liberalization and free-market trend has come to reign in this field. There is a concomitant factor that helps this process. Technology has become an important component for health. Increasing research into technologies for health care have opened new areas of treatment that brings a cure to people who had no means earlier. Hence today the cost element has become an exorbitant one. It looks as if only persons having money sources have a right to live or be liberated from diseases.

"In the developing countries where Research and Development (R & D) outlay is very small. For example in India it is barely 0.8% of GDP amounting to $3 as against $700 in Japan, $600 in the U.S., $ 300 in most European Countries and $70 even in South Korea. Further the developing countries cannot compete with developed economies in terms of original research for sheer financial constraints. It is estimated that it takes more than $100 million to bring a new molecule into the market and some $359 million to get one new medicine from the laboratory to the Pharmacist's Association of America. This acute asymmetry in the R&D profiles of developed and developing countries is only a reflection of the political profiles of developed and developing countries, as well as the low profile role of the former"[4].

The globalization process has also introduced a mechanism in several Asian countries to cut the subsides for the health sector. This has made the lives of the poor more miserable. We quote Michel Chossudovsky: "In health sector there is a general breakdown in curative and preventive care as a result of the lack of medical equipment and supplies, poor working conditions and the low pay of medical personnel. The lack of operating funds is in part "compensated" by the exaction of registration and user fees e.g. the "drug cost recovery scheme" under the Bamako Proposal…

This process, however, implies the partial privatization of essential government social services and the de facto exclusion of large sectors of the population (particularly in rural areas) which are unable to pay the various fees attached to health…

The result: with the exception of a small number of externally funded "showpieces", health establishments in sub-Saharan Africa have de facto become a source of disease and infection. The shortage of funds allocated to medical supplies, including disposable syringes, as well as the price hikes (recommended by the World Bank) in electricity, water and fuel (e.g. required to sterilize needles) increase the incidence of infection (including HIV transmission.) In sub-Saharan Africa, for instance, the inability to pay for prescription drugs tends to reduce the levels of attendance and utilization in government health centres to the extent that health infrastructure and personnel is no longer utilized in a cost-effective fashion."[5]

The increasing cost of technological investment in health care institutions like hospitals, the high cost of medicines as well as the high cost of medical professionals particularly the specialized professionals, have created a contradiction in most of our Catholic health care institutions; an increase in the cost of services to the clients thereby making the medical services available only to the well off. Even though Church personnel want to serve the poor, they are unable to do so because of the cost of maintenance of the services. In the absence of government subsidies, the increase in the privatization of health care and its rising costs in the absence of social security schemes, the Church in Asia faces a dilemma when it comes to serving the poor, especially in south, southeast and central Asian countries.

4. Some Suggestions to Remedy the Health Care Needs

– The Church personnel who are already present in the Dispensaries or Primary Health Centres, as well as in health projects and health extension care are the only hope for the poor. They should be able to concentrate on health education and more preventive and promotive health cares. Such preventive health cares programmes like immunization drives should be made widespread against all infectious and parasitic diseases such as malaria, tuberculosis, polio, measles, and tetanus.

– Through a process of health

education, promotive health care must be introduced in terms of nutritious food habits, hygienic practices and environmental hygiene. Through this process of health education the community becomes the guardians of its health. In this process maternal and child health and family well-being will be a main focus.

– In order to effect it there must be changes in the organization and management of health services. They should make health an integral part of development and formulate the principles underlying inter-sectoral activities that are acceptable to the members of a multidisciplinary planning team. This will involve the following:

- the participation of the community and its role in the organization of health care;
- priority given to preventive medicine and health education;
- the insertion of the programme in general community development programme.

– Health care and economic status are closely linked and hence an animation programme towards integral human development whereby people will work to liberate themselves from the social forces that enslave them and improve their economic base.

– There must be very good integration of all the health infrastructure in that area consciously maintained by people. The Church must help the people in villages to organize themselves into village health associations to ensure that the services of rural centres, dispensaries, mobile health units and district hospitals are well coordinated and integrated in their activities.

– The Church with the help of the people must also do a health planning process by which they tackle the following:

- the existing mortality and morbidity rates (diseases and accidents);
- the geographical distribution of the main diseases;
- the proportion of diseases and deaths that can be eliminated with available means;
- food and nutrition: per capita food supply, consumption habits and nutritive value of the main food stuff, per capita protein-calorie intake;
- the water resources, their quality and their role in the transmission of pathogenetic vectors and problems connected with the disposal of refuse and human waste.
- The best utility of the available health economic and financial resources as well government programmes and facilities.

5. Conclusion

We have given glimpses of the vast social reality called the Asian reality. We have tried to scan through the existing situations in Asia to describe, to analyze and to propose measures for the future. We have kept in mind particularly the poor and the marginalized groups as target groups which should benefit to the maximum from the health care delivery system. The particular context of globalization urges us to study the matter more in depth continuously so that we are alert and develop the capacity to serve the poor in Asia. If the Church cannot show her concern for the poor, she has lost her identity in Asia. Hence we have kept particularly this perspective in mind and have offered some proposals. We are sure that the Church, because of her commitment and option to the poor, will continue to serve the poor and become the hope for new life in Asia.

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India

Note

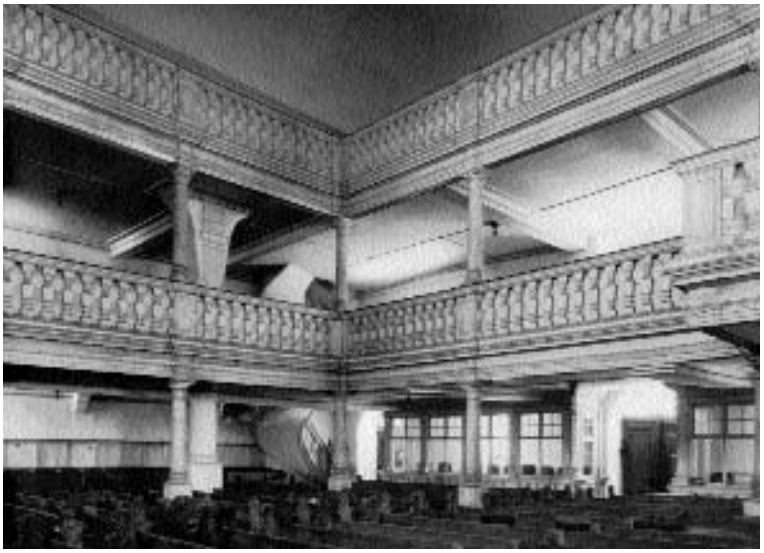
[1] JOHN W. PEABODY M. OMAR RAHMAN, PAUL J. GERTLER, JOYCE MANN, DONNA O. FARLEY, JEFF LUCK, DAVID ROBALINO, GRACE M. CARTER RAND, *Policy and Health Implications for Development in Asia*, Cambridge University Press 1999, pp. 2-3.

[2] *Ibidem* p.4.

[3] *Ibidem* p.139.

[4] COMECE: *Responsabilité de L'Europe pour le développement Mondial: Marchés et Institutions Après Seattle,* Bruylant-Academia, Belgium, ver. 2000, pp. 130 - 131.

[5] MICHEL CHOSSUDOVSKY, *The Globalization of Poverty – Impacts of IMF and World Bank Reforms,* Zed Books Ltd, London, 1997, p. 71



MARIA DEL CAMINO AGÓS

6. Europe

1. Introduction

As a hospital sister, I would like to thank the organisers of this conference for having offered me the opportunity to speak in front of you. I hope that the matching of the name of the religious congregation to which I belong and the subject of my paper will be reflected in the interest that I hope to generate in you. During the course of my paper we will touch on three fundamental concepts: the identity of the Catholic hospital; the situation of hospital institutions in the European context; and human suffering caused by illness, as a basis of the work of the Church in the world of health care. After commenting on certain general aspects, I will describe the situation of hospital institutions in Europe and then conclude with the challenges that Catholic hospitals face in this continent as well as offering, lastly, some conclusions.

The participation of the Church in health care is rooted in the healing ministry of Jesus Christ. Dialogue and the exchange of ideas, such as are taking place in this conference, offer us the opportunity to discern the way in which the Spirit moves us to live out this ministry in the new millennium. Illness and pain have always shown themselves to be human situations in which man becomes increasingly aware of his own limitations. These are thus situations that are particularly propitious for an encounter with the divine. At one time to speak in Europe of 'Catholic hospitals' was unnecessary given that most, if not all, of the institutions dedicated to caring for the sick belonged to the Catholic Church. Still today there are hundreds of European hospitals whose origins are to be located in the Church's devotion to the sick.

At the beginning of the twenty-first century the situation is very different because, as is logical, we have not arrived where we are suddenly but through a gradual process. This process has been characterised by the secularisation of European society and the European nations, together with health being seen as a public good, which, as a result, is subject to the direct regulation and promotion of administrators. In this way, increasingly limited space is left both to the Church and to other institutions that uphold their own legitimate interest in continuing to provide forms of health care to European citizens.

At the moment, however, it is not only the role of the Church in European health care systems that is in crisis. In a society characterised by permanent changes, the health care systems are subject to a constant debate regarding their funding, their limits, the definition of their objectives and the best kind of organisation to achieve such goals, their legal responsibilities, and the application of new ethical criteria.

To speak about the crisis of health care in Europe could appear to be a contradiction, especially when it continues to be the model to which many countries, and in particular developing countries, refer to guide their own development at the level of health care. There are, however, grave basic problems which, indeed, should encourage us not to fall into a state of self-congratulation. Amongst these, there stand out the incorporation of technical and therapeutic progress into health care practice in a way that is compatible with a situation of increasingly limited resources. Technological progress generates a growing demand which the biotechnological market generates by its very nature. In line with elementary economic law, supply generates demand. However, in the field of health care the supply can become limited and in addition it is based upon a principle of well-being seen in ideological terms.

In this way, every form of progress, however expensive it may be, gives the right to any European citizen to claim it in a systematic way, making the list of 'health care problems' even longer, problems that tend to include increasingly simple physiological variations – like, for example, baldness or the shape of one's nose – which previously were never seen as illnesses. In this way, citizens are not aware of their own responsibility, or to express the point better, of their own irresponsibility, when they turn in an exaggerated way to the health systems. After becoming a free and unlimited consumer good, a right that has been finally acquired, medicine has transformed any pain, any kind of suffering, even when it is transitory and irrelevant, into a need for medical technical action. The indiscriminate use of health care systems thus creates the pre-conditions for a future disaster.[1] Individuals think that they can expose themselves in a limitless way to any health risk in the belief that the system will protect them: overeating, the taking of drugs, the use of alcohol and tobacco, and indiscriminate sexual relations all belong to this category. Such a fantasy regarding the unlimited resources of health care systems proclaim their future failure and the need for deep changes which should be based upon the responsibility of the person and on the adoption of a well established system of values. The crisis of resources has also afflicted the European health care systems, and the philosophy of 'sustainable development' begins to be applied to European health care as well (Gracia Guillen, D, 2001, n. 4). The old

question posed by Fulford as to whether medicine should be seen as a branch of ethics[2] can be answered at the present time only in the affirmative.

Hospitals are not extraneous to this debate. For centuries, hospital institutions were seen as the centre of health care systems, the very *sancta sanctorum* of medicine. In them were achieved the most important advances in the fight against illnesses and in them as well were concentrated the financial and human resources allocated to health care. At the present time about 60% of health care expenditure in Western advanced societies – which represents 8% of GDP in Europe and 14% in the United States of America – is allocated to hospitals.[3] However, in recent years this traditional vision has lost force. The crisis of hospitals has given rise to the increasing importance of primary care and to health care structures outside hospitals or day hospitals, within a general effort directed towards containing or limiting hospital budgets.

For this reason, Catholic hospitals in Europe are faced with a dual challenge. On the one hand, the challenges posed at a general level to any European hospital institution; on the other, the specific challenges raised because of their Catholic character. In the sections which now follow we will engage in an analysis of these two aspects before going on to provide certain conclusions.

2. Hospital Institutions in Europe

According to the World Health Organisation, we can define a hospital as *an integral medical and social party whose mission is to provide the population with complete medical-health care assistance, of both a curative and preventive character, and whose services extend to the family context. A hospital is also a training centre for health care staff and a research centre*. Its purpose is thus to restore health, which, according to the definition of the World Health Organisation, is a state of *complete physical, mental and social well-being, and not the mere absence of illness*. Later on in this paper we will return to this definition, which from my point of view is insufficient.

In industrialised societies, such as European society, hospitals are highly complex institutions in which are to be found the interests and the aspirations of various groups. The first of these, which is also the largest, is that of the sick and their family relatives (even though at times the interests of these two sub-groups do not coincide). However, the staff engaged in providing treatment and care also play a fundamental role. This is a group largely composed highly qualified health care professionals, managers or directors, and owners – politicians in the state system and property owners in the private sphere. The confluence of these groups give rise to a system of great interaction and social encounter, where the possibilities for conflict are always high.

Given that these are structures of a high level of social interaction, hospitals rapidly reflect the changes that take place in the social and health care environment in which they are located. First of all, with regard to social changes in general, we need to refer to globalisation and the change in economic and social structures that this process involves, and which in Europe manifests themselves in a special way with the problems caused by integration. For that matter, we should also take into account the rapid development in information and computer technologies that is taking place within so-called 'information society'. At the beginning of this paper reference was made to the need to introduce profound changes into the approach of welfare systems, of which health systems form a part, which should be accompanied by discussions in the political domain about the role of the state in health care and the systems of fundamental social and ethical values. Some of the subjects of such a debate are, for example, justice, equal opportunities, and the responsibility of citizen s.[4] Lastly, we need to bear in mind the consequences of demographic change, above all the ageing of the population, (Tab.1) which involve the fact that the proportion of people of sixty-five or over will constitute 16% of the European context until 2010, although in certain regions, such as Eastern Europe, the percentage may reach the figure of 18%, according to a report on population of the European Commission of 1995.[5]

Parallel with these social changes, the health care sector in European countries is undergoing a period of rapid transformation which is expressed in the following aspects. First of all, there are strict limitations on government health budgets which are not likely to be changed and which are accompanied by the making of economies in health care policies with the application in this field of concepts and strategies that come from other areas, such as market methods, As a result, it is thought that the funding of health care systems is already at its maximum and that consequently advance must come from an improvement in the provision of services and in control of quality: in the near future 'rationalisation' and 'rationing' will be the key words.

On the other hand, it is probable that we will witness an accelerated advance in medical technology, even though more controls will be increasingly required before such innovations can be made available to patients, above all else in the public sector. This fact can have repercussions in particular in hospitals, which have developed in particular as institutions in which the most advanced technology is concentrated. Technological advance will increase the fragmentation and the specialisation of medical services but will also help to dehumanise them because the patient will be increasingly less seen as an overall human being. This explains the increase in alternative medicine, which is based above all else on a return to the relationship between the medical doctor and his patient; a relationship, indeed, which is seen as a powerful instrument of therapy. Lastly, it is probable that important changes will take place in the expectations and requests of patients, and regulatory measures are to be expected in such areas as the responsibility of patients as well as an increase in their individual financial obligations as regards such spheres as participation in meeting the expenditure on certain services or the creation of insurance policies.

Another element of great impor-

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ab. 1

Changes in the Size of the Elderly Population (Age ≥ 65 Years) in Europe: 1950-2010

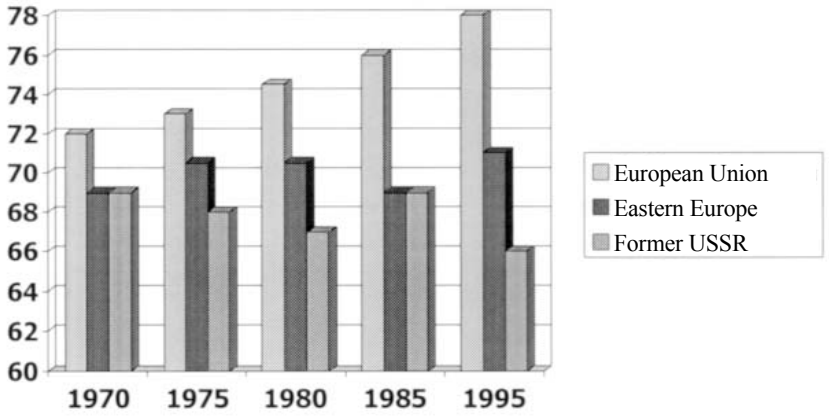
	% Elderly Population				% Changes in the Elderly Population		
	1950	1970	1990	2010	1950 1970	1970 1990	1990 2010
[1]East	7,0	10,4	11,3	13,5	2,0	0,4	0,9
North	10,3	12,7	15,5	16,1	1,1	1,0	0,2
South	7,4	9,9	12,7	16,3	1,5	1,3	1,3
West	10,1	12,8	14,5	17,9	1,2	0,6	1,1
EUROPE	8,7	11,4	13,4	16,1	+1,4	+0,8	+0,9
15-64 y.	65,9	63,6	67,0	66,2	-0,2	+0,3	-0,1
0-14 y.	25,4	25,0	19,6	17,6	-0,1	-1,2	-0,5

[1] East: Bulgaria, Czechoslovakia, Slovakia, Hungary, Poland and Romania
North: Denmark, Finland, Iceland, Ireland, Norway, Sweden, United Kingdom
South: Albania, Greece, Italy, Malta, Portugal, Spain, the region of former Yugoslavia
West: Austria, Belgium, France, Germany, Luxemburg, Holland, Switzerland

European Commission, 1998

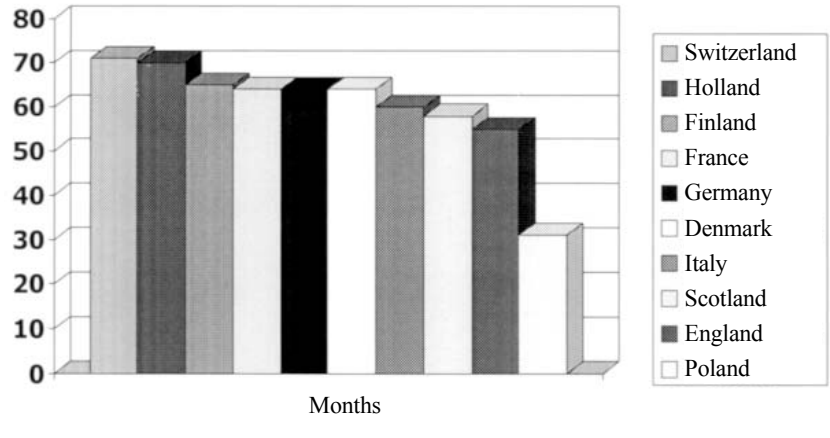
ab. 2

Life Expectancy at Birth in Europe



ab. 3

Survival Times of Patients with Cancer of the Rectal Colon



tance that should be borne in mind is the great differences that exist in relation to health and health care within the continent of Europe, a reality that has led such authoritative figures as McKee to talk about a 'divided continent'.[6] On the whole we tend to refer only to the European Union, very often forgetting about the situation in Eastern Europe, and about the former Soviet Union as well. For example, as regards life expectancy (Tab. 2), the countries of the European Union have experienced a sustained increase in levels of life expectancy over recent decades (a figure of plus six years since 1970), whereas Russia went in the other direction, with a recovery in 1985 at the time of the campaign against alcohol of the Gorbachov government. The countries of Eastern Europe are in an intermediate situation, but one which is clearly negative if compared to Western Europe. Another significant example of this state of affairs is survival in case of serious illness (Tab. 3). For example, a Swiss or Dutch citizen has an average rate of survival double that of a Pole who develops the same illness.

In these social circumstances and in this health care context, we need to pose a series of questions about hospitals in Europe:

– Should they continue to play the central role that they have had so far in health care systems? What should be their scale and size? What services should they offer?

– What concept of health is suited to hospital institutions in Europe?

– Are the services that they offer cost-effective? Could they be offered in a better way in other health care structures, for example in day hospitals?

In essential terms, we are dealing here with verifying whether hospitals meet the objectives for which they were created and if they do so in an efficient way. Providing an answer to this question is not easy for a series of reasons. First of all, because of the heterogeneous character of the concept itself of 'hospital': the term 'hospital' is applied to very different health care centres, even within the same country, and as a result comparisons are practically impossible. If we examine what takes place in various

countries, we realise that each of them has inherited a different hospital system both as regards the distribution of resources and the role played by hospitals within the health care system. For that matter, each European country is faced with different challenges, with very different health care problems, and very different expectations regarding population growth. As a result, it is not clear whether the search for homogeneity is in this case a virtue. Consequently, if we take into consideration certain comparative statistics we should not draw hurried conclusions. For example, if we analyse the relative number of hospital beds in the various European regions[7] (Tab.4), and if we study the differences between the various zones, we cannot fail to observe the decrease in hospital beds in the former Soviet Union or in Eastern Europe. This is probably because such hospital beds play a very distinct role within each individual health care system.

Taking all these factors into account, we can venture to formulate certain opinions about how European hospitals will evolve and develop in the future.[8] Health care systems will not be centred so much around hospitals and more attention will be paid to the organisation of processes and health care circuits than to the concrete localisation of services. For example, how care for the victims of road accidents will be organised (with all the systems involved such as emergency health care transport, trauma services, emergency services, blood banks etc.) will be more important than the concrete localisation of services inside or outside the hospital. As a consequence, and this is a fundamental difference compared with the past, the very existence of certain hospitals will be called into question, as well as the presence in them of certain services that so far have derived from an immemorial tradition. Decisions about hospitals will be taken at different levels of planning, and not only by the managerial bodies of hospitals themselves, taking into account both present and future needs.

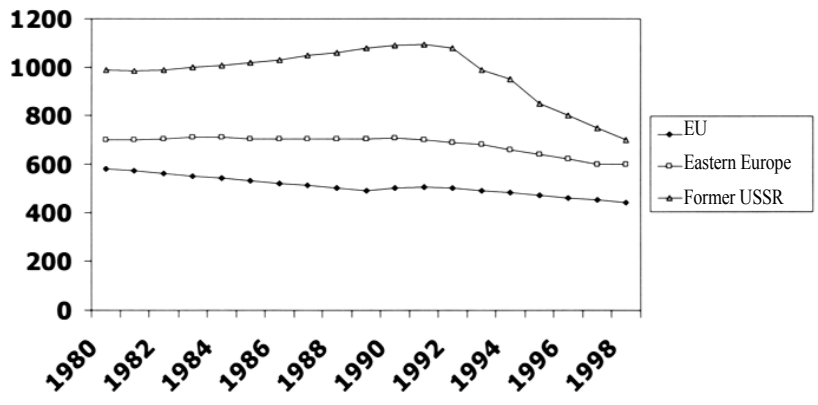
The technological instruments of European hospitals will also change, opening up new diagnostic and therapeutic possibilities. The challenge will then be to rapidly adopt the new technologies in the same way as other companies must adapt to a context that is in a state of constant evolution, technological development will tend to economise on the days spent in hospital, and for this reason, in turn, the need for hospital beds will diminish and health care centres will become smaller in size. This will bring with it another series of advantages, such as offering a more humanised environment without, however, reducing operative capacities. The surgical day hospital is an example of this, an institution which needs a larger number of surgeons.

What will then happen to long-term patients who are often elderly people and who need special forms of care and treatment and cannot be discharged? They will be transferred into other health care centres where the technological component will give way to rehabilitation, to forms of nursing care, and to improvements in quality of life. This tendency is already emerging in some countries, such as the United Kingdom (Tab.5) and Spain, where it is calculated that in 1998 there was a shortage of 200,000 residential places for disabled elderly people.

Elderly people are only one example of the needs of special groups. In a context of growing need on the part of users, hospitals must provide solutions in the form of complete care processes which

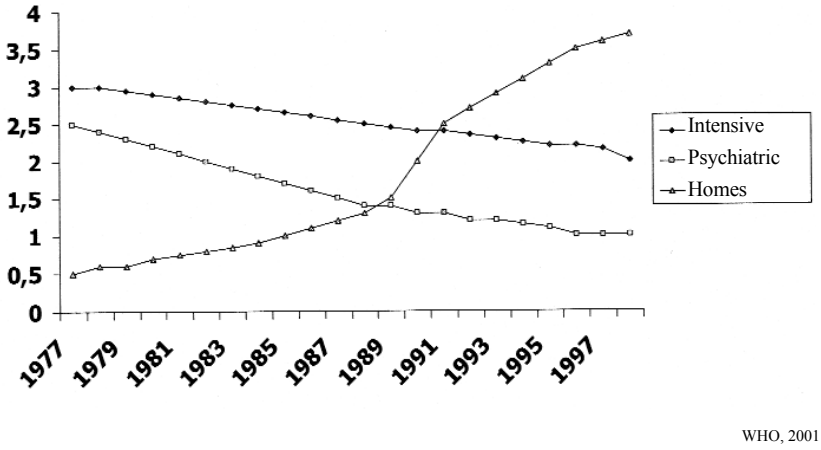
Tab. 4

Number of Beds in Intensive Care Hospitals
for Every 100,000 Inhabitants in Europe



Tab. 5

Trends in the Number of Beds
for Every 1,000 Inhabitants in the United Kingdom



can be organised adequately only in contexts on a larger scale than their own health care centres. This involves a loss of autonomy on the part of such centres, but also an enrichment, according to the extent to which their connections with other health care institutions increase. European hospitals need investments, often investments allocated to the renovation of obsolete structures. Commitment to quality also concerns the hotel aspect of hospitals because this is something bound up with the satisfaction level of the patient. Lastly, these goals cannot be possible without the suitable training of personnel and staff and a commitment to research which, in order to be objective, must be as independent as possible. We cannot accept, as us often the case, that the pharmaceutical company is the only body that finances training and research in European hospitals. The time has passed when every hospital had to tackle on its own all the challenges in front of it and saw turning to other centres as a sign of inadequacy. The solution to many problems lies in the creation of networks and alliances between centres, specialisation and the distribution of tasks, and the future sharing in the results and progress achieved.

3. Catholic Hospitals in Europe

It is evident that European Catholic hospitals do not escape any of the challenges and trends that have been commented upon in this paper. For this reason, their survival depends in part on how they adapt to these challenges, taking into account the fact that within the context of a secularised society and with a health care system which is for the most part state run they must be increasingly agile and efficient compared to other health care centres. More specifically, this situation has meant that many religious institutions have abandoned their work in hospital centres, even though we do not have concrete statistics on the breadth of this phenomenon. For that matter, the great challenge of Catholic hospital institutions is the conservation of their identity. It is difficult to offer up-to-date statistics on the presence of the Catholic Church in hospital care in Europe. The statistics that we have been available to put together beginning with the Index of 1994[10] are summarised in this table (Tab. 6). Although these statistics are incomplete both because of the developments that we have been able to monitor in recent years and because the differentiation between the centres is very complex, we can draw certain conclusions. The presence of the Catholic Church in European hospitals is still important, especially in that category of centres – institutions for long-term patients – in which the highest number of beds is found, as we have already seen in this paper. And it is probable that the number of beds for the seriously ill per hospital will go on declining – this, as we have already observed, is a general trend in the whole health care sector.

Tab. 6

The Church in European Hospitals

Europe	N.	%
Hospital institutions	2.851	30,15
Health care homes	1.498	15,76
Homes for the elderly	3.860	40,63
Centres for the chronically ill	135	1,42

Index, 1994

However, rarely has one been able to state with so much force as now that the Church plays a fundamental role in the hospitals of the Old Continent. As we have seen, many of the challenges that now face European hospitals and health care systems in general are connected with the search for values. It is in this field that the Catholic Church certainly has something to say. In facing up to these challenges and preparing for the 'struggle' two questions pose themselves: why is the Church concerned with health care and at a concrete level with hospital care? In what ways is the presence and the participation of the Church in health care different from that of other institutions? Are not all of them concerned with restoring sick people to health? In what, then, is the identity of Catholic hospitals rooted?

The Catholic Church is involved in health care because care for the sick is a fundamental part of the mandate of service of the Gospel: the Catholic health care ministry carries on the healing ministry of Jesus Christ. Catholic health care is more than mere compassion for the sick. We are convinced that illness, pain, suffering and death are part of the providential plan of God. The follower of Christ helps others to understand this plan, he experiences it and makes of suffering and death acts of redemption. To restore health means not only to return to a 'state of well-being' – something utopian or have some of you met with this state of 'complete well-being' in your lives? Without being able to discover the meaning of life to which pain also belongs 'in the explanation of itself that it receives from the glorious death of Christ the Lord' (Lozano Barragán, J. Msgr., 2000, n. 11). This truth does not eliminate suffering or pain but provides strength and trust to bear them and not to feel oppressed by them.

On the other hand, a hospital, which is the most traditional institution dedicated to serving the sick, is a reflection of European society, its conflicts and its contradictions. Hospitals are a crossroads for many baptised and non-baptised people: the practising, those who are distant from the Church, those who feel resentment towards the Gospel because of a hidden wound, and the indifferent. The Church is obliged to search for an encounter with man in suffering: in the face of pain, illness and death, man finds himself faced with his own limitations, and an exceptional moment for evangelisation presents itself. The mission of the Church, however, is not only to take care of the dying; indeed, the Church is an institution of life and not of death.

The key to the survival of Catholic hospitals lies, therefore, in conserving their own identity. It serves no purpose to ensure the maintenance of a centre if in order to do this it is necessary to make concessions that transcend the spirit of the Catholic health care institution: it is not a matter of survival at any cost. We need, therefore, to reflect on certain central features of thus identity. [11, 12, 13]

Ours is a centuries-old tradition as is borne out by our journey. If someone wants to know us, they can do so through our works where

they will recognise the effort and the dedication of religious and collaborators directed towards and centred round carrying out our mission.

The first point concerns humanisation, connected in a special way with respect for the dignity of the patient as a person. Often we can contemplate only partial forms of listening to sick people and be concerned only with certain aspects. Our objective, instead, must lie in providing overall care, by which is meant physical and psychological, social and spiritual, care. We need to try to heal the person in his totality, making the symptoms of his illness disappear or alleviating them, but also reducing his suffering, increasing his autonomy, and facilitating where this is possible his rehabilitation and reintegration into society. We must seeks to restore the health of sick people conserving their dignity and through our commitment make them the centre of our activity. All sick people, and especially the most in need and marginalized, are valuable to us. This approach must be in opposition to the depersonalisation that is often to be seen in public health care systems.

The second aspect is that connected with the training of personnel and staff. Our institutions must in particular look after the people who belong to them and try to provide them, through work, with a pathway of vocational self-realisation. The strength of Catholic hospitals lies in the extent to which the people who work in them identify with their mission and work for that mission. For this reason, all of the personnel and staff must know and share in the shared objectives, ensuring that their presence in the hospital is characterised by enthusiasm, co-operation and the taking on of responsibilities. This fact is of fundamental importance, in particular, in the face of the decline in the number of people of the consecrated life who work in hospitals; in the face, that is to say, of the crisis in vocations. It is important to be organised into work groups which consider different disciplines and professions, thereby seeking to enrich and improve the care that we provide to our patients. In the same way, we believe that on-going training is the only way by which to respond to the challenges at the level of care that we have to face and to meet the trust that our patients place in us. We need to consider research and scientific advance as paths of healing and improvement in the quality of care provided to patients, conserving an approach of a constant scientific character in our care-providing activity. The institutions that have an opportunity to carry out research must be actively involved in its implementation: we need to feel responsibility towards those who cannot engage in research. However, we should not believe blindly in scientific and

technological advance, seeing it as the only way by which to solve the suffering generated by illness. We believe in the search for spiritual peace and the meaning of existence and in the encounter with the transcendent as effective forms by which to heal the suffering of the human person.

Care for human life, especially at its beginning and its end, is also part of the essential aspects of the Catholic hospital. Its fundamental principle is that life is a gift of God: man receives life as such and administers it, trying to obtain in it the ultimate meaning of existence, namely the return to the Creator. For this reason, any implementation of death is in absolute contradiction with the mission of Catholic hospitals.

The management and the administration of resources have their own specific emphases in Catholic hospitals. Our choice is in favour of quality and diversified care as regards resources, care that is near to the patient and primarily involves care for the context, and we understand that within institutions many sick people receive only basic care. The model of management must be consistent with the mission and the established goals, but it should also be flexible and adaptable to the reality of each centre or care source. At the same time, we need to constantly strive to draw near to the processes of management and care through a model of professional clinical management so as to maintain a balance between the two and not fall into the extremes of either of these two processes.

We need to strive for efficacy, efficiency and the effectiveness of our work, bearing in mind that the appropriate use of our (economic and human) resources is of fundamental importance in achieving the success of our mission. We need to maintain the characteristic of being serious institutions, but institutions that are not austere or based solely upon economic considerations. We should not have as our aim the making of money. We must, instead, have the obligation to ensure a suitable economic reward designed to allow the continuation and the development of our institutions. As institutions that serve our mission we must give society not only certain resources but also, and especially, a way of understanding how care should be carried out: we have our specific culture and style, and we want to transmit them.

The last point on which I will dwell today is that of co-operation. We must unite our forces and wills around our mission, making possible the presence of voluntary workers, working with other social workers and institutions that have similar aims to our own, both inside and outside the Church, and actively taking part in all the professional, academic and associative contexts in which we must make our voice heard. We must transmit our knowledge, our character and our identity, committing ourselves to teaching those who want to learn from us. Through service to the sick, Catholic hospitals remind society of their existence and claim the right attention for their needs. It is not advisable to organise ourselves into a care network that is

exclusive or isolated. This network should be integrated into more general health care and social services. Because we believe in the goodness of our beliefs and our way of understanding care, we must ensure that our care reaches the largest possible number of people.

In essential terms, Catholic hospitals must identify with our mission and we must be identified through them: by being the bearers of charity and its embodiment in daily life.

4. Conclusions

Today, Catholic European hospitals are faced with very important challenges brought about by changes in society and health care systems on the one hand, and the need to remain loyal to their mission, on the other. This is, therefore, a situation of great need which tests our ability to keep alive the spirit of the Church in a critical field, the field of health and health care.

We should not forget that the first characteristic of the general situation of hospitals in Europe is the calling into question of the very existence of centres. For this reason, it is of fundamental important to abandon any form of self-contentment, not to take for granted that centuries-old traditions will in the end win out, to let society know about our mission and our style of providing care, to offer resources that are suited to the needs of the sick, and to claim for our centres the same opportunities that other centres enjoy. Our fundamental challenge lies in adapting to the moment, incorporating the new management and health care technologies, and accepting the challenges in the sphere of care that now pose themselves, yet at the same time conserving our identity. To achieve this it will become increasingly necessary to ensure that members of the Catholic laity take part in the management of centres, engaging in training, trust and joint advance.

To employ the words of Msgr. Lozano Barragán: 'the Catholic hospital is a part of the Church and as such belongs to the call by which Christ created the Church'.[14] I hope that this reflection will help us to deepen our knowledge of the challenges to be found in Europe and to understand the best way that they can be addressed.

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Superior General of the Hospital Sisters of the Sacred Heart of Jesus, Spain.

Notes

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[10] Pontificio Consiglio della Pastorale della Salute, *Ecclesiae Instituta Valetudini Fovendae Toto Orbe Terrarum* (Vatican City, 1994).
[11] J.L. REDRADO, 'Palabras de Bienvenida', *Labor Hospitalaria*, 1983, 188, 70-71.
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[14] Msgr. J. LOZANO BARRAGÁN, *op. cit.*

FRANCIS SULLIVAN

7. Australia

The Australian Context

The ministry of health care in Australia is conducted by a diverse array of ownership groups. Across our vast island continent, health and aged care services are owned and operated by the following Church structures:

Who are we?

– 69 Religious Institutes
– 17 Dioceses
– 2 Public Juridic Persons
– 31 Associations of Christ Faithful

It is a ministry alive. Spanning from west to east, north to south in a harsh and difficult environment.

A Ministry Alive

The development of the ministry has naturally followed the establishment of Australia's health and aged care systems. Historically, our country relied heavily on the contribution, and in many instances the pioneering efforts, of the religious institutes. Australia's first hospitals and major aged care facilities were established by the Catholic Church. Even today Catholic hospitals and aged care services are identified as model places for excellence in care and a commitment to high quality.

As it presently stands, the Catholic health ministry spans the continuum of care from acute health services to services in the home.

An Active Ministry

– 500 aged care services
– 330 approved resdential services
– 16,753 residential aged care bed
– 5,334 retirement, indipendent living and serviced apartments for ederly
– 58 health care facilities
– 8,500 hospital beds
– teaching hospitals
– 33 day surgeries
– 4 medical research institutes
– 5 bioethics centres
– pathology
– radiology
– expanding community and home based care.

This contribution is not only significant in size, but also in importance. The Catholic sector comprises 13 percent of the health care system. It is the only major non government owned provider to risk commercial and human resource investment in the rural settings of Australia. In other words, the Church in health care is still committed to go where others fear to tread!

Moreover, with a significant number of public hospitals, the Church is the only non-government owned health group to offer a major contribution to providing the universal access to basic hospital care. In this direct way, the Church continues to provide health care as a social good, not merely a commodity available to those who can pay.

More specifically, the Church remains the largest provider of non-government obstetric services and the largest provider of private medical specialist acute services. One in eight frail and confused elderly people needing high dependency care are served by the Church. One in six elderly people receiving care in their homes to so from the Church.

Thus the Church's ministry is very relevant and needed by a high proportion of Australians. Table 1 illustrates the nature of this partnership with government. In effect it shows how the Church's assets are being utilised for the public good.

What is paramount in undertaking this partnership is to remain clear about the identity of the ministry. Our contribution in health care is driven by our sense of mission. It is best described as being: *A mission of service, embracing sound commercial practice to maximise human dignity, promote the common good and participate in the healing ministry of Jesus.*

Table 1

Partnership: Private Asset - Public Good	Catholic	Other
Public hospital beds	10%	90%
Private hospital beds	24%	76%
Complex, sophisticated private hospital sector	42%	58%
Same day acute procedures	8%	92%
Total admissions	15%	85%

This is a carefully worded statement. It recognises the economic environment in which the ministry is conducted. It recognises the necessity for commercial prudence, but doesn't fall prey to the tendency to reduce health care to just a commercial activity. It keeps the notion of service to the fore and has the dignity of people, the prosperity of all and the witness of Jesus as both the inspiration and foundations of all that is done.

In specific terms, this mission seeks to promote a just health system where health care is understood in holistic, not just scientific terms. We seek to advocate for the poor, the marginalised and the disadvantaged. It is paramount that the health ministry looks through the eyes of the poor, understands the world from the perspective of the less well off and relates to the aspirations, burdens and frustrations of those on the margin.

Furthermore, the ministry is not limited to a social contribution. The mission of health care is to make tangible the love of God in the lives of the sick, the frail, the confused and the dying. Moments of intimacy in people's lives are also times for revelation. Ministering health care affords people the opportunity to share in the reality of God. When people are vulnerable, the health care ministry encourages a sensitivity and awareness of God's action in their lives. A gift of hope and trust.

In the Australian context, the health care ministry is conducted for the benefit of the community in general, not specifically for the Catholic community. This is markedly different to the Church's education ministry which was established to cater for the Catholic community.

Catholic health care is predominantly delivered by non-Catholics for non-Catholics. With approximately only 26 percent of the population Catholic, the Church's contribution in health and aged care stretches far beyond the Catholic community. Thus the challenge is to constantly be vigilant about the identity of the service and how to keep it relevant and viable in the evolving context of Australian society.

As with most other western democratic economies, health care is facing enormous challenges. The table below lists a number of current economic pressures on Australia's health system.

Context of Australian Health Care

– Mixed economy of Public and Private services.
– Fiscal pressures on Universal coverage – access problems.
– Escalating health costs – affordability problems.
– Deterioration in rural services, mental health care and chronic care.
– Creation of price competitive markets, commercialisation and profit incentives.
– Ageing population, deteriorating tax base.
– Expanding consumer expectations.

In short, Australia's entitlement system to health care is strained due to an ageing population, a deteriorating income tax base and a need to provide comprehensive services over a vast area of land.

Again, as with other countries, the public policy response has been to introduce market arrangements for the funding and delivery of ser-

vices. In particular, price competition has placed provider against provider in the pursuit of funding contracts. This in turn has encouraged the search for economies of scale, best achieved through consolidation of entities to share commercial risk. This results in shared or merged ownership of health services.

Whether in the public or private sectors, this type of rationalisation places individual hospitals and aged care homes at risk. It encourages the profit incentive and commercial considerations can easily displace the imperatives of the mission because the necessity to remain viable in the market is perceived to be all encompassing.

This environment presents a major challenge for the ministry. How to remain viable, thus effective and at the same time true to a service of the poor and a contribution for the common good. When health care is organised around markets, the incentives are for those interested in maximising a return on investment. The service of health care becomes regarded as a mere commodity for commercial exchange. The person is reduced to the status of a customer. His relationship with health professionals is determined within a framework of 'customer service' and the outcomes assessed similarly to those of 'customer satisfaction'. Not only the essence of health care delivery alters, but the appreciation of the whole person and the responsibilities of carers to ensure a full conduct of their duties of care become understood within a commercial rather than professional ethic.

Therefore the basic challenge for the ministry is to recognise avenues through which the market can be shaped in the interests of the sick, the frail and the poor. Often markets fail where people need extended care for chronic conditions, or suffer from disabling disease. In systems which financially reward quick, containable procedures, extended care and medical care can become too expensive and too commercially risky for many providers. The upshot is that the elderly and chronically ill experience reduced access or limited treatments. It is in these areas that the Church must remain a strong and consistent contributor.

The shift to market organised health and aged care is having a profound impact on the adjustments Catholic providers are making. The table below lists the main responses the Catholic sector is taking.

Ministry Adjustment

– Shift to collaborative processes.
– Develop new governance.
– Entities.
– Evolve "shared governance" responsibilities.
– Embrace a theology to shape the market.

Collaboration

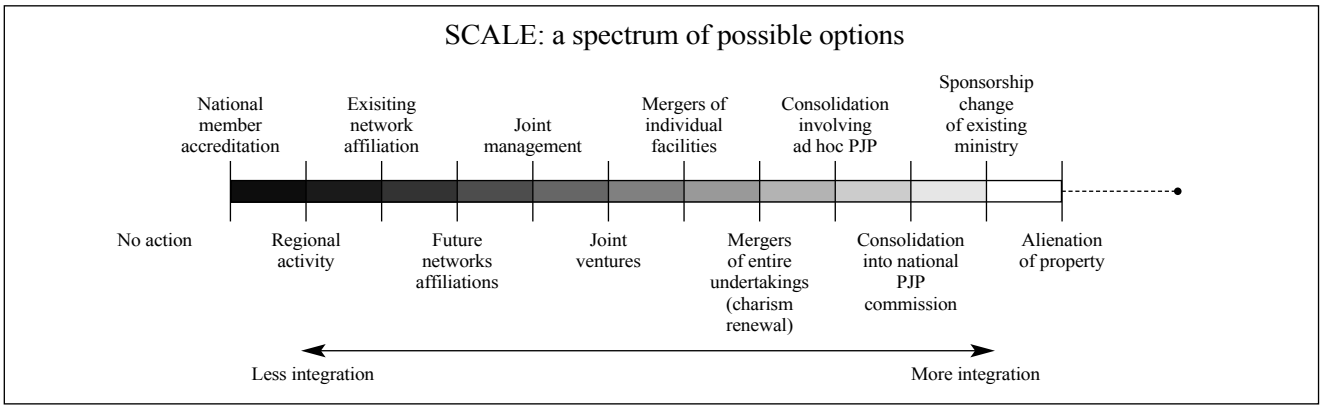
Market forces induce organizations to seek economies of scale. These can be achieved either literally through mergers or virtually through business alliances. The manner in which these economies are pursued becomes a commercial decision. However, at the same time the Catholic health ministry has a unique issue whereby its owners, religious institutes, are declining in numbers and facing a withdrawal from active stewardship. This in itself also encourages a consolidation of ownership, which in turn can facilitate more potent economies of scale.

Catholic Health Australia works to facilitate closer relationships between Catholic providers. CHA encourages collaboration as a solution to the economic and stewardship challenges facing the ministry. Table 2 demonstrates the continuum of choices available to providers seeking collaborative futures.

This continuum ranges from little engagement through to total merger. It also illustrates how ownership can shift as collaboration becomes more consolidated between providers.

In the Australian experience organizations are located along the continuum due to four main factors. The first is the capacity of the founding religious institute to participate in active governance. With the declining presence of religious personnel and their capacities to carry out the responsibilities of governance, the religious institutes must assess their longer term involvement in stewardship of the ministry. The proximity of their withdrawal from active governance motivates their desire to seek collaborative solutions. In addition, the commitment to keep the health care facilities within

Table 2 - Collaboration



Catholic health also motivates the propensity to seek out collaborative solutions within the Church.

Secondly, the evolving commercial challenges for the organization determines the degree to which it perceives threat or otherwise within the market. Where organisations assess their commercial position to be relatively strong, they normally continue to adopt a more independent approach to their future. Conversely, where organisations are threatened for a viable future, collaboration with stronger allies becomes more attractive.

Thirdly, as with all evolving human service systems, public policy changes drive institutional agenda. Thus the shift towards community-based health care has a commensurate impact on the future of some institutional health services. This may call for greater collaboration along the continuum of care and the change of ownership for some specific organizations.

Finally, the experience of collaboration is not always positive. Alliances and networks can fail. Good intentions can come undone when poor management of change or misguided structures are put in place. Mergers face the challenge of combining two or more cultures and this brings organisational tension, even inertia. Thus where religious institutes have had poor experiences with collaboration in the past, their willingness to engage again becomes tested.

New Church Structures

The reality is that new forms of governance are needed. The history of Catholic health care being identified with specific religious institutes is changing. Already in Australia new Church structures have been established to steward the ecclesial goods once under the governance of religious institutes. The canonical vehicle known as a public juridic person has been used to form collaborative structures to own and operate health and aged care services. This ensures the continuation of the ministry and enables a new expression of Church in the health ministry.

A shift in this direction involves a cultural change of significant proportions. It rightly presumes that the imperative of ministry is beyond the future of specific religious institutes and dioceses. It recognises the diminishment of some forms of ownership and the necessity for new solutions. It requires an embrace of collaboration and a 'letting go' of the familiar. In short it calls for a culture of interdependency rather than one of independency.

This movement is very much akin to a sense of Church as communion. It affirms the commitment of the Church to work together for the common good, in this case the health care needs of the community. It also acknowledges that creative solutions are needed to ensure the continued nurturing and strengthening of the ministry as an essential component of the Church's mission.

Sector Wide Governance

The Catholic health sector has developed from the efforts of individual religious institutes, dioceses and lay organizations. The future calls for a collaborative response based on interdependency. This in itself challenges the canonical responsibilities of those charged to steward the ministry.

Whereas in the past health and aged care services were governed, both canonically and civily, by a single religious institute or diocese, there are going to be many instances where new governance arrangements will need to apply.

The economic pressures on hospital and aged care services are no longer local. They are regional at best and often national. They call for control from a recognised organization that has the best interests of the ministry at heart. Note that this is very different to a control function of a single entity seeking the best interests of that entity alone.

From a practical perspective, this means that the future planning of services, even the long term ownership of those services, involves not only the organization running the services but the interests of the Church in the ministry.

Most owners of Catholic health care can rightly claim that their canonical responsibilities are theirs alone. That no other organization has a right to interfere with the stewardship of that particular ministry. However, when aggressive market forces or powerful economic pressures threaten the presence of the Church's health ministry in a particular region, the responsibility to preserve that presence falls beyond just the specific stewards of the ministry.

As such it calls for a 'shared governance' in the best interests of the ministry. This is a new concept and will require patience to evolve. It requires a specific organization, such as the national association, to be given the authority to oversee the development, nurture and strengthening of the ministry.

The potential for conflict is obvious. By its nature it will traverse the traditional functions of dioceses and religious institutes. It will seek collaborative solutions and stake a claim as a participant in ownership and service planning. Thus it will have to strike the balance between local Church identity and the commercial viability of the ministry.

A Theology of Market-Driven Health Care

Central to the identity of the health ministry is a preference for the poor and disadvantaged. This means far more than an accommodation for the poor when convenient. It means seeking to advance the interests of the poor as a matter of priority. This requires adopting a perspective where the poor, the disadvantaged and the marginalised are foremost in the mindset of policy makers.

In many ways a market orientation runs counter to the interests of the poor. Markets work best where supply and demand operate without interference. This presupposes that prices are set to maximise a market share. Consumers determine not only what is produced, but where and in what supply.

When it comes to essential human services, like health and aged care, markets challenge providers to be cost effective and responsive

to consumers. But they also can fail. They fall well short of providing for the needs of those people who don't provide a satisfactory return on investment or are too costly to serve. In many instances the elderly and chronically ill lose out.

When a health system is organised around market incentives, the role of government is crucial. So too the role of Catholic health. A commitment to the poor requires protecting their interests as the market plays out in access to health care. This means that boards and executives of Catholic providers need to adopt a theological framework for operating in the market. The table below lists the type of considerations boards could take in order to keep the preferential option for the poor central to their daily deliberations.

– Catholic presence in the system has an "ethical agenda", i.e. it liberates, does not oppress.

– The intention of Catholic health is to ameliorate market failure, not maximise market share.

– The purpose of the health ministry is to produce social goods and services, not commercial commodities.

– Commercial considerations are motivated to pursue prudent cost recovery, not stretch market tolerance.

– A board or executive team should adopt a "person first", non "profit first" motive.

– When planning for the organisation, the disposition is to pioneer essential services, not capitalise on lucrative measures incentives.

– From a social perspective, the Catholic organisation challenges existing paradigms to improve timely access, not pander to particular interests to appease notional whims or to uphold beneficial arrangements.

– A Catholic organisation places the imperative of mission before the lure of security, comfort and certainty

– Strategic decisions are taken which embrace the "folly of sacrifice" not the rational security of self-interest.

Conclusion

The imperative to continue the healing ministry calls for creativity and persistence. Making a contemporary response amidst challenging economic and social trends must be motivated by the Holy Spirit and sustained by a belief that we are all greater than the works we seek to provide. The testament of time gives hope that the ministry is robust and adaptable and can prevail.

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FIORENZA DERIU

The Survey of 'Federations, Associations and Groups Connected with Catholic Institutions Working in the Health Care Field. What Sustainability for the Future?'

The Aims of the Survey

1. The identification of the principal Catholic federations and/or associations working in the health care field and their networks of connection at a local level.
2. The identification of other forms of associative union of a Catholic inspiration working in the health care field and their networks of connection.
3. To explore the more general conditions of the sustainability of these realities with reference to:
– the economic, human and professional resources that are available;
– programmes of specific training in the sphere of pastoral care in health and pastoral care in relation to bioethics;
– the management of projects of health care that are financed;
– the spread of bioethics committees, and their guiding principles;
4. To identify the principal sets of questions and issues that the Catholic health care world has to address.

The Hypothesis of the Project

The sustainability of the work of Catholic institutions working in the health care field is influenced by the economic-financial and human resources that are available; by the level of diffusion of the connecting networks between these realities and between these and the bishops responsible for pastoral care in health.

Methodology

The survey was carried out during the course of 2001 in 121 countries belonging to seven continental regions: Western and Eastern Europe, North America and Central and South America, Africa, Asia, Oceania, and the Middle East. This was an exploratory study in which an attempt was made to identify the great questions relating to the Catholic health care world, a world that would possibly be returned to later with *ad hoc* research projects having clearer and more defined work plans.

In order to gather data, a semi-structured postal questionnaire was used which had to be filled in with care by the 127 bishops who were responsible for pastoral care in health[1] in their respective countries with the help of a group of experts on the position of Catholic hospitals and institutions working in the health care field. However, in many countries in which these bishops work Catholic health care institutions do not exist, either because they are not allowed by the laws of the State or because this kind of presence on the part of Catholics is still at an initial stage. For this reason, the number of bishops who had the effective opportunity to respond to this questionnaire at the time of the survey was seventy-six.

The questionnaire, which was translated into four languages, was accompanied by a number of instructions relating to its proper compilation. The data from the duly filled in questionnaires were placed in a computer and analysed on the basis of a precise system of analysis, whose results we will now summarise.

The Results

Of the seventy-six bishops who were able to answer the questionnaire, 71%[2] duly filled it in the right way.

1. The Principal Federations and Associations of Catholic Inspiration Working in the Health Care Field and their Connecting Networks

In connection with this first objective of the survey, it should be pointed out at this point that at the present time a complete map is being drawn up of Catholic NGOs and their respective strategic objectives, the world of federations and associations, and the groups of people that were indicated by bishops during the course of this survey. The bishops were asked if they knew about Catholic non-governmental organisations, associations or federations representing religious institutions or bodies, or 'groups of people' of a Catholic inspiration active in the health care field. The answer to this question revealed, at first reading, a comforting fact: very high percentage levels which are expressed in the following table:

Table 1: Knowledge of Catholic NGOs, Associations or Federations, or 'Groups of People' Working in the Health Care Field

	Yes	No	No Answer	Total
Catholic NGOs	88.9%	11.1%	-	100.0%
Associations/federations	85.2%	13.0%	1.9%	100.0%
Groups of people	79.6%	18.5%	1.9%	100.0%

Emphasis should be placed on the high percentage levels of knowledge about 'groups of people', elements which in general do not have the same visibility as the NGOS or the large associations and federations but which, if they are known about by the bishops, clearly engage in work of major impact in the local areas.

However, the relations, and the connecting network, between the bishops responsible for pastoral care in health and these bodies do not seem to be very deeply rooted as a method of work. The answers to the question about the *frequency* with which these bishops meet such associations and federations or the representatives of religious health care organisations may be categorised as follows:

Table 2: Frequency of the Meetings between Bishops and the Representatives of Catholic Associations/Federations or Religious Organisations Working in the Health Care Field

	%	% retro-accumulated
Every month	15.2%	100.0%
Once every three months	13.0%	84.8%
Twice a year	26.1%	71.8%
Once a year	32.6%	45.7%
Never	6.5%	13.1%
No answer	6.6%	6.6%
Total	100.0%	

If one considers that over 70% of those answering the questionnaire said that at the most they met such representatives twice a year, and that only less that one in three of those answering declared that they did this more often, it is possible to observe that the contacts between these bishops and the bodies working in their local areas are rather limited and narrow, and to argue that they should be further intensified. When the same question was posed in relation to 'groups of people', a totally different trend was evident: the bishops, in fact, seem to have more frequent contacts with such realities – at least 'once every three months'. Such informal realities, therefore, seem to favour the establishment of forms of dialogue and co-operation with these local bishops.

If the analysis is broadened to the various continental areas, the recurrence of a rather interesting fact emerges. The areas where the contacts between these bishops and associations/federations are more frequent are Europe (where networking has by now become a real and authentic work method that is energised by a shared cultural inheritance) and Latin America. This practice appears to be less consolidated in areas where a series of factors are at work that significantly complicate the concrete possibility of working through a network – one need only think of the contingent difficulties linked to moving around local areas a lack of infrastructures, or the inadequate level of telephone systems, war situations, guerrilla warfare, and inter-ethnic conflicts.

However, it should be remembered that funding comes through the NGOs and States. Dialogue and contacts with such realities at a local level should, therefore, be intensified so as not to lose opportunities of obtaining funding precisely where such funding is most needed.

This in fact is already underway, as is indicated by the data relating to the meetings with the 'groups of people' that work locally. The percentage of bishops who declared that they met such groups is very high, not only in Europe and Latin America but also in Africa. In Asia the percentage remains, in this case as well, low, and this stresses the influence of other factors.

2. The Identification of other Networks for the Connection or Co-ordination of Realities that Work Autonomously in the Local Area

In order to enlarge our knowledge about networks of connection in the local areas, the bishops were asked if they knew about autonomous networks for the co-ordination of realities working in the health care field. The answers to this question may be categorised as follows:

Table 3: Knowledge of Autonomous Networks for the Co-ordination of Realities of a Catholic Inspiration Working in the Health Care Sector

	%
Yes	72.2%
No	18.5%
No answer	9.3%
Total	100.0%

Answers in the affirmative were mostly concentrated in the abovementioned continental areas. This fact may amount to information that indicates a greater presence of such networks precisely where the need is more pressing or where the cultural of working through networks has become an established fact. The spread of autonomous connecting networks working in the local areas is thus very significant: this suggests the existence of a basic need for contact and co-operation. The local Churches could play a very important role in becoming meeting points for different resources.

What provokes worry is that despite the situation of many Churches working in countries that are especially afflicted by grave economic, political and health care emergencies, the question of the creation of networks of connection and support is not seen as being of primary importance. Indeed, the last question in the questionnaire asked bishops to express a view on the questions that they believed to be most urgent when it came to the management

and organisation of Catholic health care institutions. Their answers may be categorised as follows:

Table 4: The Most Important Questions and Issues (Multiple Answer Analysis)

Urgent questions and issues	% of all answers	% of all cases
Lack of connecting networks	8.9%	26.4%
Low numbers of Catholic health care staff	20.9%	62.3%
Inadequacy of funds	24.7%	73.6%
Difficulties in drawing up training projects	7.0%	20.8%
Inability to perform roles in pastoral care in health	11.4%	34.0%
A local health care emergency	13.3%	39.6%
Other questions and issues	13.9%	41.5%
Total	100.0%	298.1%

From the analysis presented in table 4, it emerges that each bishop who answered the questionnaire on average pointed to three possible urgent questions (298, 1/100=2.98), and amongst these those of primary importance were 'inadequacy of funds' (24.7% of all answers) for 76.3% of those who answered; secondly, 'low numbers of Catholic health care staff' (20.9% of all answers) for 62.3% of the bishops; and thirdly 'local health care emergencies' (13.3% of all answers) for 40% of the bishops.

Connecting networks were indicated as an urgent question only in 8.9% of all the answers and by just over a quarter of the bishops. It is clear that this subject, which requires material human resources if it is to be addressed, failed to emerge as a problem because of a series of contingent factors, in large measure of an economic and local health care character.

3. To Explore the More General Conditions of the Sustainability of the Work of Catholic Health Care Institutions in Relation to:

3.1. Possible professional, human and economic resources

Those who received the questionnaire were asked to indicate the legal status mainly adopted in each country by a certain number of Catholic health care institutions, namely hospitals, clinics, nursing homes, rehabilitation centres, consultancy centres, orphanages etc. Of course, for each heading more than one option could be chosen. An analysis of the multiple answers gives the following result: the legal status mainly adopted by the above-mentioned Catholic health care institutions was primarily 'private' and only secondly 'public'.

Table 5: Analysis of Multiple Answers Regarding 'Private' Legal Status

Types of Catholic health care structure with a 'private' legal status	% of all answers	% of all cases
Hospitals	39.7%	61.4%
Clinics	47.3%	66.7%
Nursing homes	55.6%	76.9%
Orphanages	53.5%	74.2%
Rehabilitation centres	53.1%	74.3%
Consultancy centres	50.0%	75.9%
'Public' Catholic leper hospitals	46.4%	56.5%

In about 40% of the answers relating to hospitals, well over 60% of the bishops declared that their most common legal status was 'private'. The 'private' legal status was also indicated for the nursing homes, orphanages, and rehabilitation centres, with very high percentages in terms of the total answers, respectively 55.6%, 53.5%, 53.1%, by over three-quarters of those bishops who answered.

The only exception was that of leper hospitals, where the 'public' legal status prevailed. This fact is of great interest if takes into consideration the programmes that have been promoted in recent years by the World Health Organisation. This means that where there is a will there is a way.

The bishops also answered a series of questions about religious, voluntary, auxiliary and medical staff and personnel. In all cases most of the bishops replied that such professional figures were 'insufficient' in numbers given needs that prevailed. The results in percentages were as follows (Table 6).

Despite the limited human resources, access to the Eucharist and to the sacrament of the anointing of the sick was ensured for 64.8% and 77.8% respectively of the bishops who replied. In addition, Catholic health care structures in about 70% of cases ensured the availability of a chapel for the celebration of the liturgy and to allow moments of prayer and for patients to be with each other.

The sustainability of Catholic health structures appears, therefore, from the point of view of economics and of human resources, to be rather difficult, taking into consideration as well the answers to the question where the bishops were asked to express their assessment/short-term forecast (two years) of the effective sustainability of the work of Catholic health care institutions: 51.9% of them declared that less than a half of such institutions would be able to keep on working over the next two years.

3.2. The programmes of specific training in the sphere of pastoral care in health and bioethics

The training initiatives in the spheres of pastoral care in health and bioethics undoubtedly constitute defining and irreplaceable elements of Catholic health care, indeed, they constitute the real added value produced by such structures. For this reason, an attempt was made to assess how

Table 6: Assessment of Available Human Resources

Human resources	Insufficient Val.%	Sufficient Val.%	More than sufficient Val.%	No answer Val.%	Total Val.%
Medical staff	53.7%	31.5%	5.6%	9.2%	100.0%
Auxiliary staff	51.9%	35.2%	3.7%	9.2%	100.0%
Male and female religious	75.9%	14.8%	7.4%	1.9%	100.0%
Volontary workers	79.6%	9.3%	1.9%	9.2%	100.0%

much is invested in this field. In this case as well, there is a divergence between the more stable economic contexts in the developed regions of the world, in which it is easier to allocate resources to such initiatives, and contexts in which daily emergencies take away resources and energies from such a commitment.

Courses to provide pastoral training appear to be very widespread (68.5% of the answers). On average, they take place once or twice a year, and last from between three and seven days at the most. These features, in reality, lead one to think that these are actually *spiritual retreats*, moments of thematic reflection on questions relating to care for the sick and the suffering but not real and authentic training courses on pastoral service. On the whole, these are managed by dioceses, diocesan committee, episcopal committees for health, chaplains and hospital consultants.

As regards courses on bioethics, these do not as yet seem to be widely spread, and this is especially the case in developing countries. It is clear that questions regarding bioethics find greater space and acceptance where advancing technology places man face to face with new questions and opens up new unexplored paths. These questions, obviously enough, are more distant in contexts where the fight is still going on for essential drugs and medicines or to ensure basic health care. However, over 50% of the bishops confirmed the existence of training programmes on bioethics, programmes which take place just over once a year and last on average for three days. In this case as well, therefore, more than courses on bioethics we seem to be faced with a course of seminars or days devoted to special study.

The organisation and administration of these courses have the following characteristics:

Table 7: The Subjects that Organise and Administer Courses on Bioethics

Subjects that organise and administer Courses on bioethics	% of all answers	% of all cases
Religious authorities	30.0%	51.7%
Owners of Catholic health care institutions/religious bodies	20.0%	34.5%
Health care managements	8.0%	13.6%
University faculties	24.0%	41.4%
Other subjects	18.0%	31.0%
	100.0%	172.4%

Given that on average each respondent expressed two options (172, 4/100=1,72), it is comforting to observe that these courses were the prerogative of religious authorities (30% of the total of answers) in 57.1% of cases; and of university faculties (24% of the total answers) in 41.4% of cases. This fact is confirmed by the contemporary trend towards the creation of real and authentic bioethics faculties.

Of no less significance is the statistic on the owners of Catholic health care institutions, and in particular religious Orders.

Amongst the other subjects that organised and administered such courses are to be listed centres and institute of bioethics, committees of archdioceses responsible for pastoral care in health, and tutors in Catholic nursing schools.

The target groups of these courses was made up for the most part of medical personnel, pastoral workers, and thirdly, technicians and nurses. The table on these data is the following:

Given that on average each bishop provided three answers (333.3/100=3.33), it is clear that 'medical staff', named in 26.0% of all the answers provided, and indicated by fully 86.7% of the respondents, were the principal target and users of such courses. 'Pastoral workers', who were referred to in 24.0% of the total answers, were indicated by 80.0% of the bishops; and 'nurses and technicians', who made up 23.0% of the answers, were referred to in 76.7% of the total cases. Administrators were conspicuous by their absence; those people who constitute the bureaucratic lever of the health care machine.

But training activity did not stop

Table 8: Professional Figures to Whom the Courses on Bioethics were Addressed

Professional figures to whom the courses on bioethics were addressed	%of all answers	%of all cases
Administrative directors	14.0%	46.7%
Medical staff	26.0%	86.7%
Nurses and technicians	23.0%	76.7%
Pastoral workers	24.0%	80.0%
Other professional figures	13.0%	43.3%
	100.0%	333.3%

there. Indeed, there were many other spheres in which human and economic resources were allocated to the training of health care workers. The bishops brought out the following areas of training:

Table 9: Other Areas in which the Training Activity of Catholic Health Care Institutions in Carried out

Other areas of training activity	%of all answers	% of all cases
Ethics and bioethics	19.4%	57.8%
Health care information	17.9%	53.3%
Health care education	14.9%	44.4%
Management and administration	20.9%	62.2%
Pharmacological up-dating	17.2%	51.1%
Other areas	9.7%	28.9%
	100.0%	297.8%

It is interesting to observe that in the economics of training activity a privileged and primary place was allocated to management and administration, which make up 20.9% of the answers for 62.2% of the respondents. This is followed by ethics and bioethics (to which reference has already been made); health care information technology, which was referred to in 17.9% of the answers and by 53.3% of the bishops; and pharmacological updating. These data provide interesting information on the direction that the health care systems are in general taking: that of becoming an organisational and bureaucratic machine which is to be managed and administered by employing the best forms of technology. A machine that is based on information technology, is efficient and highly specialised, but which nonetheless runs a serious risk: that of loss of contact, detachment from the most human side of suffering and pain.

3.3. The committees of bioethics and their guiding principles

The improvement of the machine that organises and manages health care structures is today parallel with the progressive development of biotechnologies, with the complexity of the problems posed by the advance of science and the experimental sciences in particular. This continual progress increasingly places health care workers face to face with choices which are not easily reached, where the defence of human life comes into play.

The committees of bioethics are the places where the various components of the various sectors of activity connected with the life and health of men meet in a pluralistic context and with an interdisciplinary methodology.[3] In these spaces, the members of such committees are called upon to address the various ethical problems that emerge in daily activity with the passing of time, and seek to reach a working policy that is in line with the basic principles that the committee had set out in its own statute.

In this study an attempt has been made first of all to perceive the level of diffusion of such spaces for ethical reflection within hospital structures. The data seem to confirm that this is a reality still in the process of being born, a reality that is at an initial stage. Almost two-thirds of those questioned declared that committees on bioethics 'have never existed' or 'have existed only once'. However, where such committees exist, it is interesting to observe that the sources of guidance at the level of principles are:

Table 10: Guiding Principles in the Statutes of the Bioethics Committees

Guiding principles in the statutes of the bioethics committees	% of all answers	% of all cases
The laws of the country	37.0%	55.6%
The Magisterium of the Church	53.7%	80.6%
Other principles	9.3%	13.9%
	100.0%	150.0%

Given that on average one to two options were expressed, it is possible to state that in Catholic health care institutions the Magisterium of the Church constitutes the fundamental point of reference in the statutes of such committees. This heading was responsible for 53.7% of all the answers given, and was indicated by 80.6% of the respondents. Respect for the 'laws of the country', from which the committees cannot depart, made up 37.7% of the answers and was indicated by 56.6% of the bishops. This, therefore, is an emerging reality that is in progressive expansion and which is very strongly rooted. It is a reality in which Catholic health care institutions should increasingly invest.

3.4. The management of funded projects of health care

The sustainability of the work of Catholic health care institutions is also a matter of the ability of the local Churches to promote, organise and manage funded projects of health care. The study explored this question with the bishops involved with reference to the last three years. The data reveal that over the last three year slightly more than 50% of local Churches have promoted this kind of project, and have managed them in most cases directly and only on occasions with other subjects.

Assessment is an essential and systematic element in the management of these projects. It is very important to emphasise this statistic, which demonstrates the whole of the commitment of the local Churches to the promotion of, and support for, health care guided by the values of Catholic morality. This has been the case despite the objective difficulties that the bishops who took part in the survey have to face up to every day, One need only observe that of the bishops who took part in the survey only 51% had an office to carry out their work and that most of the material resources that were available were concentrated in the hands of this 51%. One need also only observe that of those that had an office available, each on average had a computer, a printer and a connec-

tion with Internet, whereas the remaining 49% of these bishops complained about a lack of suitable human and economic resources, in addition to a lack of equipment to carry out their mission.

For us to speak about the sustainability of the work of Catholic health care institutions in the near future, we need, therefore, to take into consideration the following issues raised by the facts as they are:

Achieving fairness in relation to resources and means for the sister Churches of Africa and Asia which have to face up to grave local health care emergencies.

Investing in specific pastoral and ethical training.

Promoting and sustaining the enlargement of spaces allocated to bioethics committees.

Promoting and strengthening, where they already exist, the creation of *networks of co-operation* between the realities operating in the local area, around shared objectives.

Encouraging greater contact between local Churches – bishops responsible for pastoral care in health – and NGOs and the national governments.

Lastly, a reflection that at the end of this study I feel I can submit to this assembly. It was suggested to me by the thought of a religious who has recently passed away but whom many who are here today had an opportunity to know, and also to appreciate for his farsightedness and prophetic vision in relation to the subjects of Catholic health care – Padre Pierluigi Marchesi.

The sustainability of the work of Catholic hospitals, which is today an important challenge of the near future, is something connected with what Padre Marchesi, during his time, defined as the *alliance with lay collaborators*: an alliance to be achieved in the full sharing and realisation of the charism of hospitality, in which is formed a yearning that overcomes all needs; in which the need for care and comprehension of every human being finally finds an 'overall' answer.

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Notes

[1] The number of bishops responsible for pastoral care in health is higher than the number of countries because in some countries there are two bishops who have such a responsibility.

[2] The following is a list of countries with bishops responsible for pastoral care in health who answered the questionnaire: Ecuador, Bolivia, Argentina, Colombia, Uruguay, Venezuela, Peru, Italy, Germany, Spain, Belgium (2), Holland, Ireland, France, Benin (2), Chad, Tanzania, Mozambique, Equatorial Guinea, Zambia (2), Sierra Leone, the Sudan, Togo, Madagascar, Nigeria, Uganda, The Central-African Republic, Guinea, South Africa, Ghana, Lesotho, Georgia, Slovakia, Romania, Poland, Slovenia, Albania, the Czech Republic, China, Thailand/Singapore, Korea, Indonesia, the Lebanon, Haiti, Guatemala, Cuba, Canada, Papua New Guinea, Australia.

[3] M.L. DI PIETRO and A. SPAGNOLO, in*: Compendio di Semantica del Dolore – Dizionario algologico per materia- Bioetica,* Istituto per lo Studio e la Terapia del dolore, n.2, Florence, 1992.

II. Reflection of Experts on Economic, Political, Social and above all Religious Challenges in General with a View to Providing Support to the Catholic Identity of Health Care Institutions

DIARMUID MARTIN

1. In Politics

Politics and the Catholic identity of health care institutions! This is not an easy topic to address, as it can be approached from so many different aspects. The political and economic situation in different countries varies. The presence of Catholic Institutions varies, from being tiny and symbolic, to that where the Catholic Church is the major single health care provider. In some cases, the strong presence of Catholic institutions is due to the lack of any alternative system. In others, it is due to history. In others again, it is due to the application of the principles of subsidiarity and of a plurality of suppliers. The role of public and private in health care delivery varies, both on the theoretical level and in the day to day praxis. In some cases, there is a highly developed system of philanthropy; in others, private funding is negligent.

The political actions that Catholic health care institutions may have to undertake in this domain are also very varied. They can range from pro-life activities, to lobbying for more just health care services for all, to lobbying for the narrower – if not unimportant – specific interests of our own Catholic structures. In many parts of the world today, more and more attention will have to be given to the politics of ensuring that Catholic health care institutions can carry out their activities true to their mission, to their specific charism and in conformity with the moral teachings of the Church. Linked with this there is the question of equitable access on the part of Catholic institutions to public funds for the service that these institutions render to society.

The first thing that must be said at the outset is that the politics of Catholic health care institutions must always be *about the true mission of such institutions*. Catholic health care institutions exist because of a very specific mission, rooted in the mission of Jesus himself. All through his ministry, Jesus gave a privileged attention to the sick and needy. In various texts of the Gospels we are told that people heard of his presence and brought him all kinds of sick persons, whom he cured. Jesus enjoined the same attention for the sick on his disciples. When he first sent them out on mission, he instructed them specifically to cure the sick in the places they were to visit (Mat 10,8; parallels in Mk 6,13 and Lk 10,9). The fidelity of the apostles to that injunction, even after the return of Jesus to his father, is attested to in the healings attributed to them especially in the Acts of the Apostles.

The Mission of Catholic Health care Institutions is linked also with the mystery of sickness, suffering and pain, and with the Church's message of mercy, of special care for the poor and of gratuitous service, as has been illustrated in many of the interventions we have already heard today. Fidelity to that overall mission must always be the primary determinant factor in any political action.

Every other political factor is contingent on the ability to realise as fully as possible the specific and original mission of a Catholic health care institution. Everything else is subordinated to that. If political or financial factors threaten to impede a Catholic health care system from realising its mission, then the casting dye must always be fixed in favour of the mission. There may be occasions in which it is better to renounce public or private financial assistance and continue to work in a limited but independent manner.

And yet the task of political involvement by Catholic health care institutions must be carried out very much in the politics of the real world. Opting out may have the effect of leaving the field completely open to those who have a

very different philosophy of health. These are complex areas where prudential decisions have to be taken. Taking prudential decisions do not however mean being naive.

Decisions must then be taken in a world in which health care is becoming more competitive and at the same time more technical and complex and thus more and more expensive. Modernization today is a long way from the days in which it meant just redecorating buildings. It requires a massive investment in technology and in the capacity to utilize technology efficiently. Private health care facilities will only survive if there is

more and more cooperation among themselves to ensure that the institutions together can construct that level of "scale" which is needed to make such modernization financially sustainable.

Catholic health care institutions must always be pioneers. I do not mean this in terms of always being the most technologically advanced. If we can be that, then all the better. The pioneering I refer to must above all be in reaching out to new areas, or to areas where other services do not reach. Today this will mean in a special way addressing HIV/AIDS, but also other infectious diseases. But it might also be in the areas of palliative care, or assisting people advanced in years, especially in those counties facing the challenge of an ageing population. Pioneering could also, for example, involve more effective demonstration of the effectiveness of prevention, especially through educational programmes.

Being a pioneer might also mean moving outside the walls of our institutions and bringing health care closer to where those in need may be. I can see growing needs in the area of mental health, where mentally ill persons very often face incomprehension and lack of community support.

The concrete pioneering witness of Catholic health care services must lead in turn to political activity, to ensure not just financing, but also to ensure that the entire health care network addresses the needs that may have been thus identified or the specific quality of care that has been seen needed.

Such a pioneering spirit must also apply to the international politics of health care. The principle of solidarity should inspire innovative forms of partnership between health care centres in North and South, especially using modern information technology. In the past, problems of distance and capacity made such cooperation difficult, expensive and time consuming. Today information technology makes it a comparatively simple process which could have enormous advantages in health care. Catholic health care institutions should be in the forefront in developing models of the transfer of knowledge and technology to the poorer regions of the world.

The international politics of health care are extremely complex today, especially when we examine the nature of science which inspires them. It is all too possible to foster ideologies in the name of science. Scientific work in the area of health is not always as independent as it purports to be. All too often science is dominated not by independent, creative scientists, but by powerful financial lobbies and businesses, ably manipulated by sectors of the mass media. When research is owned by interested private concerns, the normal exchange and dialogue among scientists becomes limited if not impossible and science is placed exclusively at the service of profitable projects. Such a situation does not augur well for "the diseases of the poor".

In international health politics, Catholic health care institutions should be active in fostering that fundamental principle of Catholic social teaching: "the universal destination of created goods". This rather cumbersome formulation hides a very simple yet important principle, namely that when God created the goods of this world he meant them to be for all. This principle must be applied today to certain global common goods, such as health itself.

While Catholic social teaching has always stressed the right to private property, it also stresses that that there is a "social mortgage" on private property. This social mortgage applies to scientific progress in the field of health. It is unacceptable if medicines or treatments which could address certain fundamental human health needs today are hoarded up in order to make a greater gain tomorrow.

There are ways in which the incentive for research which the intellectual property rights system offers can be combined with urgent measures to ensure that the fruits of such research arrive where they are needed. Currently, for example, within the World Trade Organization there is an examination of how the flexibility offered within TRIPS agreement can be used to ensure that intellectual property rights are not a hindrance to public health. But there is not as yet the political courage to move forward decisively at the risk of offending certain powerful vested interests.

Another area of international concern is that of maternal and child health care. Maternal mortality is a sector within which there are dramatic inequalities between richer and poorer countries. Maternal death is today almost exclusively a developing world problem. The demanding teaching of the Church on conjugal morality challenges us to be in the forefront in providing the best possible services to mothers, as a clear witness to the fact that the Church is on the side of life. Congregations of religious women

can bring a very special contribution in this area.

A situation is emerging, in fact, within which certain international organizations doubt whether they should establish partnerships with Catholic health care institutions, because, as they would say, these do not offer "a complete range of reproductive health care services". The credibility of our Catholic health care services in this crucial sector will thus depend on the quality of the maternal health services we provide to women. It is an area where the educational and caring role of the Church has a long tradition. We must intensify our efforts in this area.

In the tension between offering services and having the ability to cover financial liabilities, it is important that Catholic health care facilities put emphasis on two factors:

The first is *quality*. Poor health care institutions are not necessarily condemned to offer poor quality services. The highest quality service possible must always be offered.

The second is that of showing a special concern for the poor. How does one do this in the face of a crisis in funding? There is no magic answer. Public funding may come with a very heavy price tag. Opting out of public funding may reduce the possibility of having any effective presence in the health care world and in the decisions taken about public health policy. The victims of limited funding can all too often be the very poor for whom our institutions were originally founded. It is important to remember that Jesus never sent any sick person away with their sickness (Mat 4,24; 8,16; 14,14.35; parallels in Mk 1,32.34; 6,55.56; Lk 4,40). Even when, in his native town of Nazareth, he did not perform other miracles, because of the people's lack of faith, he nevertheless "laid his hands upon a few sick people and healed them" (Mk 6,5). Catholic health care institutions must always have an open door for those who cannot pay, those who may have no rights because of illegal status. Even where, for historical or financial reasons, the Church offers health care facilities for the better off sectors of society, these institutions can never assume the same logic of profit as just another private provider.

Just as there will be political battles concerning health care and the beginning of life, the same will apply to end of life issues. We live in a strange world where there is enormous investment in technology for prolonging life and at the same time there are more and more attempts to justify ending life. Within the same institution, patients may be artificially kept alive through enormously expensive interventions, while others will not be afforded even water, in order more quickly to end their life. Our society needs a catechesis of life and death, which can come in part from the enlightened praxis of our health care institutions.

The nineteenth century was a remarkable period of expansion for Catholic health care institutions. Many religious orders were founded, particularly in Europe, and their spirit later spread to the new world giving rise to a remarkable renewal in standards of health care, especially for the poorest. The foundresses and founders of these congregations were very dynamic and farseeing people, especially the women. What is most striking in reading of them and of their lives was how their dynamism and practical spirit were accompanied by a deep spirituality, often mysticism. It was their simple insights into what following the message of Jesus Christ means that gave them courage and determination to move forward. It was their insight into God's loving care which ensured that their institutions were very different from others which may have emerged at the same moment.

The political influence of Catholic health care institutions will not only depend on professionalism and how they compare with their very often better endowed sister institutions. It will also depend on the originality of the inspiration of our Catholic institutions, especially in providing that quality in caring. The health care policy of the Church is not about institutions, in terms of brick and mortar, or technologies. It is about people and the ability of our services to accept people as brothers or sisters.

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UWE E. REINHARDT AND MAY T.M. CHENG

2. In the Economy

1. Introduction

The mandate posed for this essay is to explore the challenges that economic forces pose for Catholic health care worldwide. To that end, we examine, in Section II, the problem of resource allocation at the macro-economic level, that is, the allocation of scarce resources to health care and to competing ends. Next, in Section III, we make the case that economic efficiency in the use of whatever resources are allocated to health care is not only an economic imperative, but a moral one as well. Finally, in Section IV we explore the consequences for the structure of health systems that follow from the distributive social ethic for health care without, however, suggesting what that social ethic should be.

In approaching our task, we shall be guided by the Chinese attitude on "challenges," as it reveals itself in the Chinese word for "crisis":

危機

In this word (pronounced something like *wei djee*), the left character means "danger" and the right one "opportunity." It is an apt motto for a conference of this sort, because in the challenges posed by economic forces lie many opportunities for Catholic health care to do good where other segments of society fail.

By its very nature, economic analysis can be irritating, which may be why economists are so frequently decried as practitioners of the "dismal science." Quite possibly, then, this essay may include indelicate propositions that may jar the reader. By way of preemptive apology, let it be known that we march in the essay to the ancient Chinese dictum:

忠言逆耳利於行

Honest words of advice *against ear* *beneficial to conduct*

It is the constructive spirit in which our comments are offered.

2. The allocation of scarce resources to health care

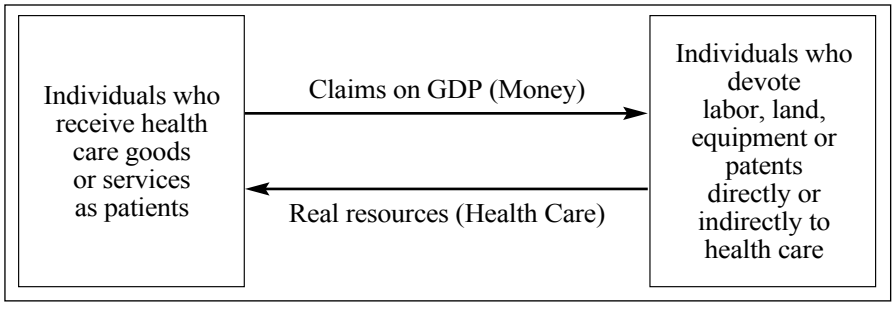
Before exploring what "resources" different nations are able and willing to allocate to their health systems, it behooves us to make clear a distinction between (1) the percentage of a nation's gross domestic product (GDP) that is said to be "allocated to health care" and (2) the real resources (human labor, equipment, structures, land, and so on) that a nation allocates to the process of patient care. That distinction seems poorly understood in the debate on health policy where "money" tends to be viewed as a form of medicine that can heal people. Figure 1 illustrates the distinction we seek to make.

Health Spending vs. Real-Resource Allocations

Like any other economic sector, the health care sector can be thought of as a set of transactions in which human beings trade favors with one another. Human beings who own real resources (human labor, equipment, structures, land) directly or indirectly surrender these to the process of caring for patients[1]. Unless they do so on an unrequited basis – as some religious persons do – these providers of real resources receive money in return. (For the sake of expediency in exposition, we shall hereafter refer to the "providers of real resources to health care" simply as "providers", with preemptive apologies to anyone who might take exception to that term.) "Money," of course, functions as a generalized claim on the nation's GDP, which is the sum of all of the goods and services produced within a nation's borders and traded in the market place[2].

It follows that the percentage of a nation's GDP said to be "going to health care" does not at all represent a resource flow going to patients. It accrues strictly to the direct and indirect providers of health care. Indeed, it is possible that Nation A devotes a larger fraction of its GDP to health care

Figure 1 - The Health Care Systems as an Exchange of Favors among Members of Society



than does nation B, but delivers to patients fewer real resources than does Nation B. It might be so, because the providers of real health care resources in Nation A (e.g., physicians or hospitals in that country) may have more market muscle than do their peers in Nation B. In that case the providers in Nation A can charge higher fees for their services, which is another way of saying that they extract from society higher monetary claims on GDP per unit of real resource that they release than their peers in Nation B can extract from their society[3].

In research on this issue, American health economist Mark Pauly[4] has found that the government-regulated European health systems typically bestow on patients *more* human resources per capita (physicians and nurses) than does the more market-driven American system, although the U.S. allocates a far higher percentage of its GDP to health care than does any other nation. As is shown in Table 1 further on, in 1997 the U.S. allocated 13.5% of its GDP to health care and the European systems only about 10% or less. This seeming paradox is explained by the fact the Americans pay their providers of health care far higher prices than do the European nations. To illustrate, in 1997 the net income (after practice expenses) earned by American physicians averaged about 5.5 times the average compensation of all employed persons in the United States. The comparable number for Germany was 3.4. For Canada it was 3.2, for France 1.2 and for the U.K. it was a low 1.4[5].

Why might this issue be of interest to leaders of Catholic health care? It may be relevant, because it bears on the preferred economic and administrative structure of a health system. If one takes as a baseline for comparison the distribution of economic privilege between the providers of health care and the rest of society that would obtain in a more market-driven health care system – such as the American system – then the more government-driven health care systems of Canada, Europe and Asia tend to succeed redistributing economic privilege away from the providers of health-care and toward the rest of the tax- or insurance-premium paying society. It is so, because the government-controlled health systems allocate relatively more market power to the payment- or demand-side of the health system than do more market-driven systems. Government-controlled health systems therefore are able to procure for their patients more *real resources* for a given *percentage of GDP ceded to the providers of real health care resources* than would be possible in a more market driven system, other things being equal.

Economists cannot offer normative judgments on the distribution of economic privilege involved in this issue; it is a political call, which, in turn, flows from ethical

predilections. One should think, however, that the leaders of Catholic health care might wish to articulate an ethical perspective on this issue. Bluntly put, in the short run the question is whom they would favor in the allocation of market power and economic privilege: (1) those who derive their life styles from health care or (2) those who directly or indirectly pay for health care, i.e., give up claims to GDP for it. This question is particularly relevant in the United States and in other countries in which out-of-pocket spending for health care by patients can be very high.

As the opponents of government-controlled health systems rightly point out, however, there is always the possibility that, beset by short-run budget crunches, politicians in such systems will purchase fewer real resources for health care than the populace might wish. To complicate matters further, there is the added consideration that, over the longer run, the pace of technical innovation in health care may be slower under tightly constrained, government-controlled health systems than it is under market-driven health systems that bestow handsome financial rewards on entrepreneurial innovators. That circumstance forces one to think of a trade-off between current and future generations of patients.

In short, this is a facet of health care on which economics and ethics interface in very complex ways.

Resource Allocation and the Valuation of Human Life

A much-cited maxim in debates on health policy is that "human life is priceless." The maxim is cited to argue that no resources should be spared to protect and prolong human life. Economists consider the maxim dubious and its commonly cited policy implication a *non sequitur*. First, the word "life" is much too ambiguous for cogent thought in this context. It is more appropriate to speak of "life years" or, as some policy analysts would have it, of "quality adjusted life years" (QALYs). Second, ever since the tragic *Fall from Grace*, humans have been forced to put a price on human life, whether wish to do so or not. They do it implicitly, through their daily economic decisions.

The distinguishing feature of life in biblical Paradise, before the *Fall from Grace*, was the absence of any constraint on resources, other than the forbidden fruit. In that world it would have been possible to allocate infinitely large quantities of real resources to health care. It would not have been necessary to bear any sacrifice – in terms of foregone opportunities elsewhere – if added human life years were achieved through a greater expenditure of

resources. In that sense, life could be said to have been "priceless."

The earthly problem of pervasive scarcity arose as soon as humans partook of the forbidden fruit and were evicted from Paradise.[6] Ever since that *Fall from Grace*, the global community, nations within it, communities, religious institutions, families and individuals have faced the task of allocating limited resources to competing ends, whose claims on resources invariably exceed the resources at hand. Occasionally, the trade-offs made in this allocation process do put an implicit price on human life years, in ways that may not be clear to decision makers at the time, but that permit economists to estimate statistically what these implicit values were[7].

One can estimate these values from the fact that automobiles, airplanes, roads and bridges are not as safe as they might be made with added resource outlays. One can estimate the value people put upon their own life years from the added wages workers demand to perform riskier jobs, or from the cost savings individuals achieve by opting for smaller, cheaper, but less safe automobiles rather than safer, more expensive ones. Finally, within the context of American health care, one can estimate the valuations that politicians implicitly put on human life years by their decision to leave some 40 million Americans (two thirds of them in low-income families) without health insurance and, thus, without the timely access to health care that is enjoyed by similar, insured individuals.

Although it may be indelicate for economists to present this aspect of the human existence to leaders of Catholic health care, the fact is that even the Catholic Church, bound as it is by severe resource constraints everywhere, must make these implicit valuations as well. A forthright exploration of what these valuations are within the Church, and within the nations of which the Church is a part, strikes us as a useful exercise. If it were found by the leaders of the Church, for example, that particular decisions on resource allocation within the Church, or within society, has put too low a value on human life years, then the occasion has arisen for demanding a more generous resource allocation to the activity in question or for directing more of the Church's resources there. It could happen even in very well endowed health systems, such as the U.S. system, if there are pockets of evidently underserved populations.

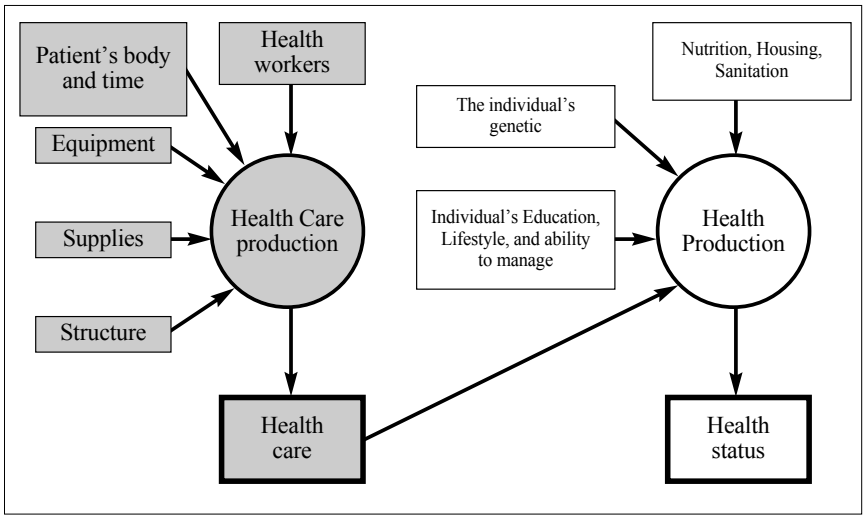
On the other hand, it may also be found that the implicit valuations put on human life years by resource allocations to health care are far above the valuations implicit in resource allocation to other areas of human activity. It would mean that too many resources are allocated to health care.

"*Health* Care" *or* "*Health* Status"?

The possibility that, in some countries, too many resources can be allocated to health care reminds one that health care is merely one of many inputs into the production of "health," and not even the most important one (see Figure 2 below). To be sure, when an individual falls critically ill, access to timely and proper health care can be a matter of life and death for that individual. To tell someone, at that time, that health care is not the most important input into the production of better health would be silly. On the other hand, variations in the *use of health care* by individuals in larger groups appear to account for only about 10% of the variations in the observable *health status* across time and across individuals[8]. Empirical research has shown that far more important determinants of health status appear to be are (1) the individual's genetic heritage, (2) his or her socioeconomic status, (3) his or her physical environment, and (4) the individual's ability and willingness to manage his or her health well which, in turn, is enhanced by the person's educational attainment. These factors together powerfully influence whether or not a particular individual will fall critically ill at a point in time.

This circumstance raises the question what the proper objective of a health system – including Catholic health care – should be. It is a natural human tendency to defend the survival of institutions from which they derive their livelihood, as health-care executives, physicians and leaders of health-workers unions never are shy to do. Such pleas have a high resonance among politicians and intuitive appeal in the general public. Economist, however, argue that the allocation of society's scare resources should be justified only with appeal to the value of the output these resources produce. Over time, a society that rationalizes resource allocations merely to employ inputs will share the economic fate of the formerly Socialist countries: their economic growth will stagnate and human

Figure 2 - The production of "health care" and of "health"



economic well being will be commensurately lower.

The leaders of Catholic health care must reflect deeply on this issue. First, they must be clear about their social objectives. Is it mainly the survival or the competitive position of Catholic health care within their wider national health systems? Or is it mainly "better health" for fellow human beings? Perhaps, realistically, it will always be a combination of both. If so, what is the right mixture?

To illustrate, consider a geographic area that is already well endowed with health care resources or, if it were short, could easily attract added capital from sources other than the Catholic Church, perhaps even from private capital markets. Would it make sense, then, to use the Catholic Church's scarce resources to construct a new Catholic hospital in such an area? It might make sense, if there were something uniquely valuable about health care rendered in a Catholic hospital, something that set it apart from health care given in secular, rival hospitals. If so, then that unique "something" would be the rationale for pouring added resources into this already well endowed region. In the United States, for example, the added "something" might be the hospital's willingness to provide more charity care to the uninsured than is provided by its secular rivals[9]. It might be the willingness to charge all patients lower prices than those charged by the secular rivals. It might even be a general culture of "caring" for patients not found in secular institutions. It might also be the hospital's willingness to treat labor not as just one more input that can be hired and fired to protect the hospital's profit margin on an annual basis, but a willingness to ride out periods with financial losses in order not to devastate the private lives of loyal employees through sudden layoffs.

Against the rationale provided by these potentially unique features of Catholic health care must be set the desideratum to use the Church's scarce resources in the production of "better health" among fellow human beings. As is suggested with Figure 2, pouring additional scarce resources into added health-care facilities might not be the best means of pursuing that goal. Indeed, on the objective of "better health" one could easily defend on moral grounds the decision of Church leaders to *sell* an existing Catholic hospital in an over-bedded area to a secular, for-profit hospital chain – as has happened in the United States – if the proceeds from that sale were redeployed in more productive activities. Such activities, for example, might include better education for the poor, especially the development of better "health literacy[10] among the poor, through schools or low-tech, primary-care clinics in low-income neighborhoods.

Limitations of space preclude us from going beyond merely raising this sensitive issue here, mainly to make at two major points. First, the proper, ethically defensible allocation of resources to health care proper, rather than to other economic activities, is a truly complex undertaking to which Catholic health presumably can contribute positively. Second, one can easily allocate too many resources to health care in ways that raise not only issues of economic inefficiency, but of ethics as well.

The Unequal Global Distribution of Health Spending

Table 1 presents data on the percentage of their GDP that sundry nations reported to have devoted to health care in 1997. Because

Table 1 - Health spending in selected countries, 1997

	NATIONAL HEALTH SPENDING, 1997	
	As percent of GDP	In international dollars
Eritrea	3,4%	$24
Yemen	3,4%	$33
Uganda	4,15	$44
Kenya	4,6%	$58
Bangladesh	4,9%	$70
Cambodia	7,2%	$73
India	5,2%	$84
Egypt	3,7%	$118
South Africa	7.1%	$396
Brazil	6,5%	$428
United Kingdom	6,7%	$1.193
Italy	7,6%	$1.589
Australia	8,4%	$1.805
France	9,6%	$2.051
Canada	9,0%	$2.095
Germany	10,4%	$2.339
Switzerland	10,1%	$2.547
United States	13,5%	$3.925

SOURCE: World Health Organization, *The World Health Report 2000*, Table 8. Data on health spending as a percent of GDP for the developed countries from Gerard F. Anderson and Jean-Pierre Poullier, "Health Spending, Access, and Outcomes: Trends in Industrialized countries, *Health Affairs*, 18(3), May-June, 1999; Exhibit 1.

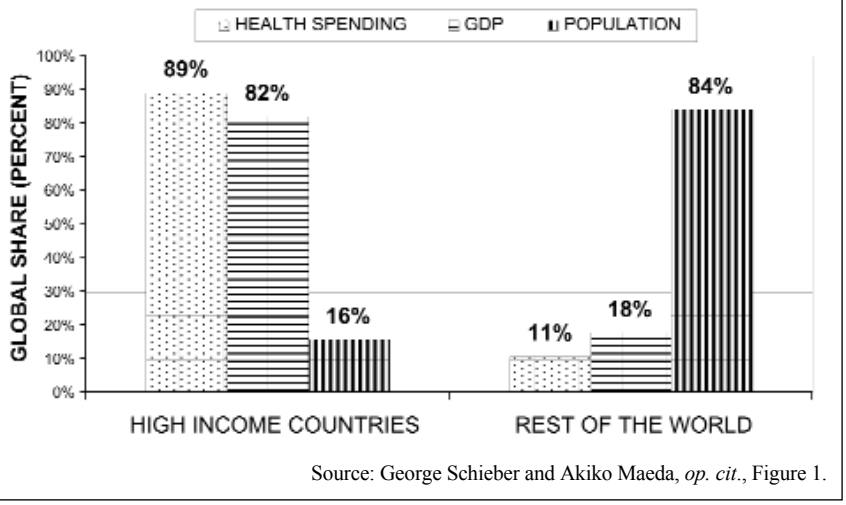
GDP per capita varies so much among nations, the percentage of GDP allocated to health care can be misleading as well. (Compare, for example, South Africa with the United Kingdom). For that reason, Table 1 also shows health spending per capita in international dollars. These absolute dollar figures are based not on official, spot exchange- rates, but on purchasing power parity among the national currencies

Although, as noted earlier, data on health *spending* tell us only what claims on GDP these nations have ceded to their providers of health care, and not what real resources have flown to patients, it is nevertheless safe to assume that far fewer real resources flow to patients in the developing world than do in the high-income countries. Figure 3, taken from a World Bank Study, highlights just how unevenly health spending (and, presumably, health care) is distributed across the globe. With only 16% of the world's population in 1994, the developed, high-income countries accounted for 89% of total world health spending (but also, of course, for 82% of the world's GDP). With 84% of the population, the rest of the world accounted for only 11% of total world health spending and only 18% of the world's GDP. There can be no question that this uneven distribution of health care raises fundamental moral questions for leaders of the developed nations, including leaders of Catholic health care.

The Moral Virtue of Global Price Discrimination: The medicines and medical equipment typically must be purchased from the developed world, in a global market. Consequently, the low-income countries will lack access to these important inputs, unless their manufacturers in the high-income countries are willing to sell them to low-income countries at deeply discounted prices, as is now done for AIDS medicines. Because the production of drugs and medical equipment tends to be associated with very high *fixed* overhead costs (often including huge outlays on research and development) but relatively low *variable* production costs, their manufacturers can earn profits even at steeply discounted prices below fully allocated unit costs, as long as these discounted prices remain somewhat above variable unit production costs.

Although the practice of charging different customers different prices for the same thing is sometimes decried as "price discrimination," economists consider it highly *efficient* in this context. Economists reason as follows: If the manufacturers of health products and equipment were forced to charge all customers the same price, then they

Figure 3 - Global distribution of health spending, GDP and population, 1994



Source: George Schieber and Akiko Maeda, *op. cit.*, Figure 1.

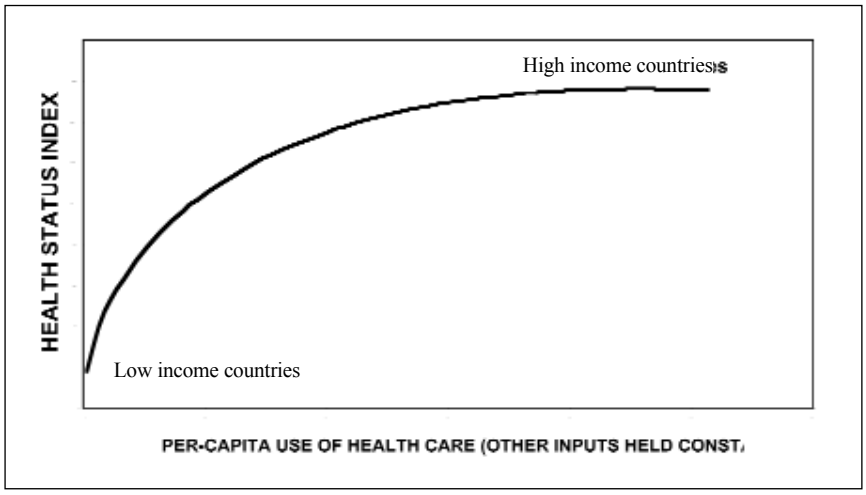
might price out of the market many potential buyers who might be able to pay prices slightly above variable production costs, but not the higher single price that recovers overhead as well. Economists regard such a situation inefficient, because the situation would prevent mutually beneficial trades from being consummated. Moralists might find the single-price policy wanting as well, on purely ethical grounds. The proposition can be (and has been) put on that the overhead costs of health products and equipment be recovered fully from the higher-income, developed countries, and to charge the low-income developing countries discounted prices only slightly above the much lower variable production costs.

In this confluence of economic efficiency with moral sentiments lies an opportunity for Catholic health care to inject its moral vision loudly into not only international health policy, but into world trade policy as well. Part of a strategy of using price discrimination to moral ends, of course, would have to be the prohibition of parallel re-imports from low-income countries granted steep price discounts to the high-income countries granting them.

The Incremental Productivity of Using Health Care: It is well known that, if all other influences on heal status are held constant, the input of health care into

the production of better health runs into strongly diminishing marginal returns, as is illustrated in Figure 4 below. It is the classic pattern of virtually any production process, including the production of "better health." On certainly observes it empirically, if "life expectancy" is plotted on per-capita health spending across countries in the world.

Figura 4 - The marginal contribution of "health care" to "health status"



It is beyond dispute that, at the level of health-care utilization customary in the developed world, additional resources poured into health care will add fewer human life years than these same resources would yield if added to the meager resource base of the developed nations. If one used any other index of "health status" – for example, quality-adjusted life years (QALYs) per capita – one would come to the same conclusion. In short, the incremental productivity of health care among poor peoples is likely to be much higher than it is among well-to-do peoples.

This circumstance stands as a major moral challenge to the leaders of the developed nations, and to the leaders of Catholic health care within those nations. It is natural for human beings to march to the dictum that "charity begins at home." Even so, the leaders of Catholic health care cannot avoid the troubling dilemma just where to direct the scarce real resources at their command: (1) to *all* citizens, rich and poor, in their home country, (2) mainly to the *poor* in their home country or (3) mainly to the even more destitute poor in the developing countries. It is a truly vexing moral dilemma, because a determined strategy to achieve with the resources at the disposal of Catholic health care the maximum increase in human well-being *globally* would imply a major withdrawal of Catholic health care from the developed countries, and an even larger presence than it already has in the developing nations.

3. The ethical imperative of economic efficiency

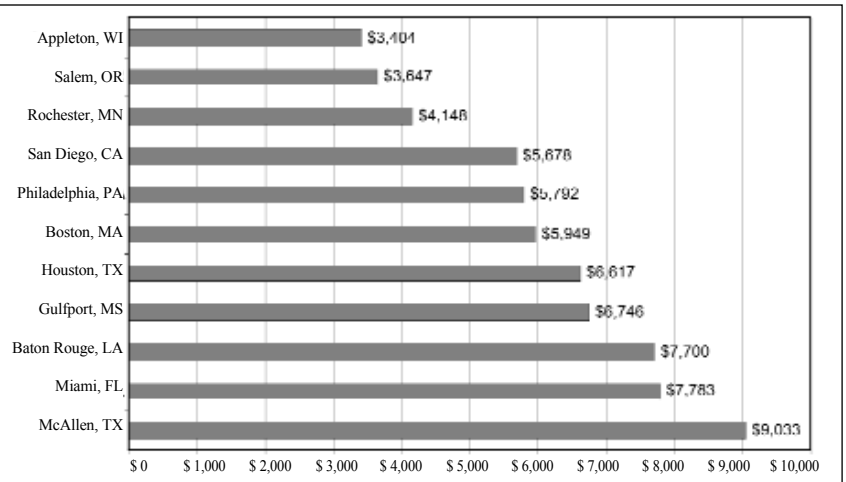
Much of the economist's work is guided by the normative dictum that society should use the real resources at its disposition "efficiently." Although that idea makes sense at first blush, the word "efficient" turns out to be highly treacherous. It is much misused in the debate on health policy, wittingly or unwittingly[11].

For example, the often-made claim that the allocation of health-care resources through the *market* mechanism would be inherently more "efficient" than allocation through alternative processes is false in most contexts. It is false, because a market-driven health system would in all likelihood distribute economic privilege in health care quite differently from the distribution that would obtain under alternative mechanisms. As a general rule, it is not legitimate to compare alternative public policies in terms of their relative economic efficiency, if these policies drive toward different goals – that is, if they result in different distributions of economic privilege among members of society. This issue is sufficiently subtle to go beyond the page limit set for this essay, but it must at least be registered.

A relatively uncontroversial definition of the term "efficiency" embodies the idea that an activity is efficient if it reaches a *stated goal* with the least possible sacrifice of real resources. At the micro level in health care, the stated goal may be to restore a particular patient to good health, or to prolong his or her life by a certain number of years. At the macro level, the goal may be to attain a set of population health-status targets by a certain time (e.g., within a decade), without allowing individual families to suffer financial hardship due to illness.

It seems uncontroversial as well to propose that attaining efficiency in reaching stated individual or social goals is an *ethical* imperative, because the needless use of real resources to attain stated goals deprives other human beings of benefits that could have been reached with the wasted resources. One would assume that "efficiency" in this sense is, or should be, an integral part of the vision for Catholic health care. The remarkable data in Figure 5 below illustrate the importance of this point.

Figura 5 - Spending by Medicare on elderly Americans, 1996 (adjusted for age, gender, illness and cost of practice)



SOURCE: John E. Wennberg and Megan M. Cooper, *The Dartmouth Atlas of Health Care in the United States,* Chicago, IL: AHA Press, 1999.

Inexplicable Variations in Practice Styles and Per-Capita Costs

Figure 5 is based on research by John Wennberg, M.D. and his associates at Dartmouth University, and is published in their *Dartmouth Atlas of Health Care in the United States* (1999). Their study examined data on health spending and health-care utilization reported by the U.S. federal Medicare program for Americans aged 65 and over. The units of analysis over which the average spending numbers per Medicare beneficiary in Figure 5 were calculated are *hospital market areas* within the United States, here designated by the major cities that fall into these areas. The authors had adjusted these data statistically for inter-regional variations in (1) the age-gender composition of the population of elderly, (2) the incidence of illness, (3) practice costs and (4) the fees paid doctors, hospitals and other providers of health care. What remained, and is shown in Figure 5, is inter-regional variation in spending per Medicare beneficiary. That variation reflects almost wholly differences in the *use* of real health care resources by statistically similar populations of elderly citizens across the United States.

The remarkable variations in per-capita health spending in Figure 5 raise the troubling question why the American health care system requires more than twice the real resources to take care of elderly patients in one part of the country (e.g., in Texas and in Florida) than it does in other parts (e.g., in Oregon and in Rochester Minnesota, home of the world famous Mayo Clinic). If the practice style of the Mayo Clinic were taken as the benchmark of cost-effective health care, then physicians and other healthcare providers in other areas of the United States evidently must be inefficient in their use of scarce resources. In its *Crossing the Quality Chasm*, the prestigious Institute of Medicine of the U.S. National Academy of Sciences remarked critically that:

"The [U.S.] health care system as currently structured does not, as a whole, make the best use of its resources. … [T]here is substantial evidence documenting overuse of many services – services for which the potential risk of harm outweighs the potential benefits".[12]

The presence of visible inefficiency in a health system raises serious moral questions, particularly in the United States, where policy makers have been searching desperately for ways to cope with the expected sharp increase in the demand for health care after the U.S. Baby Boom generation starts reaching retirement age in the year 2010. The thrust of current thinking is to make the elderly shoulder a greater share of the cost of their own health care, although even now the poorer among them devote over 30% of their meager budget to out-of-pocket spending for items (e.g., prescription drugs) that Medicare does not cover. Shifting more of the financial burden of health care onto the elderly without first eliminating the sheer waste of which the American health system is suspect strikes one as dubious public policy. It is neither efficient nor morally defensible.

It is a safe bet that the health system of most other nations exhibits similar geographic variations in the use of health care in per-capita health spending. Is the use rate of health care in Sicily and in rural Southern Italy like that in Rome or Milan? There is also apt to be in most other countries as well the overuse, underuse and misuse of health care of which the Institute of Medicine accuses American health care. Thus, in every nation there arises the following fundamental question: What *should* it cost to afford every one in society access to adequate health care?

Leaders of Catholic health care everywhere should take the lead in exploring this important question, for it deals not only with a matter of economics. As noted earlier, in the face of scarce resources, wasting these resources – that is, using them without yielding benefits for some human beings – seems to be starkly at variance with the professed ethical vision of Catholic health care.

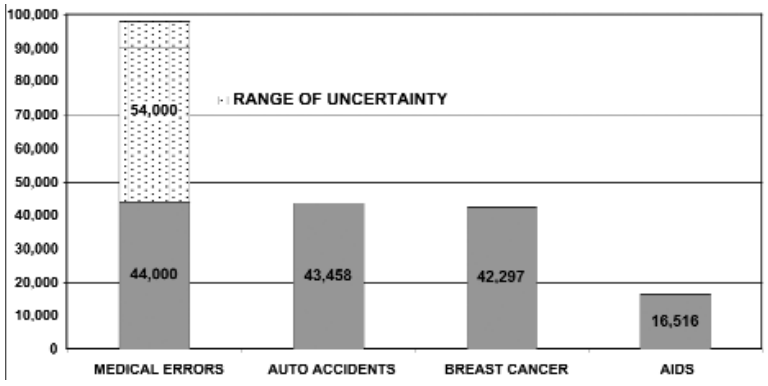
Medical Errors and the Quality of Care

One particularly troublesome form of inefficiency in health systems is the problem of *medical errors* in the treatment of patients. These errors may prolong illness and treatment unnecessarily. They may also result in the avoidable loss of life years. It is unquestionably the worst form of inefficiency one can imagine, as it so often is a matter of life and death.

As individuals, most[13] professionals working in health care un-

doubtedly always have done their best to avoid such errors. Recent health services research, however, has shown that these efforts at the individual level have not yielded acceptable results. In its *To Err is Human: Building a Safer Health System*[14], the previously cited Institute of Medicine reported the startling data shown in Figure 6 below.

Figure 6 - Selected causes of death, United States, 1997



Source: Institute of Medicine, *To Err is Human: Building a Safer Health System,* Washington, D.C.: National Academy Press, 1999.

According to the Institute's report, the number of deaths caused by medical errors in American hospitals was estimated to be between 44,000 and 98,000 in 1997 alone. The Institute hastened to add, however, that often these error rates are not the fault of uncaring *individuals* working within the health system – for example, of people who did not properly wash their hands between patients or used syringes on multiple patients. Rather, the errors are thought to result mainly from *systemic* failures – for example, from inadequate workflow processes or from outdated information systems that cannot track and control the proper administration of drugs and other therapies. Consequently, the Institute of Medicine does not call for penalties on individual practitioners, but instead for ambitious operations research for health systems and for superior industrial engineering of health institutions, on the models so successfully used in other industries, notably the airline- and food industries.

As might be expected, the dramatic Institute of Medicine's report has not gone without its critics. One of the participants in a major study cited by the report, for example, has suggested that the report has misclassified as "errors" or "blunders" some untoward events that might have been preventable, but that were not really errors [15]. Furthermore, argue the critics, the emphasis in the report on the word "error" may lead physicians to become more secretive about untoward events – even those that were no one's fault – fearing that such events will too easily be interpreted by the public and by the courts as "negligence." For that reason, both the Institute of Medicine and its critics have advocated that the reporting of untoward events be based on a "no-fault" system, as it is customary for pilot errors in the airline industry[16].

Whatever the result from this debate, there is a general consensus that the incidence of untoward events in medical practice in the United States currently is much higher than it ought to be. Furthermore, it is generally agreed also among international experts that the incidence of medical errors and other untoward events is unlikely to be lower in other countries. For all that is known, it might even be higher. The United States stands out in this regard merely because it is the first to have researched the problem carefully and to have reported on it forthrightly.

For leaders of Catholic health care the problem of medical errors clearly is a major challenge, but it also presents a splendid opportunity to show leadership in the effort to improve the lives of human kind. Progress in this area will be the most humane kind of efficiency gain.

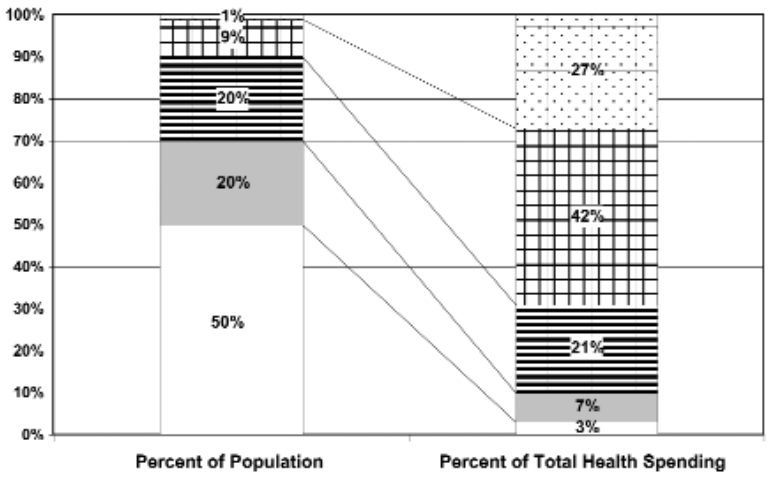
4. Economic challenges on the distributive ethic for health care

The previous section has been concerned with the moral imperative of producing health care *efficiently*. In this section we comment on distributing health care among members of society, however efficiently or inefficiently that care may have been produced. In economics, that facet of health care is referred to as the "distributive ethic," that is, the overarching social goal from which all other economic decision should follow.

The Unequal Distribution of Health Spending across Individuals

To explore the issue of the distributive ethic for health care, it must be noted, first, that the incidence of illness among any large cohort of people is highly uneven. Consequently, per capita is uneven as well. Figure 7 illustrates this phenomenon with appeal to U.S. data for 1996, although similar distributions will be found in all modern health systems.

Figure 7 - The highly uneven distribution of health spending across population, U.S., 1997



Source: Marc L. Berk and Alan C. Monheit, "The Concentration of Health Care Expenditure, Revisited", *Health Affairs,* (20(2), March-April 2001; Exhibit 1.

As is shown in Figure 7, if one ranks Americans in descending order of the spending on health care, whether made by or for them, it is found that a mere 1 percent of that population accounted for as much as 27% of total national health spending in 1996. The most expensive 5% of the population accounted for as much as 55% of total spending (not shown in the graph). The most expensive 10% of the population accounted for close to 70% of all health spending, and the most expensive 30% of the population for about 90% of total national health spending. By contrast, the least expensive 50% of the U.S. population accounted for only 3% of total national health spending. Presumably, "more expensive" here is just a proxy for "sicker."

This highly skewed distribution of illness and health spending has profound implications for national health policy. That will be especially so in the forthcoming age of the genomic revolution, which will make it easier to predict who in any birth cohort will be likely to be relatively healthy and low cost over their life cycle and who is likely to be chronically ill or have more episodes of acute illness and, therefore, causes high health-care cost. Individuals with a high probability of remaining chronically healthy over their life cycle may increasingly mimic the biblical Cain by asking why they should be their poorer and sicker neighbors' keepers in health care. If, in such a world private health insurance companies are allowed to compete for enrollees on the basis of "actuarially fair" premiums[17], their natural instinct will be to segregate their customers by predicted risk class, driving the minority of very sick and costly patients into high-risk pools for which enormously high insurance premiums must necessarily be charged. Often this means that such individuals cannot afford any health insurance at all.

Do the leaders of Catholic health care have an ethical position on this prospect? Should one take the view – increasingly popular in the United States – that most chronic illness is the result of an improvident life style in any event so that, therefore, the chronically sicker should be forced to allocate a higher proportion of their budgets to health care than must chronically healthy people? Or do the leaders of Catholic health care favor the Canadian, Taiwanese, Japanese and European social ethic according to which the financial burden of all illness – regardless of its cause – should be collectively shared strictly according to ability to pay? If so, should that ethic be implemented through the vehicle of health insurance itself – e.g., through government run insurance or through government regulated private insurance pools that must charge the same premiums to all insured? Or is it preferable to endow individuals with tax-financed vouchers for the purchase of private health insurance (with adjustments of the vouchers for the individual's risk class) letting private health insurers then segment their customers by risk class and charge the chronically sick much higher premiums than are charged chronically healthy customers?

All of these questions are now under active debate in the United States. They are likely to be raised also in many nations of the developing world – including Mainland China – especially in view of the fact that the United States government (and sometimes its substantially owned subsidiary, the World Bank) has encouraged for some time the development of market-driven health systems in those countries. These questions are now being raised also the hitherto more egalitarian health systems of Canada, Europe, Taiwan and Japan.

This circumstance provides leaders of Catholic health, at both the national and the international level, an opportunity to inject their ethical visions into the debate on national health policy. A first step in such an initiative, of course, will be to reach a consensus on a clearly articulated position in these matters. We identify three major candidates for consideration below.

Alternative Distributive Ethics for Health Care

Although the distributive ethic one may impose on a health system comes in a myriad of nuanced shades, one can group them into three distinct, major categories, to wit:

Perfect Egalitarianism: All medically necessary health care should be paid for collectively, with the individual's contribution to this financing based strictly on the individual's ability to pay. It should be impossible to infer a patient's socio-economic status by observing the medical treatment he or she receives in case of illness or for purposes of preventing illness. Persons stricken by the same illness in the same locality should re-

ceive the same medical treatments, in the same setting, regardless of their income of social status.

Two-Tiered Health Care: All members of society should be guaranteed a basic package of medical services, that is to be financed collectively, on the basis of ability to pay, and that is to be shared on an egalitarian basis by those enrolled in the basic tier. Higher-income persons, however, should be allowed to opt out of this basic tier, as long as they are then fully responsible for financing their own health care. Alternatively, they might be allowed to use their own money to jump out of queues for access to public health care facilities and use instead private, commercial facilities.

Multi-Tiered Health Care: Health care is not intrinsically different from other basic goods and services – such as food, clothing and shelter. Consequently, a health system should permit in health care the same kind of tiering by ability to pay that one observes in the distribution of food, clothes and shelter. Practically, this means that the quantity and quality of health care, along with the amenities of the setting in which that care is dispensed, can be rationed by income class.

As noted, the Taiwan health system currently seeks to operate on the first of these distributive ethics, and so do the government-run, provincial health plans of Canada. The strictly egalitarian social contract of Canada's health system, however, is currently under review. Some critics of that system would like to permit the establishment of a private tier, along the lines suggested by the second distributive ethic listed above.

Germany and several other European nations have openly espoused variants of that second distributive ethic, with two-tiered systems in which a small but still tightly regulated private health insurance system is permitted to operate parallel to the statutory or government-run systems. In Germany, privately insured patients procure health care from the same health-care delivery system as do persons insured under the *Statutory Social Insurance System* (the *Gesetzliche Krankenversicherung* or *GKV*). In the United Kingdom, the relatively small private insurance sector is complemented by a private delivery system that operates in tandem with the government-run *National Health Service*. Usually, the private sector in these two-tiered European systems comprises only about 10% of the population.

Many participants in the debate on health policy in the United States – although by no means all – now advocate the third distributive ethic. They espouse a multi-tiered health system in which the health care experience (the quantity and quality of care, and the amenities in which it is delivered) can vary by the patient's ability to pay. Such a system inevitably will ration health care by income class, with price functioning as the rationing mechanism[18]. Usually, the proponents of multi-tiered health care do not speak of tiers openly, for fear that such advocacy may not be "politically correct." Instead, they tend to camouflage their preference in this regard by calling for a "market approach" to health care.

The leaders of Catholic health care will have to reflect on which of these distributive ethics is most compatible with their own vision for their health-care systems and for their nation's wider health system. Perhaps it may not even be possible to reach a global consensus on this issue within the Catholic Church, that is, perhaps the Church's preferred ethical vision may have to be tailored to local cultures and economic circumstances. But it is important to address these ethical issues openly, first, before thinking about other facets of the economics of health care. Ideally, economics should not dictate social ethics, but should instead be its faithful servant.

5. Concluding observations

A tragic characteristic of any modern health system is that it is, on the one hand, the source of so many medical miracles and so much human well-being and yet, on the other hand, the source of so much suspicion and rancor.

It is so, because government or private insurers pay for so much of personal health care. These third-party payers forever suspect that either patients, or physicians, or both may be abusing the system. The third-party payers' suspicion is heightened by the fact that physicians and other clinicians have never been able to agree on best practices for the treatment of many illnesses, as was illustrated with the remarkable data in Figure 5 above.

There is the added fact of life that every dollar (or pound or franc or lire or yuan or peso) of *health spending* always is someone's *health-care income*. Even pure waste in health care always represents someone's income. It is one reason why the constant pleas by the providers of health care for added health care budgets so often go unheeded by policy makers. Although the providers claim to plead on behalf of patients, government officials and private insurers suspect that more often than not these pleas are merely for higher health-care incomes.

Finally, technological change and economic globalisation have served to widen the distribution of family income in all modern nations. That development makes it ever more difficult to preserve social solidarity in health care, as the upper-income classes – notably in the United States – chafe at the thought of having to finance for the lower-income classes quite the luxurious, cutting-edge and often expensive health care that the well-to-do are able to finance for their own families.

Neither a completely government-run health system nor a free market approach to health care is the panacea for these chronic woes. The replacement of one system by the other mainly would redistribute economic privileges among members of society, thereby replacing one set of problems for another. Consequently, countries the world over will experiment with different mixes of the two approaches[19], concluding after each new reform that yet further reforms will be needed. And so it will go, forever. As part

of their mission, the leaders of Catholic health should stand guard over these perennial health-reforms, lest the reforms come at the expense of the least powerful amongst us.

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Note

[1] A researcher in a pharmaceutical laboratory, for example, releases human labor indirectly to patients, as do the employees of insurance companies.

[2] The measure excludes all valuable goods and services not traded in the market – for example, the valuable work of volunteer workers, of parents raising their children, and so on.

[3] U. E. Reinhardt, "Resource Allocation in Health Care: The Allocation of Lifestyles to Providers," *The Milbank Quarterly*, 65(2), 1987: 153-76.

[4] Mark V. Pauly, "U.S. Health Care Costs: the Untold Story," *Health Affairs*, 14(3); 1995: pp. 152-9.

[5] Uwe E. Reinhardt, Peter S. Hussey and Gerard F. Anderson, "Cross-National Comparisons of Health Systems Using OECD Data, 1999," *Health Affairs*, 21(3), May-June 2002; pp. 169-81.

[6] Economists trace the origin of their profession to the *Fall from Grace*. According to a popular saying, "*For economists there is no Heaven or Hell. For in Heaven there is no want, and in Hell there is no choice.*" The idea is that any situation that does not require trade-offs among alternatives does not need the advice of economists. Fortunately, for the profession, life on earth is a station outside of Heaven and Hell.

[7] For a survey of the valuations obtained by economists, see W. Kip Viscusi, "The Value of Risks to Life and Health," *Journal of Economic Literature*, 31(4), December, 1993; pp. 1912-46. Depending on the setting of human choices, the implicit value of a life year is reported to span quite a range. For job-safety contexts, for example, they were found to range from a low $14,000 in certain job-safety contexts to over $800,000. In his "The Value of Life in Legal Contexts: Survey and Critique" *(American Law and Economics Review*, 2(1), Spring, 2000; pp. 195-222) the authors reports valuations of "life" (i.e., a string of life years) set in cour6t cases to range between $3 to $9 million.

[8] As is reported in Yeh, Jin-Chuan, *Chuan Min Jian Bao Chuan Chi [The Legend of Taiwan's National Health Insurance]* (Taipei, Taiwan: The Tung Foundation, 2002; pp. 215-6), this figure can be traced to the famous *Lalonde Report* issued by former Canadian Health Minister Marc Lalonde. The number can also be found in the Institute for the Future, *Health & Health Care 2010: The Forecast, The Challenge*, San Francisco, CA: Jossey-Bass Publishers, January 2000; Figure2-9. Additional insight on the non-health determinants of health status can be found in a volume of seminal essays the recent issue of *Health Affairs* entitled on "The Determinants of Health," [21(2), March-April, 2002].

[9] Leaders of Catholic health care could monitor the pursuit of this goal by benchmarking their institutions against similar, secular institutions on the percentage of revenue allocated to charity care.

[10] Better "health literacy" has become an important focus of health policy in the United States, both in the public sector and among private philanthropies. Pharmaceutical companies, too, have lent financial support to this endeavor. It would seem to be an even more important objective in the developing countries.

[11] For an extensive discussion of this issue, see Uwe E. Reinhardt, "Abstracting from Distributional Effects, this Policy is Efficient," in Morris L. Barer, Thomas E. Getzen and Greg L. Stoddard, eds., *Health, Health Care and Health Economics*, John Wiley & Sons., Ltd, 1998; pp. 1-53, and Uwe E. Reinhardt, "Can Efficiency in Health Care be Left to the Market?" *Journal of Health Policy, Politics and Law*, 26(5), October 2001; pp. 967-92.

[12] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, Washington, D.C.: National Academy Press, 2001; p.3.

[13] The prudent word "most" is appropriate, because there has been evidence that proper hand-washing between patients is not invariably practiced in all American hospitals. That problem may exist also in other nations.

[14] Institute of Medicine, *To Err is Human: Building a Safer Health System*, Washington, D.C.: National Academy Press, 1999.

[15] See, for example, Troyen A. Brennan, M.D., "The Institute of Medicine Report on Medical Errors – Could it Do Harm?" *The New England Journal of Medicine*, 342(15), April 13, 2000.

[16] David M. Studdert and Troyen A. Brennan, "No-Fault Compensation for Medical Injuries," *The Journal of the American medical Association*, 286(2), July 11, 2001: pp. 217-223.

[17] A health insurance premiums is "actuarially fair" if it covers the actuarially expected health care cost for the insured individual. Actuarially fair premiums naturally rise with the age of the insured and reflect as closely as is humanly possible the projected health status of the individual.

[18] In truth, the U.S. health system has been moving in this direction for some time and undoubtedly will continue to do so in the future.

[19] For the descriptions of systems that might be able to harvest the beneficial forces of competition in health care while maintaining social solidarity, see Uwe E. Reinhardt, *Accountable Health Care: Is it compatible with social solidarity?*, London, UK: Office of Health Economics, 1997.

GIAMPAOLO CREPALDI

3. In a Social Perspective

The most widespread mentality on the subject in societies that are adapting to modernity tends to see the state as something that must meet the demands of the population, and this to the point that there is amazement at its powerlessness in the face of natural catastrophes and people protest that the state has not made available all those instruments which are able to counter the effects of events that are totally unpredictable. A similar mentality is to be encountered in the attitude of populations towards health care institutions.

That hospitals and health care centres should have the instruments, even of the most sophisticated kind, to meet the needs of the population is seen as a right. The constraints that arise from a lack of staff, a lack of resources by which to acquire equipment or drugs and medicines etc., are not taken into account. People are amazed at the fact that a better form of medicine cannot be used to meet the requests of patients. At a most extreme level, the health care services are seen as a kind of supermarket where each individual can find what is most suited to his requirements.

We are face to face with a radical mutation: whereas in a world that was deprived of adequate means and instruments, the health care services were seen as works of good will characterised by free-giving and the wish to surround the patient with a network of human relationships, the conversion of care and treatment into matters that are purely technical in character acts to make such a human dimension disappear, and all too often it is thought that a health care institution has fulfilled its contract when it has ensured that the largest number of patients have received the best forms of care and treatment at the lowest possible cost.

The development which has just been outlined, which will be analysed in a more scientific way by other speakers, affects to the full Catholic hospitals and health care centres managed by religious staff. The question is to know if the concept of health care that has been cultivated by the Church over the last two millennia still conserves its value at a time when human activity is increasingly conditioned by technical regulations that require specific forms of conduct. The priority of a health care administration is not to establish a personal relationship between the patient and the person who is treating him – such a relationship is made impossible, first of all, by the fact that the health care staff are too few in number to dwell upon the personal problems of the sick people entrusted to their care, but also, and above all else, because the health care authorities of various countries issue rigorous rules on how care and treatment should be provided and see hospitals as a 'firm' in which each person should perform the task allocated to him by legislation and society.

Catholic health care institutions are involved in this process. We ask ourselves whether they should abandon the autonomy that they possessed in the past and accept being a mere auxiliary function of the state. Or do they have some other possible course of action? Co-operating in achieving goals of public interest is important, but should Catholic hospitals confine themselves to a role of mere back-up or should they take on new responsibilities which will enable them to help to determine the directions of health care services? This is the question that Catholic health care institutions are faced with in modern society. Personally, I think that they have a specific role to perform. To the question of whether Catholic health care institutions still have a place in a society that is marked by what should be called *dirigisme*, I answer that they bear witness to the *freedom* that belongs to every man, the *equality* with which every person should be treated as regards access to health care, and the *solidarity* that men are called to bear witness to reciprocally. In this way, Catholic health care institutions help to preserve values within society.

1. Catholic Health Care Institutions as Witnesses to Freedom

The possible conflict between legislative provisions and moral requirements was often taken into consideration by the Magisterium of the Church during the second part of the last century. Of special importance is the text of the encyclical *Populorum progressio* on the question of population (n. 37), where Paul VI recognises the responsibility of governments to intervene in this field and at the same time also points out the limits which cannot be overstepped without transgressing moral law and violating the respect due to the right freedom of the married couple.

Because questions connected with health care concern personal attitudes towards life, the professionals of health care have to address very specific problems of conscience and take decisions in the most immediate way. Indeed, they often have to come up against the very different judgement of another conscience. The most known about cases in this sphere are abortion and euthanasia, but there are

also many others: the kind of treatment to be followed, the information that should be given to a sick person or his family, a professional secret that must be kept etc.

Various governments want to bind the conscience health care professionals and the managers of hospital institutions and make certain practices obligatory (for example, student nurses who want to obtain their professional qualifications are obliged to take part in the practice of abortions). In the face of such difficulties, Catholic health care institutions can base themselves on recommendation n. 157 adopted by the International Labour Conference of 1977 in relation to the employment and the life and working conditions of nursing staff. Article 18 of this recommendation envisages the right to conscientious objection: 'the members of the nursing staff should, without being subject to any prejudice, be exempt from carrying out those acts that are in conflict with their moral or ethical religious beliefs, it being understood that they will inform their superiors about their objection in good time so that every necessary measure of substitution can be taken to ensure indispensable care and treatment for the patients'.

The question that has just been analysed raises a double question: that of the approach of the individual to legislation that does not respect freedom of conscience, and that of the collective approach to the goal of promoting institutions that guarantee the specific character of Catholic health care institutions.

a. The Approach of the Individual to Legislation that is Contrary to his Beliefs

The Church has always affirmed that nobody can be obliged to act against what his conscience deems wrong. This intransigence has a social significance that is not sufficiently emphasised. The great social movements have been the outcome of numerous convergent individual choices. There comes to mind the speech made by John Paul II in front of the cathedral of Spira during his visit to Germany on 1987. Here is a short passage from that speech: 'Dear brothers and sisters in Christ! Some of those amongst you will perhaps now be asking: the Christian roots of Europe, world peace, freedom of religion, the reunification of Christians, all these are great and important challenges of our epoch. But what can I do on my own? *Can I make some personal contribution*? And I answer to you: *yes*, you on your own can set something in motion; because every good resolution, every quick taking on of a task begins in the individual man. However much individual efforts must be brought together in order to be carried out on a larger scale, the fact remains that the *yes* of an individual person, given with generosity and loyally adhered to in his own sphere, can really *trigger and effectively promote* deep changes for good, at both an ecclesial and social level' (*L'Osservatore Romano*, 6 May 1987, p. 4).

What an individual cannot do alone he can do in a group. It is the responsibility of health care professionals to make their colleagues aware that it is wrong to force someone to act against their own beliefs and that it is right to come together to obtain respect for a fundamental freedom. The associations that bring together Catholic professionals must actively and organically (Paul VI talked about 'organic participation' to the International Labour Conference of 1969) take part in the definition of the ethical orientations of health care services. Trade unions should not be alone in acting in such a context. A place should also be given to the associations that defend the truth of man in their exercise of his profession.

b. The Collective Approach to Ensure that the Specific Character of Catholic Health Care Institutions is Respected

Today the question of conscientious objection is felt acutely at an institutional level because the law can compel the offering of health care services that contradict Catholic morality.

For this reason, some institutions may come to stop all of their activity so as not to co-operate in medical actions that are contrary to morality. Addressing military doctors in 1953, Pius XII observed that in the face of violence and the lack of conscience 'one can be forced to undergo injustice'.

Attention needs to be paid to the collective responsibility to foster the creation of institutions that respect freedom of conscience. Health care workers should not be left alone to address problems whose solution depends in large measure on decisions that are the responsibility of other sectors of society. John Paul has referred to 'structures of sin' (*Sollicitudo rei socialis*, n. 36) and emphasised that these come from wrong actions or the omissions of those who have not opposed injustice. A legislative system that does not respect the specific character of declared Catholic hospital structures must be modified thanks to the co-operation of everyone. Appropriate juridical measures are required to leave space to conceptions of health that are different from those imposed by ascendant opinion.

The safeguarding of the specific character of a hospital is the necessary condition to promote a freedom of enterprise that is exercised within the framework of legislative provisions and rules regarding public health care. The character of such measures must be the subject of dialogue between the interested parties. The conflicts that may arise at the moment of searching for a shared solution must be resolved through negotiations in

which each party attempts to understand the reasons why the other party thinks one of these measures is essential: an independent judicial body allows the finding of a solution to such conflicts. A Catholic hospital cannot have imposed upon it an obligation that denies its very reason for existing; a government goes beyond its rights when it imposes a measure that writes into reality an ideology or a philosophy of life that belongs to one particular group. Freedom of conscience requires that there should be respect for the specific character that individuals wanted to give to the institution that they created and which is its essential feature. The independence of health care institutions is protected when their freedom to choose the forms of medical care and treatment and the health services that they provide is recognised.

The recognition of the specific character of Catholic hospitals, and at a more general level of all those health care institutions that are created to respond to an ideal, in large measure depends on the cultural policy of the population of a country. Indeed, every country is tempted to intervene directly to impose its 'vision' of health and health care but in reality this vision is the reflection of the choices and preferences of public opinion: hence the importance of ensuring that such opinion is made aware of all the implications of the orientations that are proposed and the decisions that are taken.

2. Catholic Health Care Institutions and Equality in Access to Care and Treatment

Amongst the needs of societies that have adopted the ideal of democracy, there figures that of equality. However, modern states encounter grave difficulties in guaranteeing equality in an effective way. These difficulties can be overcome by institutions of a religious inspiration, and this is particularly true as regards the role of health care in contemporary societies.

It is true that since the French Revolution the search for equality has stood out as one of the objectives of every society that is open to the future. Modern societies and international organisations have made the equality of all men before the law a fundamental principle of the public sphere. Precise juridical norms have been laid down to offer everyone equality of opportunity as well as access to education or employment. The various systems of public welfare strive to ensure the same equality in access to medical care and treatment. The equality established by modern societies is of a juridical character. Secular societies, in fact, cannot invoke philosophical considerations, and even less can they refer to religious criteria, in order to incite consciences to accept the sacrifices that are required by the search for equality.

Despite the intention to achieve an egalitarian society, forms of inequality continue or take on new configurations. Even where peoples have been involved in a revolutionary impetus generated by the desire for equality, new dominant classes have arisen and have given themselves advantages that are not made available to everyone. This phenomenon is especially perceptible in health care systems. A map of forms of inequality in the field of health and health care would bring out the contrast that exists between the situations of the industrialised countries with a high GDP and those of countries whose state budget is unable to support a modern and widespread health system, the result of which is that there are high death rates caused by major pandemics.

The network of Catholic health care institutions is relevant. The presence of the Church in the sector of health and health care justifies governments seeing such institutions as interlocutors to be associated with the planning of the provision of health care, always respecting their specific characters. The struggle against the illnesses that are spreading in the poorest parts of society requires a form of medicine based on nearness, whether one is dealing with refugee camps or the dispossessed districts of cities, in both rich and poor countries. Not to give social workers (and here I am thinking especially of religious congregations) the means and instruments by which to carry out their service means to reject equality in access to care and treatment. Equality is built from the bottom up, ensuring that everyone in a real way has an education and the means to feed themselves, educate themselves, and obtain treatment for themselves. Experience demonstrates that when equality is sought for from the top down, large parts of the population are neglected and restrictive measures come to harm the freedom that it is proclaimed is intended for everyone.

Catholic hospitals can today encounter great difficulties in bearing witness in a faithful way to the need for equality, but such witness is more necessary than ever before.

The promotion of equality in access to medical care and treatment draws upon the shared ethics of modern states, even though at times it is difficult to achieve equality in practice, and also belongs to the vocation of Catholic hospitals. However, a difficulty is encountered which depends on the conditions of the management of a health care institution. In order to ensure a service of high quality, an institution must be constantly concerned about modernising its facilities and applying social rules and regulations, and this is something that has heavy effects on its budget. Administrators are then tempted to place accepting poor people in second place after being concerned about the efficiency of the structure. It is certainly the case that not everything can be done but care for those most in need must emerge in daily work, expressing itself in the human relationships between the medical and paramedical staff, patients, and their families. Medical doctors and nurses must bear personal witness to their own interest in situations of abandonment or anxiety. We need, therefore, to assess the human quality of services and the abilities of the staff in this field. A general spirit of readiness to help should be kept alive in institutions, even though this is an obligation that it is difficult to be specific about. Whereas the requirement to respect the choices of conscience involves cases that are quite easy to identify, here we are

dealing with a spirit that must first of all move managers so that they are able to make it live in the various services. The pursuit of such an objective has sensitive aspects, first and foremost when the management of health care institutions is entrusted to secular people employed in the basis of their expertise and skills. Perhaps one could think of asking such people to sign a declaration in which they undertake to respect the objectives of the hospital and to act in line with the orientations of the Holy See (especially in the biomedical field), as well to base themselves on the Christian concept of the humanisation of care and treatment, as His Eminence Cardinal Fiorenzo Angelini emphasised yesterday morning in a timely and convincing way. Special attention must be paid, moreover, to granting the use of the buildings of a health care institution to groups whose activity respects the principles laid down by the Magisterium of the church.

3. Catholic Health Care Institutions: Witnesses to Solidarity

Four stages can be identified in the concept of solidarity: that in which help is provided in urgent situations such as hunger and illness; the interdependence that is established between those who provide help and those who need help; the mutual respect for the values that must characterise every solidarity-based initiative; and concern about future generations in the ways in which the present is managed. All these aspects must be taken into consideration by Catholic hospitals. Indeed, their vocation is to allow the most poor to have access to medical care and treatment by co-ordinating their action with that of other health care institutions and thereby safeguarding the future of the population by defending its health. The staff of Catholic health care structures must constantly remember the need to make their best forms of care and treatment available.

It is too often the case that the concept of solidarity is seen solely from the point of view of the individual duty of every man and every institution towards those who are in a state of need. There is, however, another approach in which solidarity is no longer the virtue of individuals but a collective attitude. Society is not the sum of isolated individuals who agree to form a compact of association but a social reality, a moral person, the bearer of the choices of its members whose fulfilment it pursues. This collective will applies in the first instance to such major social services as education and health care which touch from very close at hand an interpretation of human life to which the members of a community freely adhere and which, after a certain fashion, becomes their fundamental compact.

At the end of these reflections, once again there emerges the value of a social anthropology which sees society as an overall whole, with a vision that is the pre-condition for respect for people because it has in itself a kind of antidote against the drift that leaves individuals alone in the face of the state Leviathan. To conclude, I would like to emphasise the 'solidarity' of the Pontifical Council for Justice and Peace with the efforts of the Pontifical Council for Health Pastoral Care directed towards recognising the specific reality of Catholic health care institutions. Their existence offers an opportunity to remind today's world of the human and social dimension to medical care and treatment.

H.E. Msgr. GIAMPAOLO CREPALDI,
Secretary of the Pontifical Council For Justice and Peace, the Holy See.

PASCUAL PILES FERRANDO

4. In the Religious World

1. Greeting

I would like to thank you for having invited me to take part in this conference and to discuss the religious challenges that have to be faced in order to sustain the Catholic identity of health care institutions.

As always happens when these aspects are taken into consideration, it is something that is done beginning with one's own experience, which in my case involves almost forty years as a religious and at the present time being the representative of the Hospital Order of St. John of God, which has institutions in fifty countries of the five continents and almost three hundred health care structures which the order is responsible.

2. The Premises to be Taken into Account

I will point out three such premises. I do not know if they are the only ones but they are those that I consider appropriate for this reflection.

The health care institution as a place of healing

I believe that for everyone it is clear that a health care institution is a place of health to which sick people turn in an attempt to regain and restore their health. Independently of their experience of the institution, the experience of illness, and at times of death itself, thanks to a certain way of behaving on the part of health care workers, can be an opportunity for people to encounter Christ and his salvation. Indeed, we must seek that encounter, both for the patients and for those who surround them.

Religious freedom

I believe that we must always act according to the principles laid down by the Declaration on Religious Freedom of Vatican Council II, *Dignitatis humanae.*

Thus we proclaim the awareness that as persons we have our dignity, which leads us to practice responsible freedom and to exclude any coercive instrument or means.

This leads us to defend our identity in each country of the world, whatever our ideology and our creed.

Albeit with our own creed, we thus act in a way that respects the freedom of states and of every person that we care for, without forcing them to receive pastoral care and helping those that belong to other religious confessions through the provision of various kinds of services.

The diversity of cultures and criteria

At the present time our order works in fifty countries, as I observed at the beginning of this paper. We can state that the Church is present in all the countries of the world: I do not know, in fact, if a country exists where there is not at least one seed of the Church.

As a Church, we defend our Catholic identity, on the basis of which we formulate our principles to act within the context of our institutions. These principles must be known by those working in our institutions and the implementation of such principles must be respected.

Another thing is the fact that those people who work in our institutions, and are thus all members of them, should live out in a convinced way the fact that such institutions are a part of the Church, whether they belong to other Christian denominations or whether they are agnostic.

In my experience, in this mixture of possibilities, which we can say is present in most of the places where an institution is present, we must have a pastoral approach that is based on the dialogue of charity – as the Holy Father has stated on various occasions – and have an approach of evangelisation *ad gentes,* even though we are in home territory.

This was the way in which St. John of God lived during his own time, in the sixteenth century, and which we have taken on as the legacy that he left behind to us. We have clarified this approach, for the application of which we ask respect. We share the human values of his charism with people. With others, according to the place involved, we share and celebrate faith in Jesus Christ and in our being a part of the Catholic Church, or we share and we celebrate, albeit to a lesser extent, our faith in God.

We feel that we have been called upon by John Paul II, in his recent writings, to live out an ecumenical spirituality.

3. Needs

To give an impulse to Catholic institutions, I believe that it is necessary to take into account the following considerations:

An assessment of needs in the places we find ourselves in

Our founders were always present in history through trying to meet the pressing needs of the places they were in. I would like to say, as well, that at the base of any

health care institution or initiative promoted by the Church there is the fact of trying to meet a major need.

This must take place both in institutions that have existed for some time and in places where our presence is only recent. In 'historical' places we do this trying to update ourselves in the work that we carry out. In our new presences we have to try to meet, with what we promote, the needs that surround us.

Knowledge of the legislation of the various countries we work in

We cannot think of a new foundation or remain in a country on the margins of its legislation. We must know about that legislation and try to act to improve it.

We must begin from the bottom up, that is to say by accepting the juridical conditions of each country we are in, and in this way promote the institutions involved, as long, that is, as they take into account the fundamental principles of our way of acting.

If this was not the case, we could not be witnesses to what at the outset, as an ideal, as a Church and as a religious order, we assert.

Carrying out our action on the basis of the principle of subsidiarity or complementariness

The presence of the Church through health care institutions is the result of subsidiary action in places where a sufficient development does not yet exist or in places which need support - action for which the Church has made herself responsible; or in places where this development has already taken place and where we are complementary, trying to be signs of an action of quality achieved with the culture of our foundation, that is to say overall service.

Based on these principles, we must privilege the sectors that we consider to be the most disadvantaged: the sick in general, the mentally ill, the elderly, the terminally ill, the physically or mentally disabled, etc.

Guaranteeing that the centres we found are liveable

As a Church, and as orders or religious congregations, we need to ensure the means that are required to support centres, and this so that they can ensure efficiency and continuity.

I believe that many of us, indeed the majority of us, define ourselves as non-profit making institutions; but as institutions that need resources to work as a mission.

This can be achieved through agreements with those states that are organised at the level of health care, through grants from state or semi-state bodies, through the cooperation of people who believe in our project, or through contributions from the patients that we care for and treat.

4. The Challenges that We Must Take into Account

We will now examine the challenges to which the title of this paper refers. I will certainly not seek to be exhaustive, but I would like to talk about seven challenges, and they are as follows:

To organise Catholic health care centres in line with total quality and with overall care. Such should be the model for their actuation from a technical point of view and for their approach to the human and spiritual approach. Such centres should have quality and human warmth, and place the sick person at the centre of the institution.

I believe that a health care institution of the Church, a centre promoted by a religious order or by a religious congregation, cannot exist without an action of quality being engaged in.

In theological terms, we can say that new foundations are moved by the impulses of grace, but we know that grace is embodied in nature. Employing all the gifts that God has given us, we are called upon to help grace.

Quality care requires good professional expertise and skills which take into account the most up to date technical opportunities – as far as this is possible for us – and the way in which such realities can be applied.

We should place emphasis on knowing how to serve, on knowing how to help, on knowing how to place technical achievements at the service of the person in his or her various dimensions. Otherwise, we will not have total quality and we will not provide overall, holistic, care.

Our much lamented Fra Pierluigi Marchesi was defined as being the prophet of humanisation. His thoughts about humanisation were famous in our religious order.

Down our history we have always tried to provide quality care. His thought involved us acting in a way that was professional, of a high cultural level, evangelised, and spiritualised.

Criteria such as 'it is necessary to be humanised in order to humanise', 'the sick person is our university', or 'the sick person is the centre of our institution' are all elements that have led us to reflect a great deal at a personal and institutional level, both on our own and together with health care workers.

St. John of God himself founded the first institution of our order to offer an alternative of quality after an experience within a hospital to which he had been admitted and where he did not perceive the presence of much quality or humanity.

To ensure that within the Church, health care centres are

characterised by this spirit is one of our primary challenges.

To work so that health care workers feel protagonists of the project that they are promoting, continue to feel identified with the institution, and feel themselves part of its culture and the way it expresses itself.

In the past we worked with a certain amount of paternalism: on the one hand, protecting health care workers, and on the other hand, distancing them from our reality when they did not interest us. Our way of behaving must be more involving.

On the basis of many reflections on the management and the life of institutions, one might say of such undertakings in general that emphasis is being placed on this reality, on sharing the values of the institution, on promoting them, and on ensuring that people identify with the institution, with its way of acting, and its culture and its mystics.

With due respect for the identity of all those who are the part of the institution, we must make them participants in our criteria, our style, and always be ready to improve it through their presence and the riches that are within them.

The Church has a culture, mystics and a tradition of care in frontier places. She has an idea of the person as regards his or her birth, his or her living, and his or her dying.

All this forms the inheritance of our tradition, and we must live it, sharing it, so that it illuminates our way of acting. Tradition understood well, through a correct reading, does not inhibit. Its function is to illuminate the present and to open us to the future.

In the selection of staff and personnel, of human talent as in some places is now said, we must take into account professional skill and expertise, human values, and at the same level, religious affiliation.

Perhaps all of us have had unfortunate surprises in this area because some people who apparently seemed to meet the profile that we were looking for have not always turned out to be up to the job.

To obtain the means necessary for our mission, without, because of this, ceasing to be prophets in the world of health and health care.

I will dwell less upon this challenge because it has been addressed in a specific way by other members of this round table.

In this field, and in many others, the Church must bear witness to the fact that she is not out to make money, that she is not a ‘pesetera’, as we say in Spain. I do not know if we should now say ‘euroera’, given the new currency. But it seems to me that the word does not have a ring to it.

In my opinion, in her health care institutions the Church must work not to make money but to serve. She must always seek to work without having profit in mind, as an expression of the charity of Christ and the merciful love of God for people.

This does not mean that she should not work a great deal to sustain her institutions, knowing how to manage them through public and private institutions, and physical or legal entities, and to obtain the resources and manage them well. I believe that in this we have been, at times, a little short sighted. We should, instead, be wise, in a society such as ours, which is full of other interests. In addition, the administrations of health care centres must be marked by transparency and clarity, and they must always avoid any kind of corruption.

To organise appropriate pastoral services to achieve an adequate evangelisation sustained by a well performed service.

One of the things that we must take great care of and which for this reason I maintain is a permanent challenge for our institutions, is that of having good and organised pastoral services.

In these services there must be leading figures, a priest or more than one priest, male and female religious, members of the laity, all people who are suitable and who together carry forward the pastoral action of pre-evangelisation, evangelisation, and the celebration of the sacraments, according to what the institution requires, trying to integrate into this action a greater number of people, health care workers, voluntary workers, or friends of the institution.

Pastoral work should be directed towards addressing patients and their family relatives, as well as the staff and personnel who work in the centre.

The approach requires clear criteria as regards the human sciences and theology, so as to achieve adequate action that is always healing and salvific in care and treatment, but also suitable action when the illness persists or when death arrives.

It will be necessary to bear in mind that the experience of illness and of suffering can be an element of maturation for the person, although at the same time it can also be an element of destruction.

To promote an ethical project of care in line with the principles of the Magisterium, which are applied to the concrete reality of each day.

One point that today requires constant attention in the task of providing assistance is respect for the dignity of the person. The possibilities of intervention on the human being by science are on the increase. ‘Not everything that is technically possible is ethical, moral or something that may be done with respect for gospel principles’, John Paul II has said on different occasions.

We must know and adhere to the principles of the Magisterium. We must know the thought that in the field of bioethics is constantly engaged in by the theologians and philosophers of the Church and by experts in the human sciences.

As ecclesial institutions, we must meet the daily requirements of the task of providing assistance.

We need to promote knowledge about the bases of the bioethics of the Catholic Church through courses, round tables and masters degrees, and this should be achieved in our institutions. We must promote committees on bioethical assistance or on clinical experimentation. All this helps to create a culture amongst health care workers and fosters the provision of help in concrete cases in order to decide on the case in hand.

Our religious order at a univer-

sal level has various journals that promote both reflection in the field of pastoral care in health and in the field of bioethics in various parts of the world.

In the year 2000 our order published an 'identity card' which addresses, amongst other things, the subject of bioethics and the application of bioethics in concrete situations.

To dedicate effort, in addition to assistance, to teaching and research.

As regards these challenges, after what has been said in this paper I believe that it is clear that a good form of care should be achieved but such care cannot be such without taking into account teaching and research.

In the field of teaching we give great space to training health care workers from a technical point of view but also from a human and spiritual point of view, with a specific style and a Catholic spirit.

In our institutions we must also make a contribution to research. It is clear that not all institutions have the capacity to contribute to the same extent; it is, however, certain that this is an aspect that must be promoted so that we can be witnesses in a world which is of a high level of culture and given the relationships that exist in the field of providing assistance between faith and culture.

We need to be witnesses to Christ and his Church through our service, trying to be the expression of great creativity and imagination as regards charity in a secularised society which often believes more in deeds than in words.

Our great challenge is to be at every moment witnesses to Jesus Christ and his Church through our service.

In very many parts of the world society is very secularised. As John Paul II observes in his *Evangelii nuntiandi*, a society that is more sensitive to reading signs than words (cf. *EN*, 42).

Our society is a society in which, following the exhortation of John Paul II, we Christians are called to have creativity and imagination in expressing the charity of Christ, hospitality and assistance. We are called to create a culture of life.

We Catholic Christians who work in the world of assistance, and who promote institutions providing assistance, are faced with the great challenge of knowing how to meet the needs of modernity through projects of assistance and through the implementation of these projects in ordinary daily services, to which we dedicate many hours of the day, in order to serve the person with dignity. And it was to the person that Jesus of Nazareth, presenting a project of health/salvation, dedicated his own life, always thinking of those most in need.

These will be the challenges, according to my vision of reality, that we are called to take into consideration, responding to them through our presence in the world. As I said at the beginning of this paper, perhaps there are other challenges. The experience of each one of us must lead us to enrich them.

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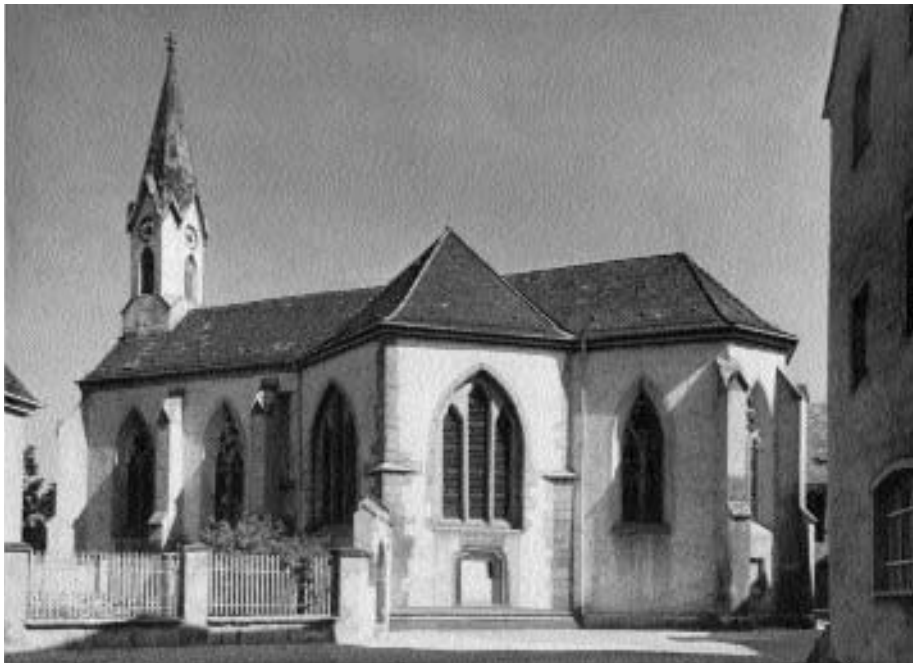

II Section

friday 8 november

Illumination of the Contemporary Reality of Catholic Hospitals by Faith

ROSARIO MESSINA

1. The History of Catholic Hospitals

Down the centuries the Church has in a strong way seen service to the sick as an integral part of her mission'.[1] This has been so for a large number of reasons: because through taking care of the sick she has obeyed the mandate received from the Lord: 'Go then, preach the Gospel and heal the sick';[2] because, as John Paul II has stated, she has written the parable of the Good Samaritan once again in time;[3] because she has followed the example of her Teacher who surrounded himself with the poor and the sick during his earthly life; because 'the Holy Church is known by this mark of charity',[4] 'charity, in fact, is the heart of the Church: without charity the Church is not the Church of Jesus Christ';[5] and, lastly, because charity is the privileged way to make the Gospel credible: 'if you see charity', wrote St. Augustine, 'you see the Trinity'.[6]

These and other aspects or faces of charity were understood and assimilated by the first Christian communities, in the same way that the Acts of the Apostles[7] and the impassioned homilies of the Fathers[8] made them a part of faith. The Fathers of the Church, with simple but fiery words, exhorted the faithful not to betray the commandment of love adumbrated in the parables of the valuable pearl, the hidden treasure, the marriage dress, the fruits of the tree, the oil in the lamp, and above all the Good Samaritan and the final judgement.

These thoughts, insistently repeated, given value by example and the holiness of lives, ended up by becoming food, nourishment, a way of thinking and a style of life of the original Church.[9]

Thus, in this very short historical excursus which now follows in this paper, I will not seek to exalt the works of charity so much as to exalt the charity of works,[10] that is to say the intimate passion, the deep love and the burning fire of charity that have made such works flourish. As Karl Rahner writes: ' the real and authentic history of the Church (if it has ever been written or will be able to be written) is the history of saints; all the rest – although important and however necessary it may be – is absolutely of secondary importance compared to this intimate history'.[11]

In a letter sent to Harsacius, the pagan priest of Galazia, the Emperor Julian wrote: 'it is a misfortune that no Jew is a beggar and that the impious Galileans feed our people as well as our own, whereas our people, as is notorious, do not have our help'. This statement of this apostate Emperor is a sure testimony to the activity carried out by the Church on behalf of the weakest social classes, and allows us to understand that towards the end of the fourth century the Christian practice of helping, on organised bases, whoever was in need had taken on notable proportions, in particular through 'deaconries'.[12]

The term '*diaconia*' from the first to the fourth centuries meant any form of 'service of charity' that the Church was able to invent or derive from the socio-cultural context of which it formed a part. Subsequently, the Church went on to project special 'institutes of charity' administered and managed by a community led by a bishop.

Because worship and charity were seen as being the inseparable and valuable images of the same diptych, the early cultural contexts, beginning with the supper room where Christ as 'a deacon-servant' washed the feet of his disciples and as a 'priest-minister' broke bread with them, also became the privileged places of '*diaconia*' (service of charity), with tasks involving gathering knowledge about situations, taking stock of resources, and planning initiatives and measures.

During the period of persecution, Pope St. Fabian in Rome, Bishop St. Cyprian in Carthage, and the *Storia Ecclesiastica* of Eusebius of Caesarea in Alexandria, were rich in edifying examples: bishops, deacons and the ordinary faithful organised themselves to alleviate the suffering of the living and to offer a decent burial to the dead.[13]

With the peace of Constantine, thanks to a capillary action of monitoring carried out by deacons, collaborators of the bishops and ministers to the poor, the subjects for care were by now identified: illegitimate newly-born children, orphans, abandoned children, widows, elderly people, invalids, the blind, the incurably ill, pilgrims – for such people institutes were founded that were endowed with fixed revenues and on which Emperor Justinian bestowed a legal status, dividing them according to needs into:[14] *nosocomia*: hospitals, the most important of which could have up to a hundred or two hundred beds; *orphanotrophia* and *brephotrophia*: institutes to take in orphans or abandoned children; *gerontocomia*: hospices for the elderly; *ptocotrophia*: hospices for the poor; and *xenodochia*: hospices-hospitals for strangers and pilgrims.

Towards the end of the fourth century, the *xenodochi* must have had special importance in social life given that even Emperor Julian urged their foundation on pagan priests. Indeed, their creation was also requested by canon n. 75 of the Council of Nicea (325), which obliged bishops to build hospices for the poor, for the sick and for strangers in every city.[15]

According to the historian Sozomenes, the first *xenodochio* was created in Edessa (Syria) in 370: during a terrible famine the deacon Ephrem enclosed some of the colonnades of the city with a fence and in them provisionally placed three hundred beds in which, every day, he ensured the provision of hospitality and care to all those inhabitants who were hungry and sick.[16]

Five years later, Basil, the Bishop of Caesarea in Cappadocia, created a vast hospital complex considered to be the largest work of care of Christian antiquity. Its size was so great as to be seen as a real and authentic satellite town which the local people called 'Basiliade'. Like modern polyclinics, it had various wards, some of which were reserved to those suffering from infectious diseases: lepers, who were subjected to ubiquitous expulsion and forced to wander around without a permanent home, were welcomed and cared for and treated by medical doctors and nurses. In addition to the hospital, *xenodochia* and various laboratories arose in Basiliade, in which provision was made for the very many needs of those who had been admitted; at the same time young people were offered the opportunity to learn a skill.[17]

A contemporary of Basil, the Bishop of Constantinople, John Chrysostom, organised care for the poor by mobilising the aristocracy of the Byzantine capital. In order to build hospitals, which he preferred to the basilicas, he drew in abundant fashion from his own goods and put up for sale marbles and precious stones that belonged to the treasury of the Church.[18] In addition, he exhorted all the Christians to transform their homes into a small *xenodochio*, in which a room with a bed, a table and a lamp had to be always ready to receive a poor person, a stranger or a sick person.

As can be seen, in this ardour of charity, the bishops were always in the front line. Helped by the deacons and supported by the generous offerings of the faithful and by the substantial donations and funds given by the emperors, the bishops built hospitals, hospices, orphanages and homes for the poor next to the cathedrals and in other areas of the city.

To list all of these bishops would be inappropriate and I will refer to only a few: Ilarius of Poitiers, Ambrose, Gregory of Nazianzus, Gregory of Nyssa, Augustine, Cyril of Alexandria, Leo the Great, Maximus of Turin, Caesarius of Arles, and Gregory the Great.[19]

Together with bishops and deacons we encounter a multitude of the ordinary faithful who worked wonders in caring for sick people of every kind and in building hospitals which they made available to the Church. I would like to refer here to at least two:

1. In Rome, Fabiola founded a hospital in which she herself served. S. Gyrolame wrote as follows on this initiative: 'how many times have you yourself carried on your shoulders sick people afflicted by leprosy and cancers. How many times have you disinfected puss-filled wounds, which another person would not even have dared to look at. You fed those living corpses, with your own hands, cups of soup'.

2. In Ostia, Pammachius founded a hospital of which the foundations were later discovered. Gyrolame wrote to him: 'I have heard it said that you have founded a hospice for pilgrims on Porto Romano (Ostia) and that you have transplanted onto the coast of Italy a sprout of the tree of Abraham. And just as Abraham wanted personally to serve his guests, you do the same in your hospice to imitate the humility of the Saviour'.[20]

In the beginning of the fourth century, the history of charity became enriched with new protagonists, namely, monks, who were destined to play an increasingly important role with the passing of time.[21]

After a spontaneous beginning, which was individual in character and not organised, the phenomenon of monasticism, which had risen in the East, also developed rapidly in the West, taking the form of community life. Together with prayer, an ascetic approach and work, monks were involved in evangelisation and social works (schools, hospitals, hospices) through which they formed a part of the organisation of services providing care of the Church, and this to the point of coming to replace the deacons themselves.

Monasticism rapidly reached Syria, Cappadocia, Palestine, Italy, Gaul, and Africa. Men such as Basil of Caesarea, Gyrolame, John Cassian, Augustine of Ippona, Martin of Tours, and Benedict of Norcia all contributed to the spread of monasticism. St. Benedict had the special merit of formulating a real rule of a universal character for monasticism, in which he placed a great deal of emphasis of love for the sick and hospitality. The leading idea was the long-standing one that sick people and pilgrims are sacred and should be loved and served as though they

were Christ himself: 'of the sick, it is written that they must be looked after before everyone else and everything else, so that they are really served as though they were Christ in person, indeed he himself said *I was sick and you visited me*, and also, *what you did to the least of my brethren you did to me*.

The ceremonial to receive the guests was highly indicative: 'all the guests that arrive should be received as though they were Christ… the Superior or the brothers should meet him with every demonstration of charity… and bow their heads or prostrate the whole of their bodies on the ground and worship in them the welcomed Christ'.

In addition, monasticism was greatly helped by the advance of medicine. Indeed, many monks were medical doctors, nurses, and specialised herbalists. In this way their monasteries became centres of health care learning and care. The Benedictine libraries were locations for medical texts of inestimable value. One of the most famous monasteries, that of Montecassino, was a pioneer in the health care and medical field and attracted crowds of the plague-ridden, lepers, and the wounded. The charitable impulse of the monks, who also created clinics outside their monasteries, give rise among other things to the famous school of medicine of Salerno. There were also other famous monasteries: S. Gallo in Switzerland, which had a very well organised infirmary; Fulda in Germany, which was famous for its school of medicine; Farfa, outside Rome, Camaldoli, etc.

The great achievement of monasticism and above all of the Benedictines was to have helped for many centuries people who could give nothing in exchange, the sick, the abjectly poor, lepers and pilgrims, people who 'like streams going towards the sea', as one chronicler noted at the time, 'flowed every day towards the monasteries'.[22]

During the whole of the high medieval period, with the support of imperial power, the Church was the principal guarantor of the administration of justice, the keeping of the peace and order in the cities and the countryside, the distribution of alms, and care for the poor and the sick.

Each bishop, according to the chapter decrees of Charles the Great, was obliged to build and maintain a hospice next to the episcopal palace for the poor, foreigners and the sick. After the death of Charles the Great, however, the empire fell into chaos and for almost two centuries there was a search for a new political and social equilibrium: 'men ate each other like the fishes of the sea' observed a Synod in 909.

The general insecurity increased abject poverty and the frequent epidemics caused innumerable victims: 'every day', lamented the Bishop of

Tours, 'we lose tens of young people who were sweet and dear, whom we had warmed at our breasts, carried in our arms, and fed with our hands'.[23]

Taken as a whole, however, the organisation of charity did not end: the institution of the tithe, sustained by the Church for over a thousand years, was born in this context. It served not only to maintain the priests and to meet the expenses of worship but also to sustain the poor and the sick.

Albeit with the limits imposed by local secular interference as regards their election, at this time as well the number of bishops who imitated the example of St. Martin was relevant: 'an array of poor people besieged the cathedral churches'; in Noyon, wrote a chronicler, 'it was not necessary to point out the residence of the bishop to foreigners because the crowd of poor people marked out the place from afar'.[24]

After the first millennium, there took place an overturning of every form of established power because of the breakdown in central authority, which was replaced by a warlike feudalism.[25]

If the feudal estate required knights to defend it against enemies, Christians did well to extend this idea and to promote the notion of knights who were to defend the weak, the poor, pilgrims, and the sick, to give a voice, we would say today, to those who were voiceless. In this way the Orders of Knights came into being, and every knight made it a point of honour to protect the most defenceless; his sword, on the day of his consecration, was blessed in the following way: 'may it ensure the defence and protection of the churches, widows, orphans, the sick, the poor and all the servants of God'.(26) In this way many orders of knights arose: the hospital order of Jerusalem, now the Knights of Malta, which organised a hospital called S. Maria in Latina which was technically so perfect that it became a model for all the other health care organisations of the East and the West.(27); the hospital order of St. Lazarus, which stood out for its care for lepers in Jerusalem and other cities of the East; the Teutonic order, the initiative of German knights who in addition to providing hospital care were also obliged to provide ambulance services during papal journeys; the lay hospitallers of St. Anthony came into being to take care of patients suffering from 'St. Anthony's fire'; and the crucifers or crosiers who ended up by having as many as two hundred hospitals.

But even more numerous were the brotherhoods that were created during the period of the 'Commons'. They were members of the laity, belonged to the most varying social classes, and came together to create or to maintain institutes of care, hospitals and leper hospitals.

In this context, the hospitals became transformed from places of refuge into authentic places of care, where a new conception of illness, the sick person and care began to be formed, with the making of a distinction between the person who was poor and the person who was sick, figures who had previously been seen as being the same. To this differentiation between forms of care for the sick and more general forms of care for the poor, the spread of medical knowledge radiating from the Universities of Montpellier, Paris, Bologna and Padua made a marked contribution.

Hygiene and diet began to improve, the first bathrooms were

built, and those who had been admitted were offered meat, fish, vegetables and cereals: these were forms of food that at that time appeared only on the tables of rich people.[28]

But what a rich history, full of pleasing surprises, is that of these brotherhoods! The spirit of charity and a deep faith in the presence of Christ in the poor and the sick dominated almost all the statutes of the Orders that grew up in the cities and the countryside: the spreading of the Gospel, secularity, popularity and free-giving, such were the shared characteristics of the brotherhoods.[29] As many statutes of these brotherhoods laid down: 'the sick person is Christ because in a more touching and expressive way he shows us the face of Christ. For this reason, he must be served with love, in a pleasant way, with tenderness and devotion'

This fervour was to be found at many levels of the Church and society: a renewal that was based upon the rediscovery and the veneration of the humanity of Christ; a renewal at whose base was always the belief that the privileged place to encounter the Christ of the Gospels was the poor and the sick.

A devotion to the humanity of Christ which in the case of St. Bernard of Chiaravelle and in a more intense way in the case of St. Francis of Assisi, involving as it did the identification of the poor and the sick with Christ, acquired an intensity that was more dramatic. 'In the poor and the sick', affirmed Francis, 'Christ himself shows us his wounds, his nakedness. When O brother you see a sick person, remember that you are in front of the mirror of the Lord'.[30]

This vision of faith helped in solving and reconciling the contemplative life with the active life in the same person. We may remember here St. Catherine of Siena, who managed to embody the life of ecstasy with the practice of charity towards the sick.

St. Bonadventure also occupies a very beautiful page in this history: 'Why', he said, 'O soul, are you the whole day anxious in the search for Christ? I, O spouse, will show you where is he that you soul loves; he is certainly lying in the infirmary'. He is there, in anxiety; he is there, tormented by suffering: run to him and serve him and show to him, a sick person, your compassion'. For this reason, and from this point of view, hospitals would be called '*Hotel Dieu*' or '*Maison Dieu*' and would be built next to churches and cathedrals almost in an attempt to unify, harmonise and fuse two loves: love for God and love for one's neighbour. Christians, in fact, after honouring and worshipping Christ in the Church in the Eucharist, went immediately to serve him and love him in his infirm limbs.

In this context I am happy to remember St. Pier Damiani who, oppressed by a thousand commitments, did not allow a day go by without going to a hospital to visit the sick, or Blessed Angela de Foligno who often declared: 'we are going to the hospital where we will find Christ amongst the poor, the suffering and the afflicted', or St. Francesca Romana who for thirty-five years served the sick of the 'S. Spirito e S. Maria in Cappella' as a nurse.[31]

Special reference should be made to the Order of the Holy Spirit which was founded in France by Guy di Montepellier. Innocent III, at the beginning of his pontificate (1198-1216), had a hospital built with the name 'S. Spirito in Sassia'. It had three hundred beds and was able to feed a thousand poor people a day and its management was entrusted to this Order.[32]

This was a hospital that would come to be known the world over. One need only consider that more than one thousand two hundred similar institutions arose in England, Denmark, Scandinavia and other countries in Europe, and that all of them wanted to be affiliated to the Hospital of the Holy Spirit, in a perfect spirit of subordination, in order to receive its rules, statutes and regulations. Not only the hospitals of Europe but also the principal hospitals of Latin America, which arose as a result of the initiatives of the Church as a first preaching of the evangelisation, adhered to the Hospital of the Holy Spirit in Rome.

Santo Domingo marked the beginning of this expansion in the new world in 1503 with the Hospital of St. Nicholas, subsequently extended to Colombia with the Hospital de S. Maria ad Nives and to Mexico City and Cuzco in Peru in 1560. The same be said of the hospital of the Holy Spirit in Lima which was joined to that in Rome in 1585.[33] In the *Liber Regulae S. Spiritus*, a valuable illuminated codex of the fourteenth century, we can find the oldest documents that exist with references to the hospital life of that epoch.

We cannot, however, close this historical period without referring to two diseases that dominated over the others in western Europe and Italy: leprosy and the bubonic plague; the first during the high medieval period and the second during the low medieval period.

Leprosy and the bubonic plague were two diseases that were typical of two contingent ages. The beginning of the second, beginning with the epidemic of the black death of 1347, was connected with the withdrawal of the second, which during the subsequent two centuries, between 1350 and 1550, was in a constant and gradual decline. And we should not forget about the emergence of syphilis during the sixteenth century which took place precisely at the same time as the discovery of the New World.[34]

The Church has always taken care of lepers and to help them with love and skill there arose the hospital order of St. Lazarus. It was, indeed, the task of the brotherhoods and the local Churches to build leper hospitals: in France alone two thousand of these were built, and in Christendom as a whole nineteen thousand were created. To deal with the recurrent epidemics of bubonic plague special lazar houses were built where those suffering from this affliction were isolated so that the malady would not spread.

Amongst the religious families that devoted themselves to taking care of the plague-stricken, the Ministers of the Infirm (Camillians) were of particular importance. The members of this religious order, precisely because of the frequency and gravity of these contagious phenomena, at the moment of their profession of vows declared, and still today continue to declare as a part of their vows, that they would 'care for the sick, wherever they are plague-stricken'. Many of them died with joy, offering their own lives in this holy service.

With regard, instead, to syphilis during the sixteenth century, which took on revolting forms with oozing or ill-smelling sores, there arose within the heart of the Church 'the Companies of Divine Love'.[35] Its promoter was a woman, St. Cather-

ine of Genoa, who together with friends and Ettore Vernazza founded the Company of Divine Love. The care provided by its members was spiritual and physical in character. The threat and the infectiousness of the disease were such as to require separate form of treatment and special hospitals. In this way in many cities of Italy were born the 'hospitals of the incurables' with the decisive support of S. Gatano da Thiene who founded the Order of the Teatini, who were involved in creating many hospitals especially for people afflicted by syphilis.

We thus come to the saddest and most critical period of the history of the charity that was humanism, defined by one authority as inhuman.[36] The causes were different and complicated and the problems involved manifold. In order to be brief I will confine myself to pointing out three phenomena which, as Luther would later observe, would slowly lead the Church to betray the Gospel.

1. The Church gradually left to the municipal secular authorities the management and direction of the old charitable structures, and in particular hospitals. Care in general was no longer seen as charity but as the task and the duty of the state; rather being seen as a brother, the sick person became a citizen who was the bearer of rights. Material interests, the pursuit of gain, began to prevail over charity.

2. The influence of a false humanism that wanted to exalt man and detach him from his spring, God himself, made itself also felt within the religious brotherhoods and orders, which thereby lost their early fervour. Some declined to the point of dying out or being closed down by successive Popes. Sick people were the first to suffer because care for the infirm was no longer up to the level of the magnificent hospitals that admitted them.

3. The influences of a neo-paganism, called humanism, penetrated in different ways and with varying intensity into the inside of the Church as an institution. Without the necessary fervour transmitted by the bishops and with the disappearance of a spiritual life nourished by prayer and the sacraments, the sick began to be treated with coldness, indifference and abandonment. The move by the Church from medieval charity to modern care was critical and painful.[37]

When the light of faith dims, the ardour of charity also grows cold. This was the most threatening storm to have afflicted the boat of St. Peter since the beginning of its adventurous journey. But the promise that Jesus made to Peter to the effect that the forces of evil would never have prevailed against the Church was fulfilled on time. The celebration of the Council of Trent, the flowering of a multitude of saints and the birth of a new range of religious orders, many of which had the vocation to serve the sick, gave new impetus and innovation to the Church enabling her to face up to this storm.

I cannot but remember here, amongst others, S. Filippo Neri, who founded charitable movements for the sick of the city of Rome; S. Carlo Borromeo, who with his pastoral and heroic zeal saved Milan from the plague; and the birth if religious orders and congregations such as the Somaschs, the Bernabites, the Jesuits and the Capuchins. In this period of grave decline for the hospitals and the abandonment of the sick, three men acquired special importance, men who are rightly seen by the Church as great reformers of health care: St. John of God, who was born in Portugal; San Camillo de Lellis, who was born in Italy; and St. Vincent de Paul, who was born in France. Employing a special slogan we could sum up their work in the following way: 'three men, one reform' - reform of psychiatric care; reform of hospital care, and reform of home care for the sick.

St. John of God not only managed to open a hospital in Grenada to take care of the mentally ill following the impulses of his own heart. He also managed to gain a series of disciples who, in line with his prediction, spread with time throughout the world, and were known in Italy with the name of 'Fatabenefratelli'.[38]

San Camillo reformed the Italian hospitals by dictating modern rules for the nurses so that they could serve patients well and fought for overall care for the patient in the totality of his person. Strengthened by his friendship with Pope Clement VIII, he managed to ensure that certain rules of Lateran Council IV which were in contrast with the freedom of conscience of sick people were allowed to lapse.[39] He also founded a religious order which had the sole aim of serving the sick.[40]

St. Vincent de Paul launched women, who were previously shut up within the walls of their convents, into the vast field of caring for sick people in their homes. With the effective co-operation of Luisa de Marillac, he founded the first school for professional nurses, created the Congregation of the Priests of Mission to reinvigorate the spiritual and pastoral lives of priests and spiritual and pastoral life in the parishes, and sent members of the laity into people's homes to exercise charity towards the sick through the ladies of charity and the conference of St. Vincent.[41]

Strengthened by these new energies, but above all reinvigorated by the holiness of so many apostles of charity, the Church began anew her journey and her task of caring for the sick, even when with the French revolution, first in France and then in Europe, she lost those instruments which for centuries had enabled her to practice charity.

While the European States slowly and with difficulty acquired the task of managing hospitals and the Church, in the climate of the Enlightenment, was searching through theological explorations for new forms of charity suitable to the times, between the eighteenth and the nineteenth centuries there was in the whole of the Christian world a new flowering of male, and even more, female congregations, defined by the historian Bremont as 'turba magna', which chose as their ideal for life care for all those weak and marginalised sections of society which governments were not able to help and for which they needed not only labour and adequate financial means but above all hearts ready to love and to give themselves totally, even when there was a danger to their lives.[42]

From amongst them all we remember the Home of Divine Providence founded by the Blessed Giuseppe Cottolengo, which became a world, a city, in the great city of Turin, welcoming within its walls over ten thousand sick, infirm, elderly and mad people, more than thousand religious to serve them, two hundred priests, and without ever ceasing to practice the total contempt for money wanted by their founder.[43]

In our days as well the Church continues to care for the sick with her own structures in very many developing parts of the world, but she

also continues such activity in industrialised countries. To limit ourselves to Italy, we need only think of the Casa Sollievo della Sofferenza of St. Pio da Pietrelcina; the Policlinico Gemelli, the location of the Faculty of Medicine of the University of the Sacred Heart in Rome; the Hospital Bambino Jesù or the hospitals, clinics, rehabilitation centres and scientific institutes of the Fatabenefratelli, the Camillians, the Capuchins, of very many other religious orders and congregations and of dioceses spread throughout the world, all of which go to make up this great mosaic of charity at the service of the sick.

If history offers lessons about life, in the light of what has been said in this paper, it teaches us, the Church of the third millennium, that care for the sick becomes a preaching of the Gospel and a witness to charity only if this service is illuminated by faith, and is able to discover, love and serve the face of God in the sick, the face of an incarnated God who is body and spirit, who is a person, to whom should be given not only care and treatment but also one's heart. In this way a hospital becomes a Catholic hospital.[44] In other words, it becomes the great Church of the world where work or prayer, service or charity, become worship of God and a pledge of immortality: *Come you blessed by my Father… I was sick and you visited me*.

On these conditions, the Church today, everywhere and always, through Vatican Council II, solemnly affirms that it is 'her inalienable right and duty to care for the sick',[45] in order to remember that the origins and the meaning of Catholic hospitality belong in a constitutive sense to the Christian message, as is demonstrated by two thousand years of history, for which care for the sick is absolutely inseparable from the preaching of the kingdom, indeed it becomes its elective sign: *heal the sick… and tell them that the kingdom of God is near to hand*.[46]

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Notes

[1] JOHN PAUL II, Motu Proprio, *Dolentium Hominum*.

[2] Lk 10:9. See also, RATZINGER J., 'Prefazione', in BARRAGAN S.L., *Teologia e Medicina*, 5.

[3] JOHN PAUL II, *Salvifici Doloris*, n.28.

[4] *Apostolicam Actuositatem*, n. 8.

[5] JOHN PAUL II, 'Alla Presidenza della Caritas Italiana', quoted by BUTTURINI G. in *Breve Storia della carità* (Gregoriana, Rome, 1989), p. 11.

[6] ST. AUGUSTINE, *De Trinitate*, n. 8.8.12.

[7] DUPONT J., *Studi sugli Atti degli Apostoli* (Alba, 1975); LEONARDI G., 'Le prime Comunità cristiane. La carità si fa struttura', in *Diaconia della carità nella pastorale della chiesa locale*, (Padua, 1985); BORI P.C., *Chiesa primitiva. L'Immagine della comunità delle origini* (Brescia, 1974); BEATRICE P.F., 'La Chiesa antica di fronte ai bisogni degli uomini', in *Diaconia della carità nella pastorale della Chiesa locale* (Padua ,1985); JAUBERT A., *La vie quotidienne des premiers chrétiens, in 2000 ans de Christianisme* I, (Paris, 1975); CHRISTOPHE P., *Les Pauvres et la pauvretè des origines au XV siécle*, I, (Paris, 1982); LIESE W., *Geschichte der caritas* (Freiburg, 1922); see also the entries 'Hospitalité, Hospitaliers' e 'Misericorde (oeuvres)', in *Dictionnaire de Spiritualité* 7 (1969) 808ss; 11 (1982) pp. 1328-1348.

[8] GRANDI V., *La carità verso il prossimo. Pagine scelte dai Padri della Chiesa* (Ed. Il Pio Samaritano, Vicenza, 1965).

[9] BAUDRILLART A., *La Charité aux premiers siecles du Christianisme* (Paris, 1903); BORI P.C., *op.cit*.

[10] BELLO T., *Cirenei della gioia* (S. Paolo, Cinisello Balsamo, 1995), p. 122.

[11] For the history of charity and care see: LALLEMAND L., *Histoire de la charité*, I-IV, (Paris, 1908-1912); RIQUET M., *La carità di Cristo in atto* (Catania, 1962); PAZZINI A., *I Santi nella storia della medicina* (Mediterranea, Rome, 1937); *Idem*, *Il Cristianesimo nella storia della Medicina* (AVE, Rome, 1944); *Idem*, *L'ospedale nei secoli* (Orizzonte Medico, Rome, 1958); DE MENASCE G., *L'assistenza ieri e oggi* (Rome, 1963); DOINY M., *Histoire de la Charitè pedant les quattre premiérs siécles de l'ére chrétienne* (Paris, 1948); QUERINI Q., *La beneficenza romana dagli antichi tempi fino ad oggi* (Rome, 1892); CASTIGLIONI A., *Storia della medicina* (Milan, 1948); BRESSAN E., *L'hospitale e i poveri* (Milan, 1980); BUTTURINI G., *Breve storia della carità. La Chiesa e i poveri* (Gregoriana, Padua, 1989); HERMANN R., *La charitè de l'Eglise de ses origines a nos jours* (Paris, 1961); HERTLING L., *Storia della Chiesa* (Rome, 1981); MEZZADRI L. and NUOVO L., *Storia della carità* (Jaca Book, Ascoli Piceno, 1999); AA.VV., *Il bene e il Bello. I luoghi della cura, Cinquemila anni di storia* (Electa, Milan, 2000); MESSINA R., *Storia della Carità. Cuore della Chiesa* (Ed. Camilliane, Turin, 2001); COSMACINI G., *La salute, la cura, la storia* (Velar, Gorle, 1994); AA.VV., *Atti del Primo Congresso Europeo di Storia Ospitaliera* (Reggio Emilia, 1960); 'Aumône: petite histoire de la charité', entry in *Dictionnaire de Theologie Catholique*, I-II, (Paris, 1931; 'Carità', entry in *Enciclopedia cattolica*, III, (Vatican City, 1949).

[12] On the deaconries see the interesting study by FALESIEDI U., *Le Diaconie, Istituto Patristico Augustinianum* (Rome, 1995); FRANK K.S., *Manuale di Storia della Chiesa antica* (Libreria Editrice Vaticana, Vatican City, 2000); MARROU H.I., *L'origine orientale des diaconies romaines* (Paris, 1940).

[13] FALESIEDI U., *op. cit.*, pp. 55-63; EUSEBIO, *Historia Ecclesiastica* (Ed. Del Ton G., Rome, 1964); HENGEL M., *Property and Riches in the Early Church* (Philadelphia, 1974).

[14] This question is dealt with and addressed in the Code of Justinian (tit. 3, book I) under the title '*De Episcopis et clericis et orphanotrophiis et brephotrophiis et xenodochis et asceteriis et monachis et privilegio eorum*'.

[15] FALESIEDI U., *op. cit.*, pp. 79-80.

[16] SOZOMENO, *Historia Ecclesiastica*, PG III, 16; PALLADIUS, *Storia Lausiaca*, PG 40.

[17] SOZOMENO, *op. cit.*, VI, 34; GIET S., *Les idées et l'action sociale de S. Basile* (Paris, 1961); COURTONNE J., *Un témoin du IV siècle orientale Saint Basile et son temps d'après sa correspondance* (Paris, 1973).

[18] CASERA D., *Chiesa e salute* (Milan, 1991), p. 47; HAMMAN A., *Riches et pauvres dans l'Eglise ancienne* (Paris, 1962), pp. 170-209; MARA M.G., *Ricchezza e povertà nel cristianesimo primitivo* (Rome, 1980), pp. 72-79, 214-239.

[19] For the role of bishops in the history of charity during the early centuries of Christianity see: AUREGGI O., 'Ospedali e vescovi', in *Atti del 1° Congresso Europeo di Storia Ospedaliera* (Reggio Emilia, 1960), pp. 38-56; HAMMAN A., *Vie Liturgique et vie sociale. Repas des pauvres. Diaconie et Diaconat. Agape et Repas de charité. Offrande dans l'antiquité chrétienne* (Tournai, 1968).

[20] MEZZADRI L., *op. cit.*, p. 30.

[21] On monasticism see MOLLAT M., 'Les moins et les pauvres', in *Monachesimo e la riforma ecclesiastica* (Milano, 1971); DATTRINO L., *Il primo monachesimo* (Studium, Rome, 1984); TURBESSI G., *Regole monastiche antiche* (Studium, Rome,1974); BERLIÉRE A., 'La charité monastique', *Revue liturgique et monastique* 10 (1935) 195-201, 252-259; PAZZINI A., *L'ospedale nei secoli*, pp. 46-52; PENCO G., *Storia del monachesimo in Italia* (Jaca Book, Milan, 1985); MESSINA R., *op. cit.*, pp. 177-188; BALESTRACCI D., 'L'invenzione dell'ospedale. Assistenza e assistiti nel Medioevo', in AA. VV., *Il bene e il bello*, *op. cit.*, pp. 49-60.

[22] BUTTURINI G., *op. cit.*, p. 59.

[23] ROUCHER M., 'La faim a l'époque carolingienne', *Revue Historique* 4 (1973) 295; BALESTRACCI D., *op. cit.*, pp. 49-60.

[24] BUTTURINI G., *op. cit.*, p. 58.

[25] PAZZINI A., *L'ospedale nei secoli*, pp. 79ss.

[26] BUTTURINI G., *op. cit.*, p. 62.

[27] NASALLI ROCCA E., 'Origine ed evoluzione della Regola e degli statuti dell'Ordine Gerosolimitano', in *Atti del primo Congresso Europeo*, pp. 901-926; VANTI M., 'Contributo alla storia dell'istituto ospedaliero da parte degli Ordini ospedalieri operanti in campo europeo', in *Atti del primo Congresso Europeo*, pp. 1287-1304.

[28] SPOGLI E., *Temi di pastorale sanitaria* (Tinari, Chieti ,2001), pp. 201-222; VAUCHEZ A., *I cambiamenti del sistema assistenziale negli ultimi secoli del Medioevo* (Milan, 1990), pp. 221-230; AA.VV., *Reinventare l'ospedale* (S. Paolo, Cinisello Balsamo, 1995), p. 14.

[29] OTTAZZI V., 'Le principali fondazioni ospetaliere d'Italia nei loro statuti dal sec. XI al sec.XIV', in *Atti del 1° congresso italiano di storia ospedaliera* (Reggio Emilia, 1956), pp. 508-522; MESSINA R., *op. cit.*, pp. 72-74,189-197.

[30] SPOGLI E., 'Malati e malattie nella vita di S.Francesco', in *Temi di pastorale sanitaria*, *op. cit.*, pp. 109-124; MEZZADRI L., *op. cit.*, 38 ss.

[31] MESSINA R., *op. cit.*, pp. 73-74.

[32] LA CAVA A.F., 'L'Ordine di S. Spirito precursore dell'assistenza ospedaliera e sociale', in *Atti del 1° Congresso Europeo, op. cit.*, pp. 667-675; CANEZZA A., *Gli arcispedali di Roma nella vita cittadina, nella storia e nell'arte* (Rome, 1933); LA CAVA F., *Liber Regulae S. Spiritus, Hoepli* (Milan, 1977).

[33] ANGELINI F., *La primera evangelización en America latina …* (Vatican City, 1992).

[34] PALEARI V., *Lebbra. Dall'emarginazione all'integrazione sociale* (Tesi di licenza Camillianum, Rome, 1994); COSMACINI G., *op. cit.*, pp. 21-32. On pestilences and epidemics see COSMACINI G., *op. cit.*, pp. 9-20.

[35] On syphilis during the sixteenth century see COSMACINI G., *op. cit.*, pp. 211-214. On the Companies of Sivine Love see: CISTELLINI A., *Figure della Riforma pretridentina* (Morcelliana, Brescia, 1948).

[36] PAZZINI A., *L'ospedale nei secoli*, pp. 152-154.

[37] BUTTURINI G., *op. cit.*, pp. 85-94.

[38] On St. John of God see: RUSSOTTO G., *L'ordine ospedaliero di S. Giovanni di Dio* (Rome,1950); MAGLIOZZI G., *Un cuore per chi soffre, Biblioteca ospedaliera* (Rome 1995).

[39] A directive of Innocent III, subsequently confirmed by Lateran Council IV(1215), obliged patients to confess and to take holy communion before having their bodies cared for and treated, and provided for the imposition of severe punishments on those medical doctors who violated this rule. On this question see MESSINA R., *op. cit.*, pp. 241-244.

[40] On San Camillo see VANTI M., *S. Camillo de Lellis e i suoi ministri degli infermi* (Coletti, Rome, 1958); *Idem, Lo spirito di S. Camillo* (Coletti, Rome, 1959); MESSINA R., *Spiritualità per chi assiste chi soffre. La nuova scuola di carità di S. Camillo de Lellis* (Edizioni Camilliane, Turin, 2000).

[41] On St. Vincent de Paul see ROMAN J.M., 'S. Vincenzo de Paoli', in *Complementi alla storia della Chiesa* (Jaca Book, Milane, 1996); AA.VV., *Le grandi scuole della Spiritualità cristiana* (Edizioni O.R., Milan, 1984); MEZZADRI L., *op. cit.*, pp. 65ss.

[42] For this period see ROPS D., *La chiesa delle rivoluzioni*, I, pp. 618-634; PENCO G., *Storia della chiesa in Italia*, II, (Milan, 1978); BUTTURINI G., *op.cit.*, pp. 109 ss.

[43] Cf. MESSINA R., *op. cit.*, pp. 292-294.

[44] PETRINI M., 'Ospedale cattolico', in *Dizionario di Teologia Pastorale Sanitaria* (Edizioni Camilliane, Turin, 1997); CONSULTA NAZIONALE DELLA CEI PER LA PASTORALE DELLA SANITÀ, *Le istituzioni sanitarie cattoliche in Italia* (EDB, Bologna, 2000); AA.VV., I *Congresso mondiale degli ospedali e dei servizi sanitari cattolici* (Tipografia poliglotta vaticana, Vatican City, 1985); BEAL J., 'Ospedali Cattolici. In che misura saranno cattolici?', *Concilium* 5 (1994) 115-129.

[45] *Apostolicam Actuositatem*, n. 8.

[46] SALVINO L., *L'identità dell'ospedale cattolico, pro manuscripto*; BAMBERG A., *Hôpital et Eglises* (Cerdic, Strasbourg, 1987); RIZZO U., 'Ospedali più umani: come?', in *Atti del Convegno Internazionale Monotematico* (Acquaviva delle Fonti ,1984), pp 65 ss.

OSWALD GRACIAS

2. Identity in Faith in Catholic Hospitals

Our Lord Jesus Christ came on earth to bring Good News to all humankind. He came to proclaim liberty to captives, to give sight to the blind, to make the lame walk, and to heal the sick. He came that we may have life and have it to the full. (John 10:10) He traversed the earth 2000 years ago, the Word made flesh. The Incarnation was not just a passing through the world, but an entrance into it, that would make an essential difference to mankind and to history. It was an entry that would transform the world from within. In Jesus Christ, God is present in the world to bring power, power of the Kingdom (Brian Hehir). No teachings have so influenced the world and no other philosophy have so radically changed the thinking of humankind as that of Jesus Christ. This is itself the diffusion of the Kingdom, and the making of the Kingdom of God more present in the world.

The Church is the continuation of Jesus Christ in time and space. As such it essentially has the same vision and mission as our Lord himself. As Jesus came to redeem, the Church continues the work of redemption. As Jesus came to teach, to liberate and to heal, the Church continues to teach, to liberate and to heal. This is part of the essential mission of the Church. (cf. *Gaudium et Spes* # 40-42) Naturally, therefore, when one looks at the Church's apostolate over the centuries, one discovers that the Church has always been involved in the educational, socio-economic and health ministry. This is not peripheral to the Church's mission, but part of her essential apostolate. It is evangelization which the Church is called to carry out – the making of the Kingdom of God present.

The principal social service institutions of the Church are, then, but a natural consequence of the Church's nature. As society evolved over the centuries, the first educational, health care and charitable institutions of the West arose within the context of the Church's apostolate. Through her monasteries and her religious personnel the Church played a major role in the structuring of the socio-economic institutions of Western society.

This continued till the seventeenth century when there was a change in the world scenario, particularly in Europe. This was the gradual evolution of the sovereign state. The state began to play a more central role in the lives of people. Other factors, too, contributed and we see that the situation is today totally different from what existed a couple of hundred years ago.

Changed scenario

It would appear that there are three main causes for the change in the world scenario in this field:

1. The development of the concept of the welfare state.
2. The process of secularization of society.
3. The personnel and resources factor.

1. Once the concept of the sovereign state evolved, its activities extended more and more to different aspects of the lives of citizens and gradually the state took upon itself more responsibility in those fields in which the Church had hitherto been very active: education, charity and health care. There wasn't any clear attempt to edge out the Church from these apostolates but, combined with the two factors mentioned below, the Church lost more and more of the space she had in these fields. The welfare state, feeling it was its responsibility that its citizens should be educated, began running educational institutions, at the school level and then at the university level; the state, concerned about the health needs of its citizens, began its own hospitals and health care institutions. In the field of charity, the state does not seem to have felt too much compulsion, but NGOs took over in areas where the state did not involve itself too much. Latterly the state has become conscious of its own responsibility in this area and where it can afford to, has begun social security schemes.

2. The process of secularization: with the acceptance of the need for professionalism in these fields, lay professionals began getting involved in these areas. The professionals developed systems independent of the Church. Institutes manned by lay people strived for excellence and it was no longer necessary for the Church to have a leading role to play here. I myself come from a predominantly Hindu country with a significant number of Muslims. Other religions also began starting these service-oriented institutions. The Hindus began in a small way and now have a large complex of schools and health institutions. Members of other religions did the same. The Church had to share space with these. There was a time when the Church was praised as a pioneer in these fields and accepted as the leading player. Hardly so now.

3. The personnel and resources factor: all these services cost money and for the Church as a non-profit organization, to continuously keep its lead in these areas was bound to be difficult. This happened specially in the field of health care services. As a result of the great development in the field of science and medicine, better and better equipment was developed and this gave rise to correspondingly higher costs. The Church found it very difficult to compete in the field of super-specialities and some of our hospitals began struggling for patients. Added to this was the problem of personnel. A fall in vocations resulted in a shortage of trained personnel from health care Congregations to run these institutions.

The end result was that the Church ceased being the main player in these areas of the apostolate. That does not mean that her apostolate is ineffective. But certainly at this moment much analysis and reflection is needed to assess the apostolate and to examine whether a reorientation may be necessary.

Identity in faith

The question that should be asked is: what is the identity in faith of our Catholic Hospitals, or, put more simply, what is it that makes a Catholic Hospital Catholic? Its identity in faith is that which enables us to recognize a hospital as Catholic. I am using the word 'Catholic' here loosely and generally it could be interchangeable with 'Christian.' There is first of all the externals, but one immediately recognizes that these are but peripheral to the nature of the institute. There is probably a Cross on the top of the physical plant to identify it as Christian. It would be named after Our Lady or some Saint known for his work among the sick or among the poor. Besides, there would probably be religious personnel in their habits moving about the wards.

This, however, does not touch the inner nature of the institute. What is really important are the internal elements that identify the institution as Catholic. At the Tenth World Day of the Sick celebrations held at Vailankani, South India, Dr. Francois Blin, Secretary General of the International Federation of Catholic Doctors, identified the elements of the Christian identity of Health Care personnel in our institutions as being their Faith, Hope and Love. I would fully agree with him.

A FAITH in Jesus Christ which gives strength and reliability even in difficult situations. Jesus Christ is Master of life and death. Our faith in His presence and His strength, our conviction of being His disciples and of being supported by His Grace is the distinctive feature of the personnel functioning in Christian health care institutions.

A HOPE of eternal life which enables one to have a proper understanding of sickness and pain and thus transcend all despair. Faith in the Lord's Resurrection, confident that pain united with His suffering, can have a redemptive value, enables us to have a proper perspective in all our work. As Pope John Paul II said "Even though the Church finds much that is valid and noble in Christian interpretations of suffering, her own understanding of this great human mystery is unique… suffering becomes a sharing in the saving work of Jesus Christ… our sufferings become meaningful and precious when united with Him" (*Message for the World Day of the Sick*, 2002)

A LOVE of Jesus Christ which results in a love of all men and women, particularly the sick and the suffering. Urged on by Christian charity which finds its supreme expression in the life and words of Jesus Christ "Who went about doing

good" (Acts 10:38), the Church goes out to meet the sick and the suffering, bringing them comfort and hope. This is not a mere exercise of benevolence, but is motivated by compassion and concern, leading to dedicated service (cf *Salvifici Doloris,* 29). As in the parable of the Good Samaritan, the health worker is invited not to just "pass by".

It is the mental and spiritual attitude of the health care personnel that gives a Christian identity to a Christian hospital. Faith, Hope and Charity, the three cardinal virtues, give rise to certain imperatives in the attitudes of the hospital, influencing all those involved in its policy making. We identify some of the elements below:

Elements of Christian Identity

1. Dignity of the Human Person: the prime fundamental attitude in a Christian hospital is faith in, and respect for, the dignity of the human person. "Man is the only creature on the earth that God has willed for His own sake and He alone is called to share by knowledge and love in God's own life. It is for this end that he was created and this the fundamental reason for his dignity" (*Catechism of the Catholic Church*, 356). Jesus Christ taught us that we are all children of the same heavenly Father. However much in distress, however mangled his body after an accident, however hopeless the medical situation of a terminally ill patient, however much his mind might be affected and not clear, he retains his inviolable dignity as a human person, created in the image and likeness of God (Genesis 1:24ff).

Jesus Christ taught us that we are children of the same heavenly Father. We all belong to the same family. Bonds of love unite us. The patient then becomes not merely a bed number or a case number in a file, but a precious human being of flesh and blood and emotions. He is treated with dignity and respect, whether he is educated or uneducated, whether he is rich or poor, whether he is cultured or simple, whether he has a suave urban background or comes from the rural village where common courtesies are of a different nature. In other words, he/she is treated as a human person, because that is what he/she is.

2. Option for the Poor: Jesus Christ decidedly sided with the poor. Health institutions administered by personnel who are His disciples must do the same. Today, equipment costs much, some specialized medicines are expensive, doctors' fees are high and the poor are sometimes unable to afford the care that they need. It is here that the Catholic hospital's role is seen, where through a system of sound management, the rich subsidize the medical care of the poor. No poor person should turn away from a Catholic hospital because of lack of money, as no one turned away from the Lord because he/she was poor.

The delicacy with which one treats the poorest, the least educated, is a good factor to assess the Christian identity of the health care institutions managed and administered by the Church. This is true Christian witness. Recently a prominent Sikh writer commented, "There is no need of a miracle to prove the sanctity of Mother Teresa. The greatest miracle is that in a predominantly non-Christian country, millions of people honor her as a Saint, because of her love for the poorest of the poor."

3. Respect For Life: the Church, basing herself on the teachings of Jesus has always been a very strong advocate of Respect for Life. Be it life of the unborn or life of the terminally ill, all human life is sacred and only the Creator who gave life can take it away. Catholic teaching on the medical termination of pregnancy is sufficiently well known and no Catholic hospital can call itself Catholic and practice or encourage abortion. The act is intrinsically evil and Canon Law imposes *a latae sententiae* excommunication on those who are involved in this. Life is also sacred at the other end. No experiments are permissible which take unjustified risks with the lives of those who are old; no medical institution which is Catholic could actively aid a person who is in pain and perhaps terminally ill to end his life. The continuous teaching of Pope John Paul II has stressed the sacredness of life (*Evangelium Vitae).* In 1994 the Holy Father instituted the Pontifical Academy for Life. Every Catholic Hospital should become an altar dedicated to the promotion of the sacredness of human life. All medical treatment and procedures should be aimed at improving the quality of the life of its patients. It is not merely in avoiding abortion or euthenasia that the Christian identity is found, but also in valuing every human life, considering it as a gift from God and a participation in His life.

4. Christian Ethics in Procedure: The field of medicine has made tremendous progress. Technology has combined with medical science to push its advances to higher and higher levels. Together with these advances there have arisen ethical problems. Not every means is licit and a good end can never justify an unethical means. The Church has repeatedly pronounced itself on many bio-medical issues. The destruction of human embryos for the preparing of embryonic stem cells is not permitted. Cloning which appeared advantageous for assisting medical research is totally unacceptable when one comes to reproducing human beings outside the sanctuary of the human person. Apart from these problems that can arise in a more advanced context, there are issues that concern a simple hospital, like sterilization, choosing between the life of the mother and the child etc.

The faith identity of a Catholic hospital consists in it following the

teaching of the Magisterium in matters of morals and never sacrificing this for the sake of convenience or patronage.

5. Holistic Approach: WHO has given a more comprehensive definition of health as " a state of complete physical, mental and social well being and not merely the absence of disease or infirmity." Jesus Christ came that we may have life and have it to the full. We now see clearly the difference between medical assistance and health care. The former involves the intervention of a physician, in relation to a physical malady. The latter is more comprehensive and concerns itself with the general health care of the whole individual.

A true Christian approach would be to see integrally the needs of the whole person, and to get him/her involved in his/her restoration to health. It is here that our Catholic hospitals can make a big difference in the age of super-specialities. This could be our special contribution in the health care field. The idea of health being more than a mere absence of illness is not widely accepted, but our hospitals can give a lead in this. Different departments in the hospital could take care of various aspects of the individual's personality so that when the patient leaves the hospital he leaves not only as a patient who has been cured of his physical ailment, but as a much more healthy person, health being understood in the sense above. Aren't we continuing the mission of Jesus in this? In His healing ministry, Jesus did not confine Himself to merely removing a physical impairment, but always healed the soul of the patient. He made him a more whole person, in the broad sense of the term. Jesus always gave a spiritual healing with the physical healing. "Go, your sins are forgiven you" went together with "Take up your bed and walk".

6. Pastoral Care: An essential element of a Catholic hospital is the pastoral care given to patients. Coming from a predominantly non-Christian nation myself, I know how much patients value the visit of the priest. In a hospital run by the Indian Episcopal Conference in Bangalore, a retired Bishop spends a couple of hours every day visiting all the patients, the vast majority of whom do not share the Christian faith. They, however, treasure the visit for the spiritual solace it gives them.

The Holy Father, Pope John Paul II, has often spoken of the spirituality of suffering. He has experienced it himself, particularly in the assassination attempt. In Christian spirituality, the Cross has an essential place. Suffering is salvific if it is united to the Cross of Christ. Good pastoral care in a hospital enables the individuals to understand and accept this. Seen in this perspective, sickness and pain take on a new rich meaning.

To quote the Holy Father "How effective is the witness of many persons… who despite being nailed to their beds by illness for years, are full of serenity because they know how precious their contribution of suffering and prayer is for the Church" (Mass for the Sick at St. Peter's, Rome, 11 Feb 2002). Even in very serious ailments like cancer or Aids, good pastoral care can lessen the pain and help the patient find meaning even in his suffering. A well equipped pastoral team should form part of every Church hospital.

7. A Christian Ethos of love: to sum up, the identity in faith of a Catholic hospital exists where Christ is present. All the elements mentioned above have the same objective in mind: to make gospel values present. Christ's presence brings love, joy and peace. And this is the atmosphere that somehow the administration and staff of a medical institution run by the Church should create.

Love, caring, and a family feeling should be evident throughout, not a forbidding atmosphere. Evidently for proper medical care there have to be rules and regulations, places which are out of bounds and times when visitors have to be turned away and patients have to be treated firmly. But in all this, the deep inner spirituality of the individuals working in the institution should be evident in a spontaneity which shows the compassionate heart of Jesus to all.

In many senses, the relatives are an extension of the patient. The pain of the sick, particularly of the more severely sick, is shared by the loved ones. In situations like these, the delicacy with which one treats these relatives should be an indication of a Christ-like attitude: welcoming, understanding and sympathetic; in other words, the heart of the compassionate Jesus. I think that our institutions have a great advantage in this field. Our nurses in particular, who come in continuous contact with the patient, could give a fully human touch to their ministry. This would result in a quicker and also a more complete healing of the whole person. Mary's attitude of dedicated service should be a model for this. She rushed to assist Elizabeth, her cousin, who was with child and needed help. Mary ministered to all her needs for three months (Luke1: 56).

Obstacles in the way

I will now change focus and identify some elements that make having a Christian identity in our hospitals difficult.

1. Lack of Trained Personnel and Fall in Resources: the fall in vocations in different religious congregations, especially those which offer specialized medical care, makes it difficult to carry on these institutions, let alone carry them on well with a distinctive Catholic identity. An important consideration, however, is to ask whether over the years some of the institutions that were run by these Congregations lost some of the true Christian identity as outlined above and at least some of those elements got blurred and their importance undervalued. As a result, a valid question posed itself in the minds of many prospective candidates for religious life: can I not render the same services as a lay medical doctor?" The lack of a special Christian identity in the institution reduces the motivation for joining the Institute and for serving the sick as a member of the Congregation. Discipleship of Jesus if seen in the running of institutions of the Congregation would prove an effective attraction for a candidate who feels called to follow the Lord according to the charism of a particular religious Institute.

2. Competition from the State and

NGOs: as was said before, the State stepped in in many areas which were the preserve of the Christian service institutions. Many NGOs mushroomed: some to render service with an altruistic motive, others with the motive of profit. These attracted many competent people who wanted to serve humanity. New advances in medicine brought in new equipment, and our religious hospitals were unable to afford the escalating demands for capital expenditure without becoming institutions meant for the affluent and which render service only to those who can afford to pay for it. Our hospitals were not able to cope with the economic demands of the age of super-specialization.

We have already spoken of how the concept of the welfare state developed and its activities gradually expanded into areas which hitherto had remained outside its concern. The state with vast resources at its command was able to run bigger health-care institutions and attract competent personnel. Feeling insecure in the face of this, some institutions found it difficult to stick to the priority of keeping the Christian faith identity always paramount in its operation.

3. Globalization: This is hardly the place to discuss one of the most debated point in world economics: the ethics of globalization. Whether we like it or not, globalization is here to stay, and the point, as the Holy Father has repeatedly stated, is to have globalization without any marginalization of the poor. The whole world has become a global village and facilities can be quickly transmitted from any part of the globe. This, however, has often contributed to making medicine more expensive and out of the reach of some who really need it. Globalization has also meant the invasion of multi-nationals into the economy of developing countries. It has meant that discarded medicines from one part of the world are dumped for profit in another part of the world. Just being a 'foreign medicine' is enough to enable it to get a good market in some places and the gullible sick are spending for medicines past the expiry date. Again, globalization has resulted in patients in developing countries sometimes becoming guinea pigs for experiments not permitted in more developed countries. Some time back there was a furore when it was discovered that a Bombay doctor was experimenting on behalf of his counterparts in another country, with medicines not approved there, on patients afflicted with AIDS; these patients did not know that they were being experimented on with drugs not yet approved.

4. Materialism and Consumerism: In a greatly secularized society, the philosophy of materialism and consumerism has become acceptable to many. India, a country known for its spiritual values, is getting affected by these philosophies, particularly in the urban areas. This has also been a side effect of globalization. The material is what is visible and soon this becomes all that matters. For these things we pay and they bring profit. Hence it is advantageous for some to create artificial needs for these.

The WHO has defined health broadly, going beyond only physical well being. The Christian meaning of health goes beyond to include the spiritual. This meaning of health has not permeated down to the administration of many Government and other NGO-run health institutions. Several of our own hospitals have not yet been able to fully integrate this into their vision of the apostolate. This philosophy that physical health is all that matters, widely prevalent, would militate against a holistic approach to health care.

Furthermore, even though it is unethical to compete through advertisements for health services, the profit motive is very much present in the minds of many involved in health-care. The myth is created that with money one can buy health. Man becomes like a machine and when the machine breaks down the technician comes, replaces parts and services the machine. If all the parts are working well, there is no reason why the machine should break down again. Hence slowly it becomes accepted that the more medicines, the more tests, the more sophisticated the equipment, the greater the guarantee of health. The myth is created that every illness is conquerable, every ailment can be overcome and that this is all that matters for a good life. The more medicines the better. Sometimes even the more expensive medicines the better. A consumeristic philosophy where artificial needs are created has begun to invade the medical field. All rightly seek to improve the quality of life, but do not fully comprehend that life has several other aspects besides the physical.

5. Media: By itself, the communications media are neutral, but in the hands of those who have a consumeristic or materialistic philosophy, they can become a tool to propagate false values. The only principle sometimes diffused widely is that pain and suffering must be avoided at all costs and by all means, ethical or otherwise. The spirituality of the Cross is meaningless in this system and what only matters is that any discomfort should be taken away. The media in general have not been in the vanguard in proclaiming the culture of life.

When there is an onslaught of this sort of ideas from the media, it gradually impacts on all exposed to it. As a consequence, values spoken of earlier which give a distinctive Christian colour to an institution get blurred.

6. Unfriendly Legislation: Country after country has passed legislation legalizing abortion. This is a civil law that states that those who perform abortions will not be punished by the State. But the unjustified jump is made to: that which is legal is also moral. Catholic hospitals have to watch against this mentality.

And this is not the only legislation that causes problems. Secularisation has sometimes come to imply that legislation will no longer be bound by Christian principles because that might mean favouring one particular religion in an era when State and Religions ought to be kept separate.

Besides there is legislation from unfriendly governments who on purpose find the Church's presence and work uncomfortable.

The point of lack of respect for conscientious objection has already been mentioned in our discussions. We know cases where nurses have to assist in abortions or sterilizations to be able to complete their training courses. And in some places, med-

ical institutions are given a quota of these operations to perform, in order to retain Government recognition. This is certainly a serious problem for our Catholic hospitals.

Challenges ahead

I began by saying that Catholic Health Services are essential to the Church's mission. She cannot abandon this without losing an element of discipleship. Difficulties there are, a few of which were enumerated above. These difficulties are but challenges for us to give an adequate response. There will always be a role for a Catholic hospital with a Catholic identity. It is when the Catholic identity is forgotten, that the Catholic institution runs into difficulty.

Looking to the future: Can I make some suggestions about the directions we could move in, in the future?

1. A Community Centred Approach: Can we not think of our hospitals having a community-centred approach where there is a tie up between the hospital and the community and where there is continuous interaction between the two?

Cardinal Ivan Dias of Bombay, speaking at the celebration of the World Day of the Sick at Vailankani in February 2002, spoke of hospitals referring to the community as their beneficiaries and calling themselves 'health providers' and said that this is a top-down approach which only leads to greater dependence in the guise of charity. If there is active community participation, it enables people to exercise collectively their rights and responsibilities and to attend to and maintain their health. The community must come to accept that health care is its responsibility. Can we think for example of home-based care? Volunteers and support groups could be formed to help in this. Community-based rehabilitation can be stressed. Village health level committees can be used by many hospitals to evaluate the impact and outcome of various health programmes and even the general functioning of the hospital. Regular meetings at the village level can bring out ideas, suggestions regarding methods of implementing programmes, and can evaluate programme impact so as to decide whether to continue or to stop health services, etc.

A Community Needs Assessment approach, promotes decentralized, need-based participatory planning and a monitoring system that emphasizes quality of health care. Hospitals need not feel threatened by this approach. It is meant to be mutually helpful.

2. Outreach: Particularly in our developing areas, every hospital could have an Outreach Programme attached to it. Many hospitals have mobile dispensaries which carry doctors and medicines to the villages. Available statistics show that in India 85% of the Church's health services are for the rural poor. Yet many areas remain untouched. Medical assistance is always welcomed, but people are often afraid of venturing out into the urban area where a big hospital is situated – either because afraid, often unfoundedly so, of the large expenses they may not be able to afford, or because they feel they are entering an unknown and unfriendly atmosphere. Added to this is ignorance about the nature of illnesses and their causes, and of the possibility of quick and inexpensive cures for some ailments. A friendly, welcoming face of the medical or para-medical person who comes to the village bringing healing, could break many barriers. It could be the best public relations' exercise of the hospital. This would also emphasize our option for the poor.

3. Holistic Approach: Sufficient stress has been given in this paper to the meaning, nature, and importance of a holistic approach to health. This approach may not bring in huge profits, but it is for the good of the individual, the family, the community and society. The Holy Father has said "Health far from being identified with the mere absence of illness, strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level. In this perspective the person himself is called to mobilize all his available energies to fulfil his own vocation and for the good of others" (Message to the Eight World Day of Sick). Catholic hospitals could give a lead in this approach.

4. Education: It has always been accepted that health and socio-economic factors are inter-linked. We have already spoken of the necessity of the availability of medical care for the poor. But we should also move from remedial care to preventive care. This is a big area that is relatively unexplored. Health care personnel may not be able to do much about the socio-economic factors since the matter is another domain. But they could move into the education of people regarding causes of ailments, prevention of these, general personal and community hygiene, supportive care etc. Apart from this, education is also necessary in relation to ecology and the preservation of nature for present and future generations so as to ensure better health care for all. If circumstances permit, pastoral care assistance could take up other areas of the health of the person for education. Our institutions could promote community-based health education, where people do not have to come to the hospital for education, but the health worker goes to the community centre and teaches the people.

5. Alternative Medicine: This is special to India and some Eastern countries. Ayurveda and Unani medicines have not yet become popular, but they have their own advantages. These medical treatments are always in harmony with nature. Homoeopathy is also accepted as a medical science. These have not become common but for many ailments they are efficient and cheap. We can make a contribution by the promotion of the acceptance of

these. At the last World Day of the Sick meeting in India, some Asian countries gave fascinating stories of the development of different forms of alternative medicine. This may not be in the interests of multi-national companies, but our institutions could promote this and share it with others.

6. Networking: Networking is already taking place in many medical institutions. It makes sound administrative sense for a hospital to focus on one area of specialization and share its facilities with other hospitals nearby, which have other fields of specialization. Regrettably, this does not take place much in our own health care institutions. In India, we have the Catholic Hospital Association of India which has begun efforts in this direction, but we have yet miles to go. Networking, mutual referral of cases and collaboration between Church-related institutes themselves and with Government institutions as well as other NGOs is the need of the hour. The idea is to be able to give better, quicker and more effective medical care for as many as possible. In this, the image and prestige of the individual institution is not the prime factor nor shall profit-making be the motive.

Networking will also result in more effective advocacy when dealing with Government legislation and funding agencies which dictate policies and so on. I should add here the need for an ongoing formation. We have already had a very interesting exposition of the results of research on our efforts to motivate the staff. Much is being done, but more concentrated efforts are needed. Competence is certainly an element of Christian identity. An ongoing formation of the staff on personnel management, techniques of care and in the principles of Christian identity would be another need of the hour.

I have shared with you a few ideas on the identity in faith in Catholic hospitals. These are only meant to set us thinking. Specialists in the medical field will be able to fine tune these thoughts. It is our prayer that each health worker will be able to walk in the footsteps of Jesus the Divine Healer and bring His care, compassion and love to all with whom they come into contact. Every Church administered hospital should become a temple of love dedicated to health care.

May Mary the Mother of Good Health who brought Jesus into the world pour His love into our hearts so that we share Him with others by our life and by our work.

H.E. Msgr. OSWALD GRACIAS
Archbishop of Agra, India

ANGELO SCOLA

3. The Principles for a Solution to the Contemporary Moral Questions and Issues of Catholic Hospitals: Methodological Guidelines

From the Hospital to the Hospital-Firm

The nature of hospitals, at least in prosperous societies, has undergone a radical modification because of the marriage between science and technology which has been underway for more than two centuries.[1] This became especially great in its impact with the extraordinary development of biology and the biotechnologies.[2] The *hospital* of ancient memory has been replaced by a technological centre with a variety of specialisations and with relevant implications at the level of management and economics. It is no accident, for example, that after the reform of 1978 in Italy, in order to plan and organise the health service, a notion of the firm and the connected tandem of workers-users has been progressively imposed.

Without wanting to follow the numerous and complex practical and theoretical aspects that have characterised the medical sciences during this major change (indeed, this is not the place for such an undertaking), the present-day configuration of the hospital-firm raises a singular concentration of burning questions, of which those of an ethical character become more acute every day, especially in the eyes of the health care worker.

Birth and death are the two poles around which the most explosive 'red issues' revolve but between these two primary poles there is a vast range of moral questions and issues which are strongly present every day in hospitals, not least those connected with the nexus between medicine, management and economics in relation to the dignity and rights of the persons of the patient and the health care worker.[3]

As a result of this state of affairs, every hospital is constantly led to redefine its own identity. A special question is raised for Catholic hospitals. If they are, specifically speaking, the principal heirs to the great tradition of the *hospital*, which without doubt came into being within the Church, how can they remain faithful to that impetus at the level of ideals which gave birth to them

without abandoning, in turn, being technological centres with a variety of specialisations, something which, if it took place, would inexorably expel them from the health care system?

I believe, paradoxically, that this synthesis becomes possible specifically if the difficult and sensitive contemporary ethical questions and issues are addressed. Such questions and issues, indeed, are not a reality that is extraneous to the daily task of health care workers of ensuring that a hospital is a good hospital. And in particular, the Catholic identity of a good hospital is not a coat of paint with which the outer surface of a building that is already finished should be covered. On the contrary: it is specifically this identity that knows how to keep the most varied medical practices within the sphere of the *humanum*. For this reason, precisely by meeting ethical provocations, even of an extreme character, hospitals in general, and Catholic hospitals in particular, are led constantly to improve their level of health care excellence.

The direct relevance of ethics to medicine, which exalts the singular fertility of the Catholic identity in a hospital centre, is evident as soon as one considers – even in a fleeting way – some especially characteristic facts of contemporary medicine. Thus, for example, without adopting apocalyptic tones, how could one ignore the dismay generated by the rise and spread of a disease such as AIDS? As Giorgio Cosmacini acutely brings out in his essay on the history of the medical profession: 'What has worried the World Health Organisation, and not least the medical world, has been the fact that this disease appeared during a historical period when it was thought that the era of the final triumph of medicine and health care had taken place. This new disease acted to upset a system and an ideology that were thought to be consolidated: as an infectious disease, that is to say belonging to an array of diseases that had in large part been weakened, AIDS appeared anachronistic, it appeared to elude scientific predictive knowledge (thought to able to effect early recognitions), it was uncontrollable during the long wait for an anti-virus pharmacy or an effective vaccine, it appeared to escape medical knowledge and power. In addition, the syphilis effect was at work once again: as a sexually transmitted disease and preponderant in sub-groups made up of marginal or 'different' parts of the population, it appeared 'perverse' and in contrast with socially dominant values'.[4]

An evident implication of this acute judgement is the impossibility of separating medical practice – with all the sciences and technologies that are involved in it – from its constitutive nexus with ethics and anthropology.[5] Indeed, only this overall approach can save medicine from the opposing risk of dissolving into the utopian delirium of omnipotence rather than being left at the mercy of a relapse into magic.

To restate the need for, and the centrality of, the nexus between ethical medicine and anthropology thus means to recognise in all simplicity that the contemporary hospital as well, however advanced it may be, cannot expunge from its own daily framework the imposing fact of the mortal nature of man. Both patients and health care workers, indeed, bear witness to the inevitability of the fear of death *in naturalibus* to be found in the place entrusted with care. As Rosenzweig writes: 'Man with his own forces is not allowed to withdraw from this fear…man is not reject earthly fear, he has to remain in fear of death…Earthly fear can be taken from him only together with everything that belongs to the earth. But as long as he lives on the earth he must also remain in this fear'.[6]

Only where there flowers a preaching of redemption, which contains the explicit promise of the resurrection of the flesh, can the fear of death be defeated on this earth. This is the offer of Christ to the freedom of man; but specifically because it is given to a freedom, this gift does not prevent him from undergoing the ultimate drama of the move through the eye of the needle of always dirty dying and all its 'forms of cheating' made up of suffering and illness. If Christ has freed us from the fear of death, he has also left us the daily struggle to educate ourselves to take upon our own persons the power of his victory: *mors ero mors tua*.

In the bundle of light that is the Christian news, there takes form a very human way of facing up to illness, suffering and death; a way that is at the same time made intelligent through every form of contribution from the sciences, the technologies, economics, and management.

It is on this terrain that Catholic hospitals encounter the principles for a solution to the burning ethical questions and issues that affect contemporary hospital institutions.

In this paper I would like to list some of these principles without aspiring to be complete. Their special methodological value is what they have in common. For the sake of convenience, I will give their headings now, immediately making clear that the word 'principles' and the word 'method' oblige us to be on the terrain of the theological foundations, in particular of an anthropological kind, of ethics, without venturing into their, albeit very important, casuistic implications. I believe that Catholic hospitals, in order to solve the ethical questions and issues that characterise every place of care, must revolve around three elements: the *primacy of the subject*, or rather the ecclesial nature of the hospital community; *overall care*; and the *witness of charity* as an adequate criterion of care.

1. The Primacy of the Subject: the Ecclesial Nature of the Hospital Community

Von Balthasar writes: 'either the Christian specific…is anthropologically meaningful or it is nothing. It either resolves the unbearable contradiction that passes through the whole of the reality of man, that is to

say the fact that man, although knowing and drawing upon what is immortal, dies, or it does not solve anything'.[7] It is not difficult for a health care worker to see that this radical alternative directly brings into focus the nature of his or her mission. In particular, the Catholic hospital is born, lives and develops within the ethical-anthropological framework brought out specifically by this *aut-aut*. In other words, the Catholic identity of a hospital centre inexorably leads patients and workers to the heart of this dilemma.

In fact, illness, with its inevitable burden of suffering, cannot in the final analysis be experienced and defined other than as a prefiguring of death.[8] The very idea of healing contains, in turn, a request to last for ever (a request for eternal life) which reveals the *being for death* of every man crudely revealed by illness. All of this is made more evident by the fact that the question of health cannot in any way be reduced to the good 'functioning' of the body and the mind, understood as a somatic-psychic machine. And the physical, mental and social well-being of the famous definition of health provided by the World Health Organisation remains rather far from my concrete experience of health, that is to say *my* real health, the health that concerns *me*. For this reason, I have written elsewhere that the request for health always implies the request for salvation, and in so doing I echoed the accurate research of by no means few scholars of philosophy and the history of medicine.[9] There returns the intertwining between medicine, ethics and anthropology – this intertwining is a matter of fact. Whether a hospital institution takes this on in an explicit way in therapeutic practice, in training, and in research, or whether it undervalues it or ignores it, does not change the substance of the issue: overall care that does not take on completely the request for health of the patient and does not take on as well, therefore, his or her request for salvation, is an illusion. Whatever the specific circumstance of illness as a result of which the patient turns to the hospital, he or she brings with himself or herself – whether he or she expresses it or not and whether he or she knows it or not – another more radical question: who will free me from death which appears in this illness given that everything inside me says that I want to live for ever?

A hospital cannot achieve excellence if it does not address health and salvation in an overall and organised unity, connecting medicine to ethics and anthropology. How can it do this? It is the Christian experience, in itself and in the extraordinary invention of the *hospital*, which helps us to give an answer. The brilliant aspect of the hospital lies in this: in the discovery that the complete answer is not that of 'how?' but that of 'who?'. Or better, the question of 'how' imposes the question of 'who'. Indeed, an adequate answer to human need does not exist unless it is an answer given in the first person. The need/wish of man, at all levels, calls into play the relationship between *me and you*, thereby bringing out the inevitability of the *other* for my *me*. The concretely located person addresses all his or her needs and wishes within the context of an interpersonal encounter. The need/wish for health does not escape this logic. The famous and tormented question of what an adequate relationship between a medical doctor and a patient actually is, continues to be raised in every hospital precisely because it attests to the free and direct primacy of the relationship between people, in which alone illness and healing can be addressed. Each one of us perceives that with this question of *who* one goes to the truth of the patient, his or her relatives, and the health care worker. In short: the hospital.

Those who deal with health must address problems every day that ultimately rest upon this fact. This is the reason why one cannot ever separate the request for health of the patient from his or her way of relating to the health care worker and *vice versa* (ethics). And this way always reveals the *who am I* who treats and the *who is he or she* who requests health from me (anthropology). This states of things is the consequence of the fact that the truth is communicated to men and amongst men in a communitarian way. (It is no accident that the achievement of a diagnosis is always the fruit of teamwork). The great tradition of the *hospital* bears witness to this in a radiant way. The *hospital* was born as a place of overall welcoming and loving sharing by healing subjects (the health care workers) towards subjects suffering from the need/wish for health/salvation, which in turn involved relatives and friends in the request for meaning according to their levels of proximity.[10] The *hospital*, not by chance called *hôtel-Dieu*, was nothing less than an ecclesial community; that is to say a reflection of the Church in the decisive sphere of health and health care.

Today, as well, the Catholic hospital must be a well-identified and identifiable ecclesial subject where any man should be able to encounter salvation. A personal and communitarian subject that documents in a

sensitive and express way the redemptive power of Jesus Christ, who died and rose again, who defeated death and today calls every man to the resurrection of the flesh, offering the possibility of healing within the prospect of eternal life in heaven.

The Catholic hospital is the place where a personal and communitarian subject lives who, bending down in a loving way before the need for health, at the same time proposes Jesus Christ to the patient, his or her relatives and to the health care worker, as the way to the truth and the life. In a few words, it is the place where one educates people, specifically through care, in the experience that neither illness nor even death are in the final analysis an objection to happiness. It is the place where, in the highest form, the truth of the Pauline paradox 'sad men, that rejoice continually' (2 Cor 6:10) is documented.

The very question of the respon-

sibilities of the Catholic hospital, and its complexity and polyvalence, which is so emphasised in contemporary hospital structures, encounters specifically in the character and substance of the ecclesial subject working there its principal factor of balance. For this reason as well, the primacy of the ecclesial subject is the fundamental principle by which to solve the ethical questions and issues that put Catholic hospitals to the test. An affirmation of the weight of the subject is the first and most decisive methodological guideline to implement that move from *ethics in the third person* to *ethics in the first person* which is at the heart of the message of *Veritatis Splendor*[11]: ethics that harmonise truth and freedom, virtues and norms, the gifts of the Spirit and human commitment.

A hospital understood in these terms will not but see special concern for the educative dimension specific to the Church as a decisive ethical challenge. And thus, on the one hand, it will be concerned to help patients and families to live out the experience of illness by opening the request for health in the progressive taking on of the request for salvation, and on the other, in challenging the needs of its budget it will courageously address itself to the ethical and anthropological training of every kind of worker.

As a complete ecclesial subject, the Catholic hospital proclaims the salvation carried out by Christ who gives of himself daily in the Eucharist, understood as a place where the freedom of God encounters the act of freedom of man. The personal experience of the Eucharist tends to affect with its logic of incarnation[12] and communion the whole of the story of circumstances and relationships of the life of the hospital, and not only of the hospital. Indeed, this sacramental logic inexorably extends itself to all the spheres of the human experience of its protagonists. All this cannot but significantly characterise the clinical acts, the therapeutic practices, the research and the organisation of the whole of the hospital.

To conclude this first point, it is not useless to say explicitly that a sensitively expressed and proved primacy given to an ecclesial subject does not identify a confessional hospital. Anybody – to whatever religious faith he or she refers to or if he or she proclaims himself or herself an agnostic or even an atheist – can breathe in, within such an institution, a climate of creative freedom. In such an institution the contribution of specific professional skills and the right recognition of technical-scientific excellence is appreciated precisely because of the fact that it knows how to place all subjects (health care workers, patients, and family relatives) that frequent it face to face with a crucial question, even if today this is a question that is often removed: 'and who am I?'[13]

2. Overall Care

Where does the request for health reveal itself at the same time to the patient, his or her family relatives and the health care worker as a request for salvation? In the experience of his or her suffering body. Here it would be most suitable to use the language of Catholic dogma, which speaks about the resurrection of the *flesh*. Only the flesh, in fact, and not the body, is suffered, is loved, is wished for: the *proprium* of the human body is to be flesh, that is to say a lived out place, a lived out space.[14]

From this point of view, illness, suffering and death are the vehicle of the whole of the *being in the world* of the individual; they become a *language* which opens up to the other. Illness and death, despite the experience of the negative that they imply, become a privileged place that removes the self from bad loneliness, truly opening it to the other. Illness and death point out to the self that the body is not an insuperable barrier but a bridge, a communicative factor, in which the communitarian figure of the truth calls the freedom of all the actors involved to be fulfilled. Indeed, these considerations can be summed up in the statement of John Paul II which in a Catholic hospital should be a normal experience: the body is the *sacrament of the whole person*.[15]

At this point, the distinctive characteristic of the ecclesial subject living in a Catholic hospital appears: care and treatment. Suffering flesh, because of the sacramental nature of the body, 'ex-poses' the patient to his or her family relatives and his or her medical doctor. In order to ask for healing he or she makes himself or herself poor: the more serious the illness, the more he or she becomes meek. Beyond his or her level of knowledge, the patient embraces in this way the supreme law of desire, which asks 'to be lost in order to be found' (cf. Mt 16:25). The patient entrusts himself or herself. What a man normally does not do when he is in good health – abandon the self-possession to which he is attached out of the fear of dissolving his own self – he is forced to do when he falls sick, It is no accident that Christian tradition likens the patient to the crucified Christ and tends to read the suffering of his or her illness as *imitatio operis*, where the *opus* is the cross of Christ.

In so doing the patient calls on the health care worker at the heart of his very experience as a man. He calls him to *ex-pose* himself in turn. And the sick man carries out this same invitation in relation to his family relatives. What is the answer to this request that explodes from suffering experienced in the flesh? It is *care* understood in overall terms. It is not useless to outline these terms in general form. Overall care is the sequence of *clinical acts* conceived as a vehicle ('sacrament') of the *therapeutic art* in order to achieve *healing*. By therapeutic art I mean the set of relationships that are established between the actors of the hospital, who, in order to take responsibility for the request for health/salvation, engage in the clinical acts, that is to say all the medical actions with a technical-experimental basis.

One well understands why this concept of *ars curandi* – which does not fear the more sophisticated scientific-technological discoveries (*téchne*) but simultaneously by bringing into play all the actors of the hospital achieves the creativity specific to the *poiesis* – constitutes a second important guideline to solve the contemporary questions and issues of medical ethics. From this point of view, indeed, the increasingly widespread temptation to reduce the task of the health care worker to mere clinical intervention, and that of the hospital centre to being a mere provider of services, is removed at the roots by the mutual self-exposition of the actors on the scene; the question of the relationship between the medical doctor, the patient, and his or her family relatives finds in such a hospital the natural channel to be addressed by

each of them according to the physiognomy of their upright freedom, supported and corrected by the community structure.

If the patient who exposes himself or herself, beginning with the request for health, is offered the possibility of concretely addressing the request for meaning in his or her life (the request for salvation), and thus in the relationship with the other he or she is allowed on walk along the path of his or her fulfilment, the health care worker, for his or her part, is given the possibility of overcoming the pernicious dualism of the well-being of his or her person and profession: on the condition that, in turn, he or she exposes himself or herself to the clinical act with the whole of his or her person, bringing into play the therapeutic art with all the professional expertise of which he or she is capable. The family relatives, lastly, who are called to interact with the patient and the health care worker, are strongly faced with the question – which is often dulled – of the meaning of their existences. To support this question – which is not different from the search for truth in itself – should be dedicated, through service to the needs of the patients and family relatives, each action of voluntary work in the health care sphere. From the point of view of overall care, there is thus produced a growth of humanity in a Catholic hospital which at the same time is increased by the 'ecclesial we'. The Eucharistic root of the Christian community – in which the definitive character of the death and resurrection of Jesus Christ for the salvation of men is prefigured, thereby making tangible the promise of the resurrection of the flesh – becomes in this way a meaningful paradigm for overall care. Respecting due differences, one can say that the sequence of clinical acts provides the *matter* through which the constitutive *form* of the therapeutic art is expressed. Aware of this Eucharistic structure of care and treatment, the actors of a Catholic hospital become especially sensitive to the logic of communion to whose reality they bend their request and their skills. From this point of view, healing takes on in turn the profile of totality because death as a real possibility is within its own breast. From a burning defeat at having missed the target of eliminating illness, it becomes the mysterious actuation of the concrete event of salvation: entrustment to the Father.

In a hospital conceived of in such terms, it is inevitable that everything will be done to foster, save and take care of life from conception to its natural end, and the intrinsic limits of every clinical act will be accepted with humility. The overall character of care and treatment, ensuring the primacy of the subject, does not eliminate the wounds and the tearing pain of dying, in the same way as it does not take from illness its character of being a trial and being suffering. But it does give personal freedom to each person in the face of fear of death, opening up to the certain hope that in the death and resurrection of Christ the dying of man is not a matter of 'kicking it', as Adorno observes.[16] It is not a matter of falling into nothing but of going towards the Father.

3. The Witness of Charity as an Adequate Criterion of Care

However, the Eucharist in itself, and as a principle and criterion by which to address every circumstance and every relationship, does not possess a magic character: it possesses one that is dramatic. It is the privileged point of encounter between the freedom of God and the freedom of man.[17] In the Holy Mass, Jesus Christ, the living and personal truth, offers himself in his body and his blood to the whole of mankind. Thus, by sacramental logic, every circumstance and every relationship is in a certain sense a gaining of access to Jesus Christ-the truth through my freedom. The *sacramental mystery* – this is how Scheeben brilliantly defined the sacrament and sacramental logic(18) – is not an object that can be possessed by man as though it were a thing, nor is it a theory which he can take possession of so as to then apply it to his life: it is something that characterises an interpersonal relationship that always and once again, *here and now*, involves subjects. The truth, precisely because it is living and personal, calls for my decision. In promising itself, through every circumstance and every relationship, it calls on the individual act of my freedom.

The place dedicated to overall care, whose root is the Eucharist, does not, therefore, confine itself to affirming the primacy of the subject but also requests of the subject, for his or her care, a precise criterion of action and effectiveness – *witness*. Through witness, the patients, family relatives and health care workers are called to 'expose' themselves.

Every other way of approaching care or a place of care, that is to say every curative action in which the subjects who are involved do not expose themselves through precise clinical acts almost as a sacrament of the therapeutic art, becomes ideological. It oscillates permanently, as I have already observed, between the poles of omnipotence and a lapse into the magical. Only the action of a witness gives meaning to illness, to care for the suffering and to death because it brings out their intrinsic salvific force. Thus calling oneself to the body of a sick person to ascultate it or to wash it or to carry out any other action in relation to it for a diagnosis, prognosis or therapy, becomes a symbol (sacrament) of the involvement of the whole of the person of the medical doctor or the nurse with all of the person of the patient. Opening up to each other, the medical doctor and the sick person, in the name of aware or unaware belonging to Jesus Christ, specifically through the very concrete request for health, enrich their personal humanity. The patient and his or her family relatives find relief, and the health care worker can defend himself or herself from the opposite risk of alienating cynicism or inconclusive emotionality. In this way, they actuate amongst themselves that good life that at the same time builds up the Church and society.

In the perspective of witness not even an instance of suffering is lost. It is suffering that always wounds, above all in the defenceless and the weak; there does not remain only an inevitable and bitter destiny which cannot be removed but a destiny which, imitating the work of the cross of Christ, generates life. As St. Paul reminds us, it really adds to the flesh of the individual that which is absent in the sufferings of Christ because it exalts his freedom and accompanies him to completion (cf. Col 1:24) At the same time, it bestows growth on the dimension of communion of a Catholic hospital. In this way this hospital, through its

direct or indirect relationship with the family, will make its benefits felt for the whole of the ecclesial community.

Christians do this as witnesses starting with the sickbed of illness; they do not cease to affirm to man – even to today's man who is sophisticated but lost – the constructive beauty of the follower of Christ's: 'While we live, we live as the Lord's servants, when we die, we die as the Lord's servants' (Rm 14:8).

If the subjects who work in a Catholic hospital are witnesses in action, then the character of this action is charity. *Charitas Christi urget nos* (cf. 2 Cor 5:14). The *witness*

of charity thus reveals itself as a *third decisive guideline* by which to solve the contemporary ethical questions and issues which Catholic hospitals today are called to address. This is to be seen first and foremost from a single fact: the ability to always start from need. As is historically proposed. Through precise circumstances and relationships, the need for health *pro-vokes*, calls witness into play. From this point of view, there is space for the employment of the most sophisticated technological instruments for diagnosis and treatment, just as there is space for the most humble clinics and the loving care of the dying in the desolate outskirts of great cities. But not only this: the witness of charity becomes a decisive ethical criterion by which to identify the most correct hierarchy of the needs of health and thus the allocation to them of the necessary resources. On the one hand, it leads to the offering to everyone, even to the inhabitants of the South of the planet, the fruits of the most advanced kinds of research; on the other, it cuts down to size that will to power that at times leads the health care systems of the rich countries of the world to engage in improper investments.

Charity as a complete criterion for the action of the witness in the health care sphere becomes able to actualise the Hippocratic ideal by always and only acting to serve life. A health care worker will serve life by not taking the place of the conjugal act of love between a man and a woman in giving origin to a human being. He or she will never suffocate a life that has flowered in the womb of a mother. Faced with the drama of final suffering he or she will try to alleviate pain and accompany the dying person without ever arrogating to himself or herself the right to extinguish life. In a few words: he or she will never act to place his or her art at the service of good and of bad, indifferently. If he or she breaks dependency on good and if he or she transgresses the lordship of God over life, how can one still trust that health care worker?

4. 'Every Day Contemplate the Face of the Saints so as to Draw Comfort from their Words'[19]

The exemplary figures of the hospital saints concentrate in a persuasive and living way in their industrious witness of charity in the world (which is still today effective and relevant) an approach to which the subjects who work on Catholic hospitals can refer. They represent the prolongation in history of the figure of Christ the physician, well documented in the gospel saints (cf. Mt 9:12; Mk 2:17; Lk 4:23 and 5:31) and widely taken up by the Patristic tradition (Clement of Alexandria, Cyril of Jerusalem, Origines…).[20]

Camillo, John of God, Cottolengo, Mosacati, Pampuri, and many, many others, what do they teach us? Normally, at the origins of their witness, there is the encounter with need, the response to which coincides with their total identification with Christ. This has generated authentic subjects and personal and community ecclesial places directed towards overall care. While they offered the whole of their lives – moving from the *status viatoris* (of pilgrims) to the *status comprehensoris* (of blessed) – they were in this way witnesses to a brilliant tandem of charity and intelligence, raising in themselves and others certain hope.

In this way, men who are engaged in that social outpost, the Catholic hospital, can still today contemplate the face of these saints so as to draw comfort from their words.

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Notes

[1] Cf. H. JONAS, *Tecnica, medicina ed etica* (Einaudi, Turin, 1997), pp. 8-27.

[2] Notations on the subject in the collective volume A. SCOLA (ed.), *Quale vita? La bioetica in questione* (Mondadori, Milan, 1998).

[3] Cf. A SCOLA, 'Religione, economia e salute', *Dolentium Hominum*, 15 (2000), n. 43, 37-43.

[4] G. COSMACINI, *Il mestiere di medico* (Raffaelo Cortina, Milan, 2000), pp. 151-152.

[5] Cf. A. SCOLA, *Questioni di Antropologia Teologica* (PUL-Mursia, Rome, 1997), pp. 215-227.

[6] F. ROSENZWEIG, *La stella della redenzione* (Marietti, Milan, 1985), p. 4.

[7] H.U. VON BALTHASAR, *Gloria* v. 7 (Jaca Book, Milan, 1991), pp. 80ss.

[8] It was once again Bathasar who said that 'illness and need enable death to be already felt within life', H.U. VON BALTHASAR, *Homo creatus* (Morcelliana, Brescia, 1991), p. 45.

[9] Cf. A. SCOLA, *"Se vuoi, puoi guarirmi": La medicina tra speranza ed utopia* (Edizioni Cantagalli, Siena, 2001).

[10] Cf. *ibid.*, pp. 56-59.

[11] Cf. *Veritatis splendor*, 16-24.

[12] Cf. *Fides et Ratio*, 94.

[13] Cf. G. LEOPARDI, '*Canto notturno di un pastore errante dell'Asia*', v. 89.

[14] Cf. A. SCOLA, *"Se vuoi, puoi guarirmi"*, pp. 79-81.

[15] Cf. JOHN PAUL II, *Uomo e donna lo creò. Catechesi sull'amore umano* (Città Nuova, Roma, 1992), p. 75.

[16] 'The biological destruction that takes place with death is specifically effected by aware social will. A kind of mankind for whom death has become no less indifferent that its members can impart this in an administrative way to an unlimited number of human beings. The famous prayer of Rilke is a miserable deception, by which an attempt is made to conceal the fact that men, nowadays, kick it and that's all': T.W. ADORNO, *Minima moralia* (Einaudi, Turin, 1988), p. 284.

[17] Cf. A. SCOLA, 'Donato all libertà', in N. Reali (ed.), *Il mondo del sacramento. Teologia e filosofia a confronto* (Paoline, Milan, 2001), pp. 367-374.

[18] Cf. M.-J. SCHEEBEN, *I misteri del cristianesimo* (Morcelliana, Brescia, 1960), § 81.

[19] *Didaché* IV, 2.

[20] Cf. G. DUMERGE, 'Le Christ médicin', in *Dictionaire de spiritualità*, t. X (Beauchesne, Paris, 1980), pp. 891-901.

JESUS ETAYO ARRONDO

4. The Principles of Pastoral Practice for Today's Catholic Hospitals

1. Introduction: a Look at our Realities

The world is the area and the place for the mission of the Church (*EN* 13, 14, 15).[1]

Yesterday, reference was made to the reality of Catholic health care institutions in our very many-sided and pluralistic world.

At a social level we experience a culture of contrasts. On the one hand, health is promoted and well-being is strongly sought after. The 'body is worshipped'; indeed, to such an extent as not to allow the appearance of any symptom of pain. Death is concealed, denied, and when it does occur it is experienced as the greatest of frustrations. On the other hand, however, forms of behaviour are lived out which are not at all healthy from all points of view (stress, competitiveness, speed, smoking, drugs, etc.). We have before us a great paradox: sensitivity towards nature and ecology, and at the same time the abuse and exploitation of nature.

If we look at the health care world we discover that the defects become challenges and opportunities with regard to our pastoral work: the secularisation of medicine, dehumanisation, the lack of ethical training, health care economicism, the preponderance of the technical, and little appreciation of, and attention paid to, the spiritual and religious dimension.[2]

When we look at the health care centres of the Church we observe that they often co-operate with the state in which they are located. At times this can generate conflicts between their identity and their survival. Religious staff are increasingly fewer in number and it is not always easy to conserve a personnel made up professionals who actively live out the gospel of Jesus Christ. In addition, not all the people who turn to the health care centres of the Church are Catholics, and it often happens that when they are Catholic they say that they are not practising or that they are not very interested in the spiritual or religious dimension. There is not always an adequate integration between the evangelising action of a Catholic hospital and Church pastoral care as a whole, and greater dialogue, co-ordination and co-operation are required.

In these circumstances, and accepting the challenges they involve, the existence of Catholic health care institutions has a meaning today and forever. Firstly, we are dealing with a requirement of the Church, which is called to carry out her own evangelising mission, to engage in her own gospel-based project of offering sick people the health, the compassion and the love of Jesus Christ, as he himself did. The final justification for this mission is rooted in the Christian faith which invites the believer to place himself at the service of the human person with an urgency that is proportionate to that person's weakness.[3]

On the other hand, this is a right that is based on the right to freedom of conscience and the right of association. The Church, like any other social group, has the right to offer health care service to society, beginning with her own special understanding of life, illness and death. Citizens, for their part, have the right to turn to these services, where they know the ethical and spiritual aspects of health care will be respected and defended.[4]

2. The Mission of the Catholic Hospital

It is clear that the mission of the Catholic hospital forms a part of the mission of the Church, which strives to be faithful to the mandate of Christ to preach the Gospel to all people (cf. Mt 28:19; Mk 16:15).

Jesus never separated his healing ministry from his proclaiming of the Kingdom. On the contrary: these were two components that integrated the contents of his evangelising action, of his mission. The action of Jesus was summarised in the gospels in the following way: 'And he went about all Galilee… preaching the gospel of the kingdom and healing every disease and every infirmity among the people' (Mt 4:23; 9:35; Lk 6:18, etc.).[5]

The acts of Jesus on behalf of the weakest and those marginalised within society – acts in which he revealed the value and dignity of every person and all people – are for the Church an appeal to engage in service to the sick and primarily to those who, in addition to the weakness and the marginalisation that every illness involves, suffer other limitations because of a social or economic marginalisation or a marginalisation brought about by other circumstances.[6] Service to the sick is an integral part of the mission of the Church.[7] (SD, 15)[8]

Faithful to this mandate and this vocation, the Church must reacquire an awareness of her healing action by rediscovering and developing the healing power of evangelising action when it is inspired and driven by the Spirit of Jesus: to offer man Christian salvation in such a way that he is made to live out sickness and health, pain and death, in a more human way, providing an ultimate meaning and a definitive hope to the aspirations of life enclosed within the human being[9] (CHC).[10]

The Church and her institutions must be involved in such work, and in our case we are referring to Catholic hospitals and health care

centres. Their mission must be that of evangelising the world of suffering and illness through the promotion of health care works and organisations that provide overall care to the human person and promote the healing action of Jesus Christ.

Jesus Christ is the real model for pastoral care for all those who work in Catholic hospitals and for all pastoral workers. In such hospitals the Church makes herself present and renews herself in her encounter with the sick: 'Born of the mystery of Redemption in the cross of Christ, the Church has to try to meet man in a special way on the path of his suffering. In this meeting man "becomes the way for the Church"'(SD, 3). With the sick person she listens to the Word from the depths of his illness, she prays, she celebrates the presence of Christ so as to help him to experience his situation taking faith as a starting point, and she offers to this secularised world the service of the Gospel in an approach of sincere dialogue from her insertion into pain and suffering.[11]

3. The Principles of Pastoral Action in Catholic Hospitals

Every person, whether they are a believer or not, at one time or another in their lives is admitted to a hospital. A hospital, for this reason, is a privileged area for evangelisation. People turn to a hospital with the primary goal of being examined and possibly cured of their illness. For this reason, a form of care and treatment that is responsible and qualified from a professional and technical but at the same time human point of view is indispensable. With this we should offer, in freedom and respect, the health and the strength that come from Jesus Christ, bringing at the same time the specific instruments of the Christian faith that the Church makes available to us.

The whole of the hospital, with its structures, must be organised in a way that is consistent with its mission. Economic management, the management of care and of human resources, training, the style of providing care of the centre, the ethics of management and so forth, must be impregnated with gospel-based criteria and principles so that its evangelising mission is effective and consistent. The mission of a Catholic hospital cannot remain exclusively in the hands of the pastoral team or the religious service. All the services and all the health care workers, each at their own level, with their work well carried out, through witness and words, must make a contribution to the harmonious performance of the evangelising mission of a Catholic hospital (*EV*, 89)[12]

This mission requires the commitment of everyone in order to conceive and implement evangelising pastoral care which is broader than that form of care which is only doctrinal or sacramental. I would like to refer to certain points that are needed to develop such pastoral care with evangelising force, elements that all those who work in a Catholic hospital must bear in mind, above all those who dedicate themselves specifically to spiritual care. Evangelisation must take as its starting point:

– the salvific experience of Jesus Christ, in order to be witnesses to him;

– the evangelising style of Jesus, in order to act with the spirit of Jesus;

– the community of believers, in order to build up a living community;

– listening to life in the light of faith and the gospel;

– effective commitment which transforms;

– modest means although those best for the sick are sought after;

– the contagion of Christian hope.

In the ultimate analysis, it is believers who evangelise: through their way of being and loving, living and celebrating their own faith, working and humanising life, they become the Good News of Christ for those that they meet on their journey, in this case the sick, their families and colleagues.[13]

Taking into account what has been said about Catholic hospitals and the observations that I have just made, I would like to point out, to continue with my paper, certain principles that today, as I see things, must be borne in mind in the carrying out of your pastoral action:

3.1. In communion with the Church

It could not be otherwise: in communion in the juridical, doctrinal and pastoral fields and in all other contexts, with the local bishop and his representatives as well, above all taking part in and joining in the overall pastoral initiative of the local Church. It is very important for the hospital to have the nearness, the support and the assistance of the Church in a world as complex as the health care world.

In a hospital, the Church encounters Christ who is suffering in the sick, whom she accompanies and to whom she offers her life.[14] (*EV*, 88).[15]

3.2. The sick person is the centre of attention

All efforts must be directed towards reaching the highest possible level of care and treatment, using for this purpose suitable methods, necessary techniques and the specific instruments of our time, with the attitudes and the style specific to a gospel-based project.

Together with the sick person, we must include today his family and in a broader sense society itself. We have to answer their questions, hear their views on the decisions to be taken, and consider and promote associations representing the families of sick people.

3.3. Overall, personalised and team assistance

We need to be concerned about the biological needs of patients, as well as their psychological, social and spiritual needs.[16] This is a really demanding challenge which belongs specifically to the style of Jesus, who drew near to the sick and dedicated himself to them in a personal and overall way. In order to advance this principle, we need to aim for a model of care that fosters teamwork. Only beginning with a correct inter-disciplinary approach will we be able to take care of the sick in an overall way, thereby overcoming the risk, which is today so widespread, of specialisation.

3.4. Sensitivity, commitment and solidarity in relation to the poor and the new needs that arise in society

All of this forms a constituent part of the Church and thus of her institutions. A Catholic hospital, and the services and the people who constitute it, beginning with the management, must always be open to paying attention to the poor and those in need through the provision of suitable social and economic formulas. In the same way, the management must be innovative in its readiness to care, prevent, and engage in research – according to its possibilities – in relation to the new needs that emerge. People sick with AIDS, immigrants, the mentally ill, the physically and mentally disabled, drug-addicts, and sick people who need home care etc., must all meet welcome and hospitality in the hospitals of the Church (*SD*, 28).[17]

3.5. Commitment in relation to the principles and values of Catholic ethics

The project of the Catholic hospital is called to achieve a service to the life of the person from his conception (watching over, defending and promoting the rights of the unborn child) through a dignified life; to care for and treat him during illness; and to enable him to die with dignity.

The world of health and health care in general, and of hospitals in particular, require special care and an ethical assessment of the different realities involved. This should take place in the light of the specific principles and values of Catholic ethics. The professional health care workers of such hospitals should receive training in matters of ethics and bioethics. In the same way, the creation of an ethics committee that helps in the study of, reflection on, and production of solutions to the various situations that arise is also necessary. Here a great work of evangelisation can be engaged in, as well as an important promotion of the dialogue between faith and science, and more in general with culture. The freedom of conscience of professional workers requires due respect; indeed, an attempt should be made to find appropriate solutions in situations of conflict regarding the identity of the institution: the formation of an ethical sense and rational instruction as regards the rules and regulations of the institution. Interdisciplinary dialogue that is on-going and serious will reduce the instances of conflict to the utmost, and these in any case will be examined by the ethics committee.[18]

Commitment to Christian ethics, leaving aside the professional code of ethics and the dimension of assistance, should reach all the internal contexts of the hospital, including those connected with care and treatment, the management of staff and resources, and, of course, research. To this end, it is necessary to have a committee for the ethics of research as well, which, in addition to watching over research from a legal point of view, watches over, defends and promotes fundamental ethical values.

3.6. Commitment towards the professional workers

They constitute the chief potential of a Catholic hospital and on them depends in large measure the setting in motion of the evangelising project of the hospital. Because of this fact and also because such a hospital is an ecclesial institution, great care must be taken in the management of human resources, which should be in conformity not only with the existing laws of each country but also, and above all else, with the principles of the social teaching of the Church. Working conditions that are suitable and stable, a suitable wage, an adequate training and the promotion of personnel should all be provided, and there should be a real concern about the personal development of the members of the personnel. Criteria should be followed that are in line with an ecclesial institution and here I refer to the welcoming of people, support for, and assessment of, the work of each person, accompanied by the creation of programmes of participation and the delegation of responsibilities according to the qualities of each individual person. Here there are many aspects to be taken into consideration, which, in my view, are essential to the good working of a hospital and to which we must pay attention if we do not want to lose vitality and capability at the level of evangelisation and pastoral care.

On the other hand, we need to realistic and aware of the fact that not all the professionals who arrive and who work in a Catholic hospital live out their faith in a committed way. However, always on the basis of respect and keeping the gospel-based identity of the hospital alive, it is necessary to seek out and unite all the forces possible in order to go on evangelising, beginning with good and competent profession-

als.[19] Special attention should be paid when selecting staff and personnel.[20]

3.7. Commitment towards volunteer workers, benefactors and friends

In some hospitals some of these will be present and in others all of them. I believe that their presence, in addition to be being a good sign for the hospital, is also a duty. In addition to being a real help, voluntary workers bring their dedication, their commitment, and their charity which is born, in many instances, from their faith. We are dealing here with a breath of fresh air, of love and of generosity, because it infuses life and witness into the hospital. For that matter, the hospital must foster and promote areas of commitment for many people who meet Christ in the sick, and can help in the development of their faith and their Christian lives. For this reason, the hospital must welcome them, train them, and accompany them. (*EV*).[21]

The same may be said with regard to the friends and benefactors of the hospital in their various guises. The hospital is thus transformed into a centre for living and growing in faith and Christian commitment.

3.8. Commitment as regards the management of economic resources

Clarity, transparency, participation and fairness are the basic principles of correct and honest management. Today, we are experiencing times that are very sensitive to all of this, especially in this part of the world. I believe, on the other hand, that the Church and all its institutions must not have a profit-making motive; indeed, I would say that they should all be non-profit making both in theory and in practice. I know that this is something that is difficult to achieve, and also something of a polemical character, above all when one is dealing with institutions that need very substantial means in order to carry on their work.

However, there are two questions of a truly gospel-based character that give great moral force in relation to society. On the one hand there is clarity and transparency. Frequent and correct auditing can be a helpful instrument as regards society as whole, its various bodies, and the centre itself. On the other hand, there is a need for a management that does not have profit-making motives but only seeks to obtain what it needs to carry out its mission and offer a correct remuneration to its workers. This is certainly a complex question.

3.9. Commitment as regards the quality of assistance

All the efforts of the hospital should be directed towards obtaining the best possible quality as regards assistance to patients and their families. This requires commitment at a personal level and at the level of the whole of the organisation in order to achieve a harmonious reconciliation of the use of the best technical means possible with the principles of humanised assistance.

The term 'quality' is relatively new in the hospital field. However, far from being confined to certain headings and statements, it must refer to the daily effort made in order to develop to the utmost the project and the mission of the hospital in all its technical, human, spiritual etc. breadth. A revision of usual methods and practices in order to be self-critical and improve the assistance that is provided will help us to grow in relation to the quality of assistance.

I think that it is important to at mention humanisation, which, indeed, must prevail in any hospital and naturally enough in a Catholic hospital. Assistance to patients which is not human assistance is bad assistance and is thus not even Christian. It is essential and requires personalised attention and a form of attention that is worthy of the needs of the patient and understood as an inalienable right. In essential terms this means stopping in front of the sick person, our neighbour, and recreating the scene of the Good Samaritan (Lk 10: 25ss). Here are the roots of real quality in assistance.

3.10 Being open to co-operation with local bodies and agencies

A hospital is not an island. It must be integrated into society with which it establishes a fundamental relationship and with which it must co-operate by providing resources and means that will facilitate the provision of care for people and improve their quality of life. This co-operation can take place with ecclesial bodies and agencies, with its own administration or with any other kind of private body or agency with which it has shared aims.

I believe that this is a major field

as regards the building up of the Kingdom, and beginning with which Catholic hospitals and the Church can make a great contribution to society. It is clear that this cannot take place at any price. The hospital must conserve its own identity and despite the difficulties must always carry forward its own project of evangelisation.

Only beginning with these constituent elements can a hospital adequately carry out its mission and engage in the co-operation that it provides. Here we need to be careful in the face of economic temptation and the temptations of other kinds which very often can obscure the work and the mission of a hospital.

3.11. Commitment as regards training and research

Training is fundamental in all areas of life and above all in the hospital world, which today is so specialised. However, this must be a training that is well balanced between what is technical and personal and the institutional values that are connected with the mission, the principles, the goals and the actions that we may term pastoral; indeed, a form of training that is always open to everything that involves improvement in care and treatment for patients.

It is certainly the case that research is a constituent part of the life of the health care professional, research, of course, carried out according to his capacities and characteristics. However, it must be carried out in line with certain criteria, whose first objective, naturally enough, is the promotion and improvement of people's lives in line with the values and principles of Catholic ethics. We also need to be vigilant so as to avoid the manipulation of the person in all his breadth and not to fall into a business mentality which at times engenders money-making motives and the search for mere personal and scientific prestige.

3.12. Commitment as regards spiritual-religious care for sick people

This is a right that we cannot stamp on. Illness creates a very special situation for the person: at times denial and rebellion in relation to God (a development which emerges at the beginning), and at others an opportunity to encounter ourselves and meet God, to look back over our lives, a *kairos*. In all cases we need to attend to and accompany the sick and their families, at all times with respect and in freedom.

Given that we are dealing with a Catholic hospital, this dimension should be dealt with, approached and fostered in a special way by offering those suitable pastoral in-

struments that the Church makes available to us. Nearness and accompanying during the unfolding of the illness, prayer, the Word and the sacraments, in addition to the human side and witness of the health care workers, can help the patient to find the healing and health-giving actions of Jesus Christ and will really be a therapeutic contribution of the first order. All sick people are the objects of spiritual care and we need to have a respectful and ecumenical approach, making the religious care of other confessions available when this is requested.

In order to carry out this task, the presence is necessary of people who live out the experience of faith and Christian love and have suitable training in pastoral care. The health centre should promote and follow the pastoral care team and/or service for religious assistance that engages in such a service. In addition to this, it is indispensable, in a Catholic hospital, that the whole of the staff, and in particular its members who provide care, whatever the category to which they belong, knows about, and engages in, spiritual and religious care as an essential element of overall care. Here, however, a great deal of work remains to be done.

3.13. Creating a culture of life

That they may have life: this is the appeal of the Lord. This is the mission of the Church and in practical terms of Catholic hospitals, where every day people afflicted by many illnesses arrive, people who at times are near to physical death and at times to moral death. When a hospital is able to give life, to improve it, to respect it, to care for it carefully and in a dignified way until death, and in addition to promote attitudes of hospitality, brotherhood and solidarity in relation to those who are most in need, it creates and promotes the life that Christ offers us. It also helps to create a culture of life beyond that culture of death which so often surrounds us. Lastly, it also follows the invitation of John Paul II to bring about a new culture of life (*EV*, 77, 95).[22]

I would like to end this section in the following way. Perhaps some people are amazed at the fact that all of these principles are defined as being pastoral in nature. On the borders of different kinds of terminology, and taking into account the fact that pastoral care refers to the actions that the Church engages in to promote her evangelising mission, I believe that all these principles are essential to ensure that the mission of Catholic hospitals is really evangelising in the overall sense indicated above. In this way the Church performs her mission by practicing charity, proclaiming the salvific message of Jesus Christ, celebrating life in a Christian way in its various aspects and carrying out her salvific mission through the promotion of justice, the defence of the rights of sick people and the condemnation, in an explicit way as well, of every manipulation and abuse of life.

The Eucharist is thus the engine of the life of the hospital. It is a cel-

ebration of life that provides care, that calms, and that accompanies until the great crossing from death to life. The evangelising project that is engaged in is celebrated and given thanks for, a project supported and fostered by the Lord. The paschal mystery is celebrated, a meaning and an alive hope for men, even when they suffer and die. The Eucharist renews the commitment of the hospital to continue with evangelisation. In the Eucharist all the members of the hospital receive the strength, the faith and the nourishment to go on transmitting the freeing love of Jesus Christ.

4. The Service of Religious Assistance (SRA)

Although it is certainly the case that the whole of a Catholic hospital, the services and the people that go to make it up, are the active agents of its evangelising mission, there should also be within the hospital a service of specialised care which deals with the spiritual and religious needs of patients and their families.

The existence of this service on the one hand meets the requirement and the commitment of a hospital to be an ecclesial institution sent by Christ to evangelise. On the other hand, it also meets the need to offer overall assistance, as has been already pointed out in this paper. Lastly, it is a result of the need for the sick to be cared for in a spiritual and religious sense, something, indeed, that constitutes a fundamental right.

4.1. The orientation of the SRA

This is a hospital service that carries out its task and mission together with all the other services of the hospital. I believe that we should aim at a therapeutic orientation for the SRA. With the other professional workers and with the patient and his family, the members of this service contribute through their presence, their witness and their actions, to the care and treatment of the sick person. If we are convinced that the Good News of the Gospel of Jesus Christ is healing and salvific, it must reach the sick, and in a special way it must do this through the SRA. Such an orientation requires well-trained and dynamic people as well as a suitable organisation.

This way of orientating the work of the SRA also requires interdisciplinary work with the other professional workers of the hospital so that the religious worker is not an island in a sea but, in contrary fashion, a person integrated into a team that is fully aware of its mission and who carries out his very concrete therapeutic mission as a member of the SRA.

4.2. Its fundamental objective

Its fundamental objective is to attend to the spiritual and religious needs of patients, their families and professional workers by following and recreating the actions and approach of Jesus of Nazareth in relation to sick people in need, thereby contributing to the evangelising mission of the hospital and the Church.

4.3. The people to whom the SRA is directed

In general, such people are those listed in relation to the fundamental objective of the SRA, namely the sick, their families and the professional workers. All these categories are those to whom the SRA is addressed, each one according to their specific needs.

In line with actual possibilities, contact with the parishes and the Christian communities from which patients come is important if we want to maintain our ties with them. It is certainly the case that this must be integrated and co-ordinated with the pastoral care in health provided by the parish to which the hospital belongs and the diocese in which it is located. Here there is certainly a great task of supporting and promoting pastoral care in health.

It is very probable that there will often be non-Catholic patients who ask for religious care provided by other confessions. The members of the SRA should ensure that they are suitably catered to, and they should also promote, when the circumstances so require and so allow, areas for dialogue and ecumenical celebration.

4.4. The contents and actions of the SRA

The contents will be of an evangelising character – liberating, healing and a source of life. Evangelisation is engaged in beginning from: the salvific experience of Jesus Christ, the evangelising style of Jesus, the community of believers, listening to life in the light of faith, commitment that transforms, modest means and the infectiousness of Christian hope. In Jesus of Nazareth we find the real and fundamental model of pastoral action and the contents of pastoral care as well.

The Church is present in a Catholic hospital, in particular through the SRA, and lives in communion with the patient whom she encounters. The Church offers him: her presence and nearness, sincere dialogue about his life and situation, the Word, the sacraments, and readiness to provide him with overall care.

To ensure that a SRA engages in such evangelising and healing activity, the following actions may be proposed:[23]

4.4.1. Accompanying the patient and his family: a good and effective accompanying of the journey of illness and of the patient's experience of faith is the key to achieving suitable pastoral care. We are referring here to accompanying, to building bridges, to offering opportunities in a way that respects the patient and leaves the initiative to him. His trust must be gained if he is to open himself up. Often this is a matter of special moments for the patient, to whom time should be given, as well as readiness to help and one's presence. At other times one should act as a 'stimulus' or clarify confusions: often this will only be possible through one's presence and one's accompanying of the patient.

Hence the importance of pastoral visits, visits that probably cannot take place every day. However, the members of the SRA should follow a certain criterion as to what is of primary importance in their visits: they should pay more attention to those people who are undergoing greater difficulties, the dying or patients who are experiencing difficult moments after their diagnosis.

In addition, members of the SRA should always be ready to help as regards calls for assistance in urgent cases.

4.4.2. Identifying spiritual and religious needs and establishing a suitable pastoral diagnosis. The investigation and exploration of spiritual and religious needs is becoming increasingly important. However, there is a still a great deal to be done in this area. For many people these continue to be confusing terms which refer to rites, and in this area there are many taboos. This can also often be observed amongst medical staff. Hence the need for a better training of this aspect in all health care workers because they, too, have to look after the religious and spiritual welfare of patients given that usually this is a factor in achieving improvement at the level of therapy.

Each person has their own spiritual life, of varying levels of richness and awareness. It is this sphere of the life of man that touches upon the requests for meaning (the meaning of life, of death, of illness, of good and of evil), the values that guide life (the hierarchy of values that lie behind our actions and which move us to carry them out), and the beliefs that help us to rise above ourselves in various ways, amongst which is to be found opening ourselves to God and for Christians, to the God of Jesus Christ. This last element is not lived out by all human beings in the same way. For some people, their beliefs do not go beyond their ideas, their philosophies, or other merely 'earthly' elements. Other people, who are open to God, find in Him the answer to many questions and to the meaning of their existence and the existence of other people: hence the various religions and confessions.

By adopting this perspective it is possible to accompany and help all people who are sick beginning with their own realities, offering them (always with respect and in freedom) the love and the health of Jesus Christ. We can come across many distorted spiritual and religious experiences, which have to be identified and treated in a suitable way.

4.4.3. Offering the healing resources of prayer and the sacraments, in a way that takes account of the special circumstances of being in a hospital. To achieve this, the liturgy and the administration of the sacraments should be celebrated with creativity and dignity. The celebration of the sacraments should usually be the culmination of a meaningful relationship with the sick person and the result of a process of faith followed by him.

Despite this, a major effort as regards formation and catechesis in relation to the sacraments should be made when it comes to patients and their families, and at times the professional workers as well, especially as regards the sacrament of the anointing of the sick, which is often seen as a sacrament of death.

Prayer with and by patients is of particular importance during such moments. It should be connected to the realities and the experience lived out by the patient.

4.4.4. Providing advice in religious and moral questions to those who ask for such advice. This is a very important kind of activity which can be carried out starting with the ethics committee and consultations, visits and meetings. In some cases the mission involved could be that of condemnation and of an appeal to engage in care, but it should always involve contributing to the ethical training of professional workers.

4.4.5. Pastoral care for the health care staff. In a Catholic hospital the SRA must:

– work with the other professional workers. Through personal contact and daily work it can find a great deal of space to bear witness – through its own approach and example – to the values of the Gospel, so as to engage in sharing and to dialogue about various situations, guiding them in line with the perspective of faith etc;

– help in and contribute to the training of professionals in the spiritual and religious field so as to look after patients in a better way;

– strengthen and work with the Christian commitment of professionals;

– promote groups of Christian reflection, prayer and liturgical celebration who really bring about a real Christian community within the hospital;

– answer the questions raised by the health care staff, drawing near to them during the intense moments of their lives and creating the highest possible level of trust with them.

4.4.6. Care for those patients who are most in need. The seriously ill and the dying, the mentally ill and invalids, the elderly, the marginalised etc. must all be a priority for the members of the SRA.

4.4.7. Sharing in the humanisation of hospital care and treatment. Without spiritual and religious care there can be no real humanisation. This is the great co-operation that is required. 'The humanisation of hospital care and treatment means seeing the sick person as a person who suffers in body and spirit and who must be looked after in his entirety, that is to say in all his dimensions. The person who is sick needs to be loved and recognised, listened to and understood, accompanied and not abandoned…This means seeing him as responsible for his health and a protagonist of his health, of his own care and life, and a bearer of rights and obligations'.[24]

The pastoral worker must be careful to perform his work with sensitivity and in a way where he is near to those who suffer, always defending their rights.

4.4.8. Co-operation with the local Church. The SRA must be open to co-operation and co-ordination with pastoral care in general and with pastoral care in health in particular, both in the parish and in the diocese. It can certainly contribute a great deal and receive a great deal.

4.5. The pastoral workers

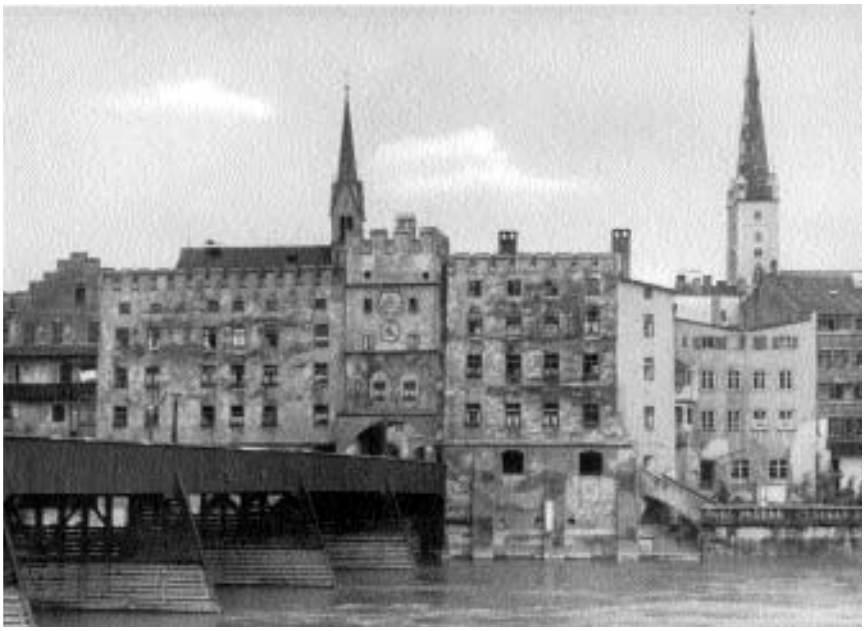
After what has been said, the pastoral workers in hospitals are the following:[25]

4.5.1. All those who work in the hospital in a general sense and according to the extent to which they make possible the development of the project of evangelisation within the centre. However, it has already

been pointed out in this paper that full awareness and motivation cannot always be guaranteed.

4.5.2. All the believers, all the Christians that live and work in the hospital are called to be pastoral workers, each one of them beginning with the place where they work and with the responsibility that belongs to them.[26]

4.5.3. The sick people and their families. They are the recipients of a mission in a hospital centre but at the same time they are agents of evangelisation for those who surround them. 'A person who suffers, struggles, accepts his own limits, guides and helps the sick, knows how to be grateful for what he receives from other people, helps to relativise values and forms of life in our society and calls us to be realistic by reminding us that we are limited and fragile but that we are in the hands of the Lord of life, can carry out great pastoral work by being a live witness to Christ'.[27]



4.5.4. Members of the SRA and the pastoral team. People with a strong experience of encounter with God, sent by the Church to be a sign of the presence of God, so as to bring the love, the consolation and the peace of the Lord to the sick and their families. They must also have a suitable grounding and human and theological-pastoral training, as well as a good capacity for dialogue, teamwork and human relations.

The chaplain, at times male and female religious and also laymen, are members of the SRA. All of them have the mission of advancing the programme of the SRA. They are not 'functionaries' or mere 'religion professionals' but witnesses to the faith who illuminate, stimulate, co-ordinate, integrate, and transmit hope, experience and life.

The pastoral team is made up of the members of the SRA and the health care staff, voluntary workers, and where possible sick people and their families. It is, so to speak, the nucleus of the Christian community within the hospital and its purpose is to help the SRA in the drawing up, the implementation and the assessment of the pastoral plan and programme, to motivate religious care amongst the professionals, and to promote areas for reflection in the light of faith, prayer and liturgical celebration.

Although this is not indispensable, both the SRA and the pastoral team or other resources are usually led by the priest, who is the highest authority in this sphere. Whatever the case, it is easy to understand that the figure of the leader is the key to achieving their successful work. He should have the best qualities possible as well as a healthy realism. Above all, he must be a pastor, a witness, and have a vocation for this pastoral work and be sufficiently trained.

4.5.5. Other pastoral workers that could be added to this list are: the bishop of the diocese, the parish, the pastoral council of the hospital (where it exists), voluntary workers etc.

4.6. The organisation of the SRA

Like any other hospital service, the SRA must be suitably organised and conserve its identity and its own characteristics, but at the same time it should in fundamental terms follow the organisational criteria of the other services and departments in the hospital. Good will and a good attitude constitute an essential approach but are not in themselves sufficient. This is a fact that is borne out by experience.[28]

There are many ways of organising and planning an SRA, according to the place, the kind of hospital involved, the possibilities present, and the human and material resources. What is indispensable is that it is organised. In short, I would say that there should be at least two levels:

4.6.1. The pastoral plan. Here we are dealing with drawing up a framework of reflection which establishes the bases for religious assistance, defines the needs of patients, their family relatives and the professional workers in the centre, and fixes the services that it must offer and the instruments that it must employ for the care it provides, in line with the style of assistance and the identity of a specifically Catholic hospital.

This is a broad framework which, starting with a real knowledge of the context and the hospital, caters to the meaning, the purpose, the instruments, and the actual recipients of the service according to the kinds of patients that the hospital looks after (patients who will probably require different modes, methods and forms of action), the services that can be offered in practical terms to the patients, to their families and to the professional workers, the means that will be necessary, and the difficulties and possible solutions that

may be found in the implementation of the pastoral plan.

4.6.2. The pastoral programme. The pastoral plan will provide us with the basic framework of the organisation of the SRA. Many of its subjects will be habitual because they will always be borne in mind. The pastoral plan will be that planning which the SRA will carry out every year and in which, in addition to the essential elements, there will be those concrete and special elements on which it believes emphasis should be placed, both to strengthen them and to set them in motion and assess them. They should always correspond to certain needs and motivations.

In fundamental terms, the pastoral programme should meet certain objectives and have certain characteristics:

– 4.6.2. a. A general objective which defines the mission of the SRA.

– 4.6.2. b. Specific objectives and concrete actions:

- Connected with providing assistance: the objectives and concrete actions will be pointed out for each of the areas or kinds of patients (the terminally ill, children, the mentally ill, the elderly, surgery, internal medicine, blood transfusions etc.).
- Connected with training: objectives and training activity will be programmed for the SRA, for the pastoral team and for the professionals who work in the hospital.
- Care for families.
- Care for the health care staff.
- Support for, and participation in, humanised care and treatment within the health care centre: an ethics committee, other committees, groups for reflecting about the institution.
- Participation in, and co-operation with, the local and diocesan Church, especially as regards pastoral care in health.
- Religious assistance for patients belonging to other religious confessions, where this is requested by such patients.
- The training, stewarding and strengthening of the pastoral team and the SRA.

– 4.6.2. c. An assessment of the programme by using suitable technological instruments and tools in order to achieve a valid and critical approach to such assessment. From this point of view, and taking into account the inevitable variants, we can speak about work of a pastoral character in so much as it helps to achieve a critical assessment of pastoral activity with the sole aim of improving the care provided to patients. This will also be a way by which to gain credibility in the hospital world and an opportunity to demonstrate the benefits of spiritual and religious assistance. Everything that remains to be done is without doubt a challenge for the SRA.

5. Conclusion

This paper has been long and exhaustive. For this reason, I would like to conclude by pointing out that a Catholic hospital is a theological place of encounter of the patient and the person in need with God, a place where the Church carries out and embodies that evangelising mission entrusted to her by Jesus Christ. Hence the importance of the fact that a hospital is an integral part of ecclesial pastoral care which is in communion with her pastors.

This mission involves a evangelising project that requires the Catholic hospital to engage in a constant process of revision and detection in the light of faith, taking into account the reality of the world and the context, of the real needs of men and women and of the complex hospital and health care world: and all this with the goal of responding to its mission in a more effective way, in a way that conserves its identity, which is, indeed, the real foundation of its project.

In this mission all the individuals (the management, health care workers and other workers, voluntary workers, etc.) and all the services in the hospital are the agents of evangelisation. Professional skill and expertise and witness to faith at an individual level, and the consistency of the way the hospital is organised with gospel-based values, are two fundamental aspects in assuring that the hospital is really Catholic in nature.

'The essential aspects that should characterise it are: service to life from its conception to its natural end; preferential concern for the less advantaged classes with the exclusion of interests based solely on profit making; overall care for the person of the patient and all his needs, without any kind of discrimination; exemplary professional skills and expertise; the humanisation of the conditions of work and the promotion of real co-operation between professionals; the ethical training of the staff; the effective establishment of an ethical committee which is concerned with safeguarding the Catholic identity of the hospital and studying ethical questions and issues'.[29]

'When a Catholic hospital acts starting from a real gospel-based and evangelising spirit it not only has a reason for existing within the service provided by the Church to sick people, but also becomes a point of reference for health care assistance inspired by the Catholic faith'.[30]

This is the mission and the challenge of the Church and so many other ecclesial institutions which throughout the world have the mission of bearing witness to the charity of Jesus Christ in devotion to the sick, to those who suffer, and to those in need.

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Notes

[1] PAUL VI, Encyclical Letter *Evangelii nuntiandi*, 13, 14 and 15, Rome, 1975: 'To evangelise, in fact, is the grace and the specific vocation of the Church, her deepest identità. She exists to evangelise. The Church remains in the world while of the Lord of glory returns to the Father…And it is indeed her mission and her condition as an evangeliser which she is above all else called to continue'.

[2] Cf. REDRADO, J.L., 'Programmazione e animazione della pastorale nel campo sanitario', *Dolentium Hominum* (24) 1993, 66-75.

[3] Comisión Hospitales Iglesia Católica (COHIC), 'Configuración del Hospital Católico', n. 1, *Labor Hospitalaria* (188) 1983, p. 73.

[4] AAVV, Congreso Iglesia y Salud. Tercera ponencia, *Para que tengan vida, la Iglesia en el mundo de la salud y de la enfermedad* (Madrid, 1994), p. 167.

[5] *Ibidem*, pp. 147-148.

[6] COHIC, 'Configuración del Hospital Católico', n. 3, p.73.

[7] JOHN PAUL II, Motu Proprio *Dolentium Hominum*, n. 1, 11 February 1985.

[8] JOHN PAUL II, *Salvificis Doloris*, n. 15, Rome, 1984: 'As a result of Christ's salvific work, man exists on earth *with the hope* of eternal life and holiness. And even though the victory over sin and death achieved by Christ in His cross and resurrection does not abolish temporal suffering from human life, nor free from suffering the whole historical dimension of human existence, it nevertheless *throws a new light* upon this dimension and upon every suffering: the light of salvation…This truth radically changes this picture of man's history and his earthly situation'.

[9] Congreso Iglesia y Salud. Tercera ponencia, *op. cit.*, p. 148.

[10] COHIC, *Configuración del Hospital Católico*, n. 4, p.73: 'In this way care for the sick understood as witness to the value of the person and the Christian option in favour of the weakest, becomes transformed into a privileged place so that the Church can carry out her mission, bear witness to the charity of Jesus Christ, proclaim the requirements of justice and equality amongst men and make available to everyone the salvific force that, guided by the Holy Spirit, she received from her Founder'.

[11] Comisión Episcopal de Pastoral – España, *La Asistencia religiosa en el hospital: orientaciones pastorales* (Madrid, 1987), nn. 39-43.

[12] JOHN PAUL II, *Evangelium vitae* n. 89 (Rome, 1995), 'Agencies and centres of service to life… need to be directed by people who are generous in their involvement and fully aware of the importance of the Gospel of life for the good of individuals and society… Their profession calls for them to be guardians and servants of human life'.

[13] Cf. PAGOLA, J.A, *Acción pastoral para una nueva evangelización* (Santander, 1981); 'La comunidad cristiana y los enfermos', *Labor Hospitalaria* (215) 1990.

[14] Cf. LOZANO BARRAGÁN, J., 'Aportes para la identidad de un hospital católico', *Dolentium Hominum* (41) 1992, pp. 60-66.

[15] JOHN PAUL II, *Evangelium vitae* n. 88, 'These should not merely be institutions where care is provided for the sick or the dying. Above all they should be places where suffering, paid 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*'.

[16] JOHN PAUL II, Motu proprio *Dolentium Hominum* n. 2.

[17] JOHN PAUL II, *Salvificis doloris*, n. 28, 'The parable of the Good Samaritan belongs to the Gospel of suffering. For it indicates what the relationship of each of us must be towards our suffering neighbour. We are not allowed to "pass by on the other side", indifferently; we must "stop" beside him. The name "Good Samaritan" *fits every individual who is sensitive to the sufferings of others*, who is "moved" by the misfortune of another'.

[18] COHIC, 'Configuración del Hospital Católico', 23 and 26.

[19] Curia Provincial H.S.Juan de Dios. *La Orden Hospitalaria, Comunidad Evangelizadora. Sant Boi de Llobregat* (Barcelona, 2000), pp. 17-18.

[20] *Ibidem*, p. 18, 'Health care professionals must be chosen on the grounds of their technical competence, which is an indispensable condition, but at the same time with an assessment of their human capacity. They must have a good knowledge of the philosophy, the identity and the mission of the place their enter to work in and they must identify with it because, were this not the case, there would be serious problems not only for the hospital in its relations with its employees but for these latter in relation to their own personal values'.

[21] Cf. JOHN PAUL II, *EvangeliumVitae* n. 90.

[22] Cf. JOHN PAUL II, *Evangelium Vitae* nn. 77, 95, 'We are asked to love and honour the life of every man and woman and to work with perseverance and courage so that our time, marked by all too many signs of death, may at last witness the establishment of a new culture of life, the fruit of the culture of truth and of love'.

[23] Cf. *La Asistencia Religiosa en el Hospital*, nn. 50-144. Cf. AAVV. Congreso Iglesia y Slaud. Quinto intervento: *Los servicios de Asistencia Religiosa Catolica en los hospitales*, pp. 241 ss.

[24] *Idem*, n. 137.

[25] Cf. *La Asistencia Religiosa en el Hospital*, nn. 145-151. Cf. REDRADO, J.L., *op. cit.*

[26] *La Asistencia Religiosa en el Hospital*, n. 149, 'the Catholic professional layman who works in the hospital takes part in the mission of the Church. He plays in it a specific and absolutely necessary part: to fill and improve the reality of our world with the Gospel spirit, thereby bearing witness to Christ, especially in the practice of his profession. He is called to serve the patient in a human and Christian way through honesty and skill…to work to ensure the hospital is at the service of best care for the patient, to study and investigate the grave ethical questions that arise, to see his work as an opportunity for great service, to become aware that he is joined to he who suffers as an 'envoy of the Lord'.

[27] *Idem*, n. 151.

[28] Cf. REDRADO, J.L., *op. cit.*

[29] Congreso Iglesia y Salud. Terzo intervento, *op. cit.*, pp. 167-168.

[30] *Idem*, p. 167.

[31] Cf. REDRADO, J.L. *op. cit.* bibliography.

5. Inter-religious Dialogue: The Identity of Health Care Institutions

ABRAMO ALBERTO PIATTELLI

5.1 The Identity of the Jewish Health Care Institution

One can without doubt state that the social philosophy of Judaism revolves first and foremost around two precise principles, which constitute its fundamental essence. On the one hand, there is the statement of Holy Scripture to the effect that man was created in the image and likeness of God, from which derives not only the principle of the dignity of man and his free will, but the fact that the identity of the whole of mankind as a whole makes up a single image. On the other hand, we find affirmed the principle of the sacredness of human life and the effort that is required of the individual to preserve it at all costs and to defend the dignity and the decorum of every individual to whom it belongs.

A society that wants to proclaim itself a fair society cannot envisage the moral and material subjection of one individual to another as a result of inequality and prejudice. The promotion of a harmonious relationship between the various social classes, between the rich and the poor, between the young and the old, and between the healthy and the sick, on the basis of fairness and justice, are a fundamental element of the Jewish tradition. At the same time, the conditions must be created in which the personality of man, above all where there is most need, can develop and mature its physical and spiritual integrity.

Both Biblical and Rabbinical Judaism emphasise the need for every individual to have an adequate standard of life – a primary aspect as regards material goods – as well as the duty to engage in charity to protect every man in the face of the disabilities caused by old age, illness or unemployment.

As happens in religions in general, in Judaism, as well, the theme of *imitatio – Dei* is recurrent. But how is this very important and fascinating theme of Judaism understood?

The revelation of the attributes of love and mercy as described in the Book of Exodus and the text of Deuteronomy, according to which 'You shall walk after the Lord your God and fear him, and keep his commandments and obey his voice, and you shall serve him and cleave to him' (13:5), involves these attributes being seen as a source of the sublime principle of *imitatio Dei*. Israel is not only the servant of God but also the people that is called to even cleave to Him, that is to say to imitate Him as regards His principal qualities: just as He clothes the naked (cf. the story of Adam and Eve), so you should be concerned to clothe those who are in need; just as He visits the sick (cf. the visit the God makes to Abraham just after he has been circumcised), so you, too, should adopt this role; just as He buries the dead (cf. the case of the burial of Moses on Mount Nebus), so you should concern yourself with burying the person who needs this service.

Mortal man cannot imitate the infinity, the omnipotence or the eternity of God. These are aspects that are beyond the comprehension and the imitation of man. However, man recognises God's mercy and thus can follow His ways, which are made up of goodness and altruism. In this way piety is a divine attribute, and man is never closer to God than in this moment of compassion for, and participation in, the needs of another.

The Bible, as we know, established many laws which in practice are real and authentic taxes for the poor: the *eket*, the *scichà*, the tithe, the corner of the field, the sabbatical year and the jubilee year, as well as many others. Post-biblical Judaism uses the word *zedakà*, which means something more than mere charity. Etymologically it means 'rectitude', 'justice', and with this choice the Rabbis brought out how much value this principle had in their vision of religion and Jewish practice. By *zedakà* is meant a kind of equilibrium-creating justice. The owner cannot do what he wants with his own goods: 'every good', says the Torah, 'must first of all serve those most in need'.

From the point of view of law, it is very important to observe that all the contributions received by those in need are not received as a gift, and their owner does not give them out of the goodness of his heart: they are due to the poor as a

right just as the state has the right to the taxes and the contributions of its citizens.

'And your brother shall live with you' (Lev 25:36). From this teaching developed the entire complex web of *zedachà* in the people of Israel. The box (*kuppà*) for the distribution of help in the form of money, kitchens for food, rest homes for the elderly, orphanages, dormitories, clothes stores, and psychological help are all an essential element of the community structure, and this is not seen as alms for the poor but as a fundamental element of Jewish life because a Jew commits a grave transgression if he does not fulfil the obligation to give a poor person what is his due. We have an obligation 'to scrupulously follow the precept of *zedakà* more than any other affirmative principle', declares Maimonides, 'because *zedakà* is a sign of *zaddik* (right), lineage of Abraham; as is said: 'because he bequeathed it so that you command his sons to practice *zedakà*'. The condition of Israel is not stable, and the religion of the truth is only kept through *zedakà*: as is said 'make me stable in *zedakà*'. And Israel will only be redeemed through *zedakà*, as is written: 'With justice Zion will be redeemed, and its exiles, through charity''. These words are not only a moral injunction but also a *halachà*, a well established rule.

In the light of what has been said in this paper, one can well understand the teachings of the great teachers, which capture the whole of their philosophy and their vision of reality.

'Doing deeds of *zedakà* brings peace, calm and safety'; or 'thus explains Rabbi Shimon, the son of Jochai: 'It is written in Isaiah (32:20) 'happy are you who sow beside all waters'. This sowing refers to *zedakà*, as is written in Hosea (10:12): 'Sow for yourselves righteousness, reap the fruit of steadfast love''.

We could go on but all this demonstrates how the doing of works of charity is fundamental in the philosophy and the community structures of Jewish society.

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5.2 The Identity of Islamic Health Care system

Two Islamic beliefs have chartered the development of health care institutions and characterized their identity

First: The relationship between God and the individual human being is a direct one without any intermediate, which eliminated any church-like institution or hierarchy

Second: There is no division between a State and any religious Institution in an Islamic \ State i.e Islam \ combines a religion and a code of \ statehood.

In Islam there is no organized Church and no clergy in the Christian sense. Islam believes in the direct contact relationship between God and man, with no intermediary of clergy, saints or prophets. Every Moslem is directly responsible towards God and can accept any interpretation he/she fancies or propose an interpretation which he/she favors. As a guide a Moslem is to follow the teachings of the Holy Quran, which we believe are the words of God revealed to the Prophet Mohammad. When the Quran does not rule on a particular issue, the sayings and doings of the prophet are taken for guidance. In Suna Islam the preachers, religions judges, and chief justice are all state employees. In Shiaa Islam the organization is more developed but still nowhere near the organization of Christian Churches, it is more like the Society of Friends.

Medical activities in Islam have to be looked at with this difference in mind.

The Arab active participation in universal medical knowledge cannot be forgotten or ignored, since it did not only construct a bridge binding the ancient with the modern, but also made an unmatched and significant contribution[1].

The purpose of this paper is *neither* to talk about the great Arab physicians, for *example* Ibn Sina, ar-Razi, al-Tabari, and others, nor to shed light on their role in the advancement of medical knowledge. We will concentrate on the principles of medical education, medical practice as a science and as an art, licensure, ethics, malpractice, medical records, quality control, verbal autopsy, and related issues which govern the health care delivery system.

Islamic Principles Governing Medicine

One of the noteworthy and fascinating aphorisms attributed to the Prophet of Islam is the saying:

"al-Umu 'ilman, 'ilm al-adyan wa-'ilm al-abdan", thus, equating the importance of the study and practice of Medicine with that of Theology and Islamic Jurisprudence.[1, 2]

In fact, strengthening the concept of maintaining well-being is a top priority in Islam which was crowned by the following verse from the Holy Quran:

That if any one slew a person – unless it be for murder or for preading Mischief in the land – It would be as if he slew the whole people – And if any one saved a life – It would be as if he saved the life of the whole people.

These and similar concepts, both religious and social, constituted and added impetus to the esteem of the medical profession and emphasized the intrinsic value of the healing arts, thus giving the physician a respectable position in his community and within the learned circles. It was also Islam that emphasized the right of the human body to be taken good care

of by every believer, by providing it with its nourishment and promoting healthy living conditions.

Medicine was defined by Muslim physicians such as ar-Razi[1] (865-925) and Ibn Sina (908-1037) as an art which is concerned with the preservation of good health, the combating of diseases, and the restoration of health to the sick. It was as early as the third/ninth centuries that most of the medical texts divided the healing art, for the purpose of classification, into two parts: theory and practice. Under the theory of medicine, the student and practitioner studied the elements, the humors of the body and their function, (physiology) the faculties of the body and soul (anatomy), the organs and their utilities, and the temperaments. But under the practical part, the following branches were taught: therapeutics, including the use of simple and compounded drugs and medicinal recipes; bone setting; and minor surgery.

The role of Arabs in relation to medical education and practice can, historically, be summarized into three stages:

The first was marked with the transmission and assimilation of intellectual legacies of earlier civilizations. Under the Abbasid caliphs, competent scholars in Iraq and neighboring countries embarked on the translation of the best available writings from Syrian, Sanskrit, Nabataean, Coptic, and Greek into Arabic. The richest, finest and most influential in medicine, pharmacy and the allied sciences were these translations from the Greek legacy.

The second stage witnessed the acceleration and abundance of locally manufactured good quality paper.[1, 2] After learning the process from Chinese artisans and trans-Oxiana, Muslims established the first mechanized paper factory in Baghdad in 794. Very shortly thereafter, this industry, coupled with that of manufacturing writing tools and inks, reached an unprecedented degree of significance in the history of mankind. From Iraq, this knowledge was passed on to Syria, where high quality paper was made and, from there, to Egypt, North Africa and Spain (al-Maghrib). Arabs monopolized paper making for more than 5 centuries. Paper making was not introduced into Christian Europe till the 14th century. The availability of paper as a cheap and convenient writing material resulted in the first "I.T." revaluation. Thus, the copying of manuscripts, cataloging, binding, selling and collecting of books led to new crafts, industries and trades which brought added wealth and high measures of prestige to those involved in them. This not only gave medical education and the spread of medical knowledge a boost, it also made possible the keeping of detailed individual medical records and quality control, as we will see later on.

The third stage coincided with the rise of educational and medical institutions – public (state-sponsored) and private – such as libraries, hospitals and medical schools which greatly contributed to the sound foundation and steady advancement of medical education. The first hospital, in the modern sense of the word, was established in Baghdad during the reign of Harun ar-Rashid (786-809). The hospital continued to receive adequate attention, and financial and moral support from succeeding caliphs. In other cities, physicians of great renown such as Yuhanna b. Masawayh (d. 855), ar-Razi (d.925) and Sinan b. Thabit 9d. 941) practiced and trained others at the same time. As word spread of the accomplishments at Baghdad, hospital construction proliferated into other big cities which included, Damascus, Antioch, Mecca, al-Madinah, Cairo, al-Qayrawan, Morocco, and Granada. Al-'Audi, the most renowned hospital in Baghdad, was founded in 978-979 by 'Adud ad-Dawlah. It was generously endowed and provided with a full medical staff of twenty-four physicians, surgeons, oculists and pharmacists, in addition to administrative personnel for the building, the kitchen and hospitals management.[1, 2]

Of special interest to medical education was the attention ar-Razi paid to the physician-patient relationship and the maintenance of high professional ethics.

In the Arabic medical texts, we find many clues suggesting the physician's involvement, not only in the professional practice of his calling but also the part he should play in the affairs of his community.[3] The physician was presented in these texts as a socially concerned individual and an enlightened citizen who cared about what was going on in his environment. He was also depicted as thoroughly instructed regarding medical ontology and professional ethics.

Quality Control

The Al- Hisbah (Ihtisab = Infinite of Hisbah) system was highly developed in the Arab world very early and reached a state of perfection in the 8th and 9th centuries.[4]

The principles upon which al-ihtisab is based are partly religious and partly the result of common sense, together with good judgment on the part of the ruler. It is mentioned that Caliph 'Umar Ibn al-Khattab (634-644) was the first to have understood and made this type of ethical and religious system of control operative under his supervision.

Yet we have to await the first half of the ninth century, years after the founding of the Abbasid capital, to see the hisbah system starting to spread and to become well established, organized and recognized in the state's administrative structure. It is possible that what al-Mamun[1] (813-833) and al-Mu'tasim (833-842) initiated in Baghdad, paved the way for the first government enforcement of ethical codes for the health professions.

During the tenth century, the hisbah system was established in Egypt, and from there it spread to North Africa. It is interesting to note that in Muslim Spain the first known Muhtasib to be appointed by the Caliph was the pioneer medical reformer and practitioner, Ahmed b. Yunis Al Harrani (970).

The Muhtasib's job is closest to that of a consumer protection judge. The job of the Muhtasib is to ensure quality and standards in the market place, from checking balances to the quality of products and services. The books on Ihtisab included rules and procedures for controlling medical practice. New in this are: the procedures for certifying physicians, keeping detailed individual medical records, deciding when malpractice occurred, and procedures for informed consent in medical procedures all made possible through the availability of cheap paper. The Muhtasib is assisted in his duties by the Chief Physician of a town and serious cases are referred to higher courts. The records of these courts show the thoroughness of the investigations and the impartiality of the judges as to race or religion.

Islamic (Arabic Medicine)

Islam denotes not just a religion but a whole civilization, including many things that, if the Western world classifies them, would not be regarded as religious in any sense. The term "Islamic art", for example, denotes virtually any kind of art produced within the Islamic world and marked by certain cultural and not merely religious characteristics. The term "Christian art" for example is limited to devotional and ecclesiastical art and would certainly not be extended to include art produced by Christians, still less by non-Christians living within the world of Christendom. Similarly, "Islamic Medicine" means all medical sciences (basic and healing), pro-

Medical Institutions Run by Islamic Organizations

Jordan	The Society of the Islamic Philanthropic Centre Hospital –Amman -Aquapa
Lebabon	The Islamic Philanthropic Society Hospital Tripolis-Lebanon
Lebanon	The Islamic Maqasid Charity Institutions: Schools, Hospitals ... etc
Yemen	The Welfare Reform Society University of Science and Technology – Medicine dentistry
Egypt	Al Azhar Medical School = Islamic state owned
Indonesia	Several Islamic Organizations (Non political) 1. The Indonesian Forum for Islamic medical studies Operates:- - YARSI University (Including a medical college) 2. Islamic University-Sultan Agung Semarang – Indonesia 3. Muhammadiyah Movement (Non political) Operates:- - Muhammadiyah University of Yogyakarta - About 30 hospitals
Pakistan	1. Islamic International College Trust - Islamic - Non-profit - Non-political - Non-sectarian Mission "Establishing of state of the art educational institutions, with a focus on inculcating Islamic ethical values" Runs: - Medical College - Engineering College - Several hospital 2. Islamic Medical Association of Pakistan Operates:- - Hospitals - Medical centers - Educational institutions and charity work
Turkey	Hayat Foundation for Health & Social Services Operates:- - Several hospital - Social and medical centers
Uganda	An Islamic charitable, cultural organization Operates:- - Kibuli Muslim Hospital in Kampala - Social centers

duced within the Islamic civilization and expressed normally in Arabic, occasionally in one of the other languages of Islam. A good portion of medical science is the work not of Muslims but of Christians and Jews living in Islamic lands and constituting a part of the Islamic civilization in which they were formed.

In contrast, the term "Christian Medicine" is not used to designate the medical achievements of Christians and others in Christendom. Indeed, it is not a word and if so it has an entirely different meaning.

As there is no organized "Church", Islamic medical services have always been and still are largely initiatives of individual benevolent donors or individual benevolent committees, whose aims in establishing medical services or medical schools is the service of the Creator.

This is not to say there is never a "political" motive or a "missionary" motive, these are often there and in any medical and educational activity anywhere.

Interestingly enough, organized missionary activities in Islam were always directed towards converting Moslem beliefs from one Islamic sect to another and almost always politically motivated. The adoption of Islam by a vast number of Africans and East Asians was due to *ad-hoc* activities carried out by individual merchants and not by any organized missionary organizations or by conquest.

The largest Islamic countries, Indonesia, Nigeria etc. adopted Islam through the activities of individual merchants.

A good deal (probably the majority) of physicians practicing in classical Islamic societies were not Moslems (Jews, Sabians, Christians of various Sects). This has continued to this day. Among physicians in the Arab world today Christians contribute proportionally much more than their numbers to medical services (physicians, pharmacists, nurses, lab personnel etc).

It is interesting to note for example that the first two directors of the Moslem Makassid Benevolent Society in Jerusalem were Christian – the first a Greek Orthodox and the second a Protestant. This hospital was established and is maintained by a private Moslem society.

Some thirty years ago some NGOs were established dealing with Islamic medicine supported by Islamic physicians from mainly Western and East Asian countries and by some funds from gulf states. Their main activities are in Africa and east Asia.

These organizations are still limited but with a chance of growth. The equivalent of the Red Cross Societies and modelled on them are the Red Crescent Societies – they are members of the world federation of Red Cross and Red Crescent Societies and carry out activities identical to those of Red Cross Societies elsewhere.

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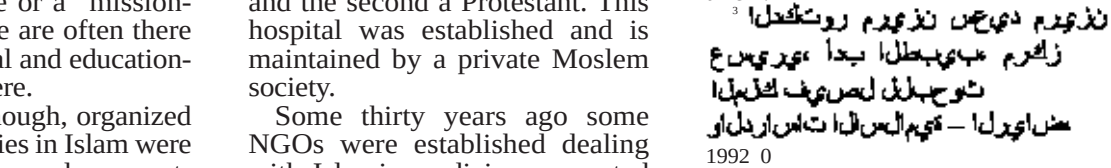
[3] 
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VITTHALDAS S. BHAT

5.3 The Hindu Perspective

"Oh, east is east and west is west, and never the twain shall meet", has been disproved in this astronautical age. The closer we come to each other in the present century, the more we realize our common ancestry, our common heritage, the common heritage of our cultures, and the identity of our aims, aspirations and experiences as one man in one world. This is the spirit of scientific inquiry of this century. We no longer live in ivory towers and no longer recognize any international boundaries or intellectual barriers.

With the advancement of civilization, human race has made tremendous achievements in many fields. One great accomplishment has been the successful control of many infections and communicable diseases, and life expectancy has almost doubled as a result of this success. On the other hand, many new diseases have arisen which are directly related to our way of life, full of stress and tension in the concrete jungles of the modern era. Heart disease has become one of the biggest killers in our times. We are living in an age where the neurotic personality has become very common. The medical world is trying its best to combat a formi-

dable enemy termed psychosomatic diseases.

I am grateful to the organizers of this 17th international conference for Catholic health care institutions for inviting me to participate in inter-religious dialogue and giving me an opportunity to express my views on Health Care Institutions and the Hindu perspective.

The role of religion plays a great part in health care systems since it is faith and devotion that brings results. The study of religion provides basic information, an appreciation of cultural contexts, and an awareness of personal feelings, all of which are essential for intelligent and responsible action. Religion is a code of conduct for man in his society; religion is a social system in the name of God for the benefit of human society. God, the soul and nature are three different entities, which form the basis of religion. The endeavor of religion is to get rid of the gulf between man and God and restore the lost sense of unity.

Hinduism is a system of living. Differently from other religions, there is no founder of the Hindu religion. It does not worship any one God. It does not lay stress on any one principle. It does not believe in any one philosophical doctrine. It does not recognize any particular ritual or action. On the other hand, it does not minimize the faith and belief of any other religion; in fact it only represents a system of living.

Health is a common theme in most cultures, in fact all communities have their concepts of health as part of their culture. Among the definitions still used, probably the oldest is that health is the "absence of disease". In some cultures health and harmony are considered equivalent, harmony being defined as "being at peace with the self, the community, God and the cosmos". The ancient Indians and Greeks shared this concept and attributed disease to a disturbance in bodily equilibrium, what they called "humors".

WHO definition of health is: "Health is a state of complete physical mental and social well being and not merely absence of disease or infirmity".

The proponents of holistic health believe that the time has come to give serious consideration to the spiritual dimension and to the role this plays in health and disease. Spiritual health refers to that part of the individual which reaches out and strives for meaning and purpose in life. It includes integrity, principles and ethics, purpose in life, commitment to some higher being and belief in concepts.

Health care is an expression of concern for fellow human beings. It is defined as "the multitude of services rendered to individuals, families or communities by the agents of the health services or professions, for the purpose of promoting, maintaining, monitoring or restoring health". Health care includes "medical care" and many people mistakenly believe that both are synonymous. Medical care is a subset of the health care system.

Primitive men instinctively found treatment for all their ailments and injuries. As the mind of man matured, archaic medicine became a combination of religious, magical and empirical views and practices. Thus, in ancient civilization, extending from the Indus to the Nile, where religion formed an important part of daily life, disease was considered a punishment from heavenly bodies, spirits, demons, and witches. This led to the creation of various gods, demigods and mythical heroes.

Allopathy came into existence in the 15th century. Louis Pasteur advanced the germ theory of disease. Though many communicable diseases were conquered through antibiotics and preventive methods, there was no headway in treating psychosocial diseases. It has become imperative to find alternative systems of medicine that will be acceptable, accessible, keeping in view the cultural factors and customs prevailing among the masses.

The chief source of Aryan culture and medicine are the four Vedas. These are said to have been originally revealed by the creator, Brahma, to the sages some six thousand years before the Christian era, according to Indian traditions. The Rig Veda is considered by most scholars the original source of Hindu medicine, and is comprised of hymns and prayers addressed to different deities whose medical and surgical skills are also extolled. But the Atharva Veda, which was composed at a later date, is replete with prayers, encantations spells and charms to protect people against all kinds of disease and natural disasters.

It is already proved in India that the Ayurvedic system of medicine is highly popular not only in urban but also in rural areas; many qualified ayurvedic physicians

are already practicing in every nook and corner of India. People have accepted Ayurveda not only because it is delivered cheaply but also because it suits their cultural beliefs.

The medical system that is truly Indian in origin and development is the Ayurveda. Ayurveda by definition implies the "knowledge of life" or the knowledge by which life may be prolonged. Its origin is traced way back to the Vedic times, about 5000 BC. During this period, medical history was associated with mythological figures, sages and seers. Dhanvantari, the Hindu god of medicine, is said to have been born as a result of the churning of the oceans during the 'tug of war' between the gods and demons. According to some authorities, the medical knowledge in the Athar-

va Veda (one of the four Vedas) gradually developed into the science of Ayurveda.

It may be noted that the ancients anticipated our attitude towards the practice of medicine and they did not call it a science of therapy or cure but a science, which pervades all knowledge of life. Ayurveda is probably the earliest medical science that laid stress on positive health, a blending of physical mental, and social, moral, and spiritual welfare. The main aim of Ayurveda is well expressed by Charaka when he states "it is the knowledge of life which deals elaborately and at length with conditions beneficial or otherwise to the humanity, and to factors conducive to the happiness, or responsible for misery or sorrow, besides indicating measures for healthful living for full span of life". This stresses the need for balanced living to ensure normal health or a disease free state (arogya). All the ancient scriptures also lay emphasis on healthy living as a prerequisite for achieving the four supreme ends of life, i.e., righteousness (dharma), wealth (artha), cultural and artistic values (kama) and freedom (moksha).

The teaching of Ayurveda and the seers of Ayurveda clearly indicated that the human body is the product of food. Normal health or otherwise is largely dependent on ingestion, digestion, absorption, assimilation, and the metabolism of food. Health or disease has a definite and distinct relationship to the ingestion of food, i.e., wholesome or unwholesome, agreeable or otherwise. Meticulous care has been taken to indicate food substances that are wholesome and agreeable for the normal functioning of the body. The type of diet also equally influences the mental and spiritual developments. The Charaka samhita makes it abundantly clear that a number of diseases, difficult to cure or incurable, arise out of lapses and indiscretions regarding dietary habits. The concepts of nutrition found in more recent works on physiology are also reminiscent of the ideas of the ancient physicians of India and their recognition of the role of diet in the maintenance of health and causation of disease.

According to Ayurveda, a healthy person (swastha) is one in whom there is an equilibrium of the humors and the body tissues, with normal digestive as well as excretory functions associated with the gratification of the senses, mind and the soul. The disease is due to an imbalance of the equilibrium of either or all of the above. Of these constituents, soul (atma) is the cause of animation, the mind (manas) constitutes the psychic or mental component, and the equipoise or otherwise is dependent on the inherent qualities of these constituents (trigunas i.e., satva, rajas and tamas). A person with predominance of satwa quality possesses mental equipoise, clarity, purity of thought and ideas, pleasures, etc.; one with rajas quality is full of activity and energy; and one with tamas quality possesses in abundance inertia, passivity, bewilderment, delusion and ignorance. All these depict states of mind, and as such it is appropriate to state that satva, rajas and tamas are qualities (gunas) of the mind (manas).

Just as there are three qualities of mind, there are three components connected with the body whose equilibrium or otherwise decides its state. They are the three humors, vata, pitta, and kapha. The ayurvedic texts also sum up the composition of man as a union of mental, spiritual, and physical factors. Ayurveda is a system, which has explained in detail how we can not only control but also prevent psychosomatic and psychosocial diseases.

Modern medicine now recognizes the role of the mind and the emotions in the causation of disease termed psychosomatic diseases. "Bad vibes" or " the energy there was great" are becoming household phrases. Meeting someone and instantly liking or disliking him without knowing anything about him; we like his "vibes". We can tell when someone is staring at us and we look up to see who it is. We may have a feeling that something is going to happen and then it does. We begin to listen to our intuition. We "know" things but we do not always know how we "know". Sometimes during an argument with someone we may feel as if something is being pulled out of our solar plexus, or we may feel stabbed. On the other hand we sometimes feel surrounded by love, caressed by it, bathed in a sea of sweetness, blessings and light. All these experiences have a reality in the energy fields.

Modern science tells us that the human organism is not just a physical structure made up of molecules, but that like everything else we are also composed of human energy fields (HEF).

They can now even measure electromagnetic fields around the body with a sensitive device called SQUID (super conducting quantum interference device).

Ancient Indian spiritual tradition, over 5000 years old, speaks of universal energy called PRANA. This universal energy is seen as the basic constituent and source of all life. PRANA the breath of life moves through all forms and give them life.

The Chinese posited the existence of a vital energy, which they called "Chi". All matter animate and inanimate is composed of and pervaded with this universal energy. This "chi" contains two polar forces the YIN and the YANG. When the YIN and YANG are balanced, the living system exhibits physical health. When they are unbalanced, a diseased state results. The ancient art of acupuncture focuses on balancing the YIN and the YANG.

The ancient Hindu Vedic texts, Tibetan and Indian Buddhists, Japanese Zen Buddhists, describe the human energy field in detail. The Hindu health care system aims at increasing the positive energy of both the patient and the healer. To become a healer one needs spiritual as well as technical training. Energy and power acquired by spiritual training must be used with integrity, honesty and love, for cause and effect are always at work in every action. You always get back what you put out. That is what is called KARMA. As the energy flowing through as a healer increases, so does your power. If you put any of this power to negative use, you will eventually experience the same negativity coming back at you.

Yogis practice manipulating this energy through breathing techniques, meditation and physical exercise to maintain altered states of consciousness and youth far beyond their normal span. Maharshi Patanjali the father of the modern concept of Yoga and a great physician himself, in the 3rd century BC defined Yoga as the complete mastery of mind and emotions. Let us first clear away some popular misconceptions about Yoga.

– Yoga is not, for instance, an orthodox religion like Christianity, Islam or Buddhism.

– You can belong to any religion or no religion at all and still be a Yogi.

– Neither is Yoga a philosophy, although there is much philosophy in it.

– Yoga is not an ascetic cult that denies all joys of living. On the contrary it brings much joy and meaning to life.

– Yoga is not dangerous to practice any more than it is dangerous to eat or drink or play tennis.

– Unlike so many other philosophies of the world, it is a scientific philosophy that is wholly practical.

– Yoga is an exact science which has its foundation on certain immutable laws of nature and establishes 'Mind over Body'. The gaining of a healthy body with a calm and steady mind under all circumstances is the common aspiration of every individual. Real Yoga-Sadhana leads to harmony and the perfection of body, mind and spirit.

The word Yoga is derived from the Sanskrit word 'Yuj' which means 'control' or 'unite'. Yoga is a science which enables us to learn to unite our 'Individual soul' (Jivatma) with the 'Universal soul' (Paramatma). The mental frame and intellectual attainment are different in different individuals. Based on this the whole human race is divided into four categories. In Hinduism there are four classical paths to reach the ultimate goal of Yoga.

1. BHAKTI YOGA – the path of devotion, for Man of Heart – The Emotional.

2. GNANA YOGA – the path of knowledge for the Man of Head – The Intellectual.

3. KARMA YOGA – the path of action for the Man with equal development in Heart and Head – The Active.

4. HATHA YOGA – the path of mysticism for the Man who is underdeveloped in Heart and Head.

The theme of all these YOGAS is one and the same and the scientific theory in these techniques is based on mental integration and self-purification. The different techniques ingrained in these Yogas are to accommodate different temperaments and types of people.

All the four Yogas help to withdraw the mind from its preoccupations with the sense objects. He reaches the junction which connects the main trunk road leading to temple of truth. The first portions of the practice is called 'DHARANA' i.e. concentration which leads to 'DHYANA' i.e. meditation.

Meditation is the final gateway through which man enters the arena of ultimate experience of the ABSOLUTE. The great Maharshi Patanjali described eight steps of Hatha Yoga which comprise:

1. YAMA – Abstention
2. NIYAMA – Observance.
3. ASANA – Posture.
4. PRANAYAMA – Control of prana i.e. breathing.
5. PRATYHARA – Sense of withdrawal.
6. DHARANA – Concentration.
7. DHYANA – Meditation.
8. SAMADHI – Sublimated transcendental super consciousness.

The only form of Yoga which has been scientifically studied is Transcendental meditation, a special meditation technique as taught by Maharshi Mahesh Yogi, who founded a European university in Switzerland to propagate the tenets of the Yoga.

We face environments around us of four main types; Physical, Psychological, Physiological and Social or Cultural. Yoga with its physical and mental disciplines can mould the behavior of an individual promoting perfect harmony with his environment to relieve him from any suffering. Yoga is a discipline which seeks to bring the internal environment of an individual under his control, thereby making a good adjustment of the individual with his surroundings.

Man, we all agree, is a mysterious creature. He is made up of many elements – his body, his thinking mind, his feelings and desires, his ideals and conscience – to mention a few. Many of these elements are frequently at war with one another. We are a battleground for our urges, wishes, repressions and so on. Though we have probably not met one, we

can imagine an ideal, perfected person in whom all these warring elements are united under the command of the will. This person would, as a result, have perfect physical health, great courage, complete confidence and immense power. But of course the will that commands all the little selves must be an enlightened will; otherwise the result will be a Black Magician who uses his great knowledge and power in a selfish, egocentric way, bringing suffering on his fellowmen.

The ancient Indian sages, the Yogis, believed – and mystics of all ages agree – that man has within him the potentiality of the enlightened selfless will. This potentiality is the Divine spark. When it is fanned into a flame, the lower selves submit before the infinite wisdom. Man's will identifies itself with the divine will.

This then is the high and ultimate purpose of Yoga – to teach man to integrate himself, so that he feels complete union within himself, with the whole universe and with his creator.

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MASAHIRO TANAKA

5.4 The Identity of Buddhist Health Care Institutions

I am the chief monk of a temple called Saimyouji which is located just north of Tokyo in Japan. The temple was first built in 737 A.D. I am also a doctor of internal medicine. Saimyouji is a temple associated with one of the four main Buddhist pilgrimages in Japan. Buddhist services praying for world peace are performed for two months during October and November in the temples of our Buddhist pilgrimage. At our temple, we have several institutions for health care and for the aged, such as a hospital, a nursing home, a nursing unit that performs house calls, and two group homes. Because I am both a Buddhist monk and a medical doctor, today I would like to talk to you about science and Buddhism. I think that when we discuss matters which are refutable, we should use scientific knowledge for critical analysis. And, when we discuss matters which are not refutable, we should consider them in terms of humanism and with reference to the classics.

In this speech I would like to discuss two things. First I would like to talk about the issues of dying with dignity and organ transplantation, with regard to a specific case that involved our hospital. Then I would like to follow that with a scientific and humanist discussion and finish by talking a little about these things from the point of view of the Buddhist religion.

The case involving the issues of dying with dignity and organ transplantation that I would like to present concerns a 53 year old woman who arrived at our hospital as a so-called DOA (Dead on Arrival). At around 1:00 PM, on October 9th, 1992, a woman was stung by a hornet and half an hour later she went into anaphylactic shock. Unconsciousness, convulsion and cardiac arrest occurred while she was being carried to our hospital by a neighbor's car. Cardiopulmonary resuscitation was performed immediately on arrival. Endotracheal intubation was done by a trained anesthesiologist. Intravenous fluids were administered through an I.V. drip and drugs such as epinephrine and steroids were injected. Although her blood circulation recovered, around 13 minutes had passed between cardiopulmonary arrest and the starting of resuscitation and the patient's brain did not recover despite our efforts. A deep coma continued during hospitalization. Artificial respiration

by a respirator continued, and although spontaneous breathing was observed temporarily, it disappeared again. Cough reflex remained negative. Although a weak light reflex appeared temporarily, it, too, disappeared again. The amount of dopamine required for blood-pressure maintenance increased gradually. After one week, we had to explain to her family that recovery was impossible.

And, when this diagnosis was presented to the family, the termination of life support and organ donation were proposed. These proposals were met with agreement by the family because the patient had both an organ donor's card and a living will expressing her desire to die with dignity. However, both her desire to die with dignity and her desire to be a organ donor were met with difficulty. She was HBs antigen positive. Because she was HBs antigen positive, the regional kidney transplant network judged that this patient was disqualified as a donor, and refused her donation. We could not agree with this judgement and so we did a computer search for medical papers on the subject. We searched for papers concerning kidney transplants and Hepatitis B on the INDEX MEDICUS and came up with 20 papers. Please see references 1 through 20 at the back of your copy of this discussion. Of the 20 papers that we found, references 1 through 10 all concluded that the relationship between HBs antigen positive donors and a recipient's prognosis were unrelated. There were no papers that declared, positively, that a person who is HBs antigen positive is unsuitable as an organ donor. It was shown in 2 papers that the prognosis was bad when the recipient was HBe antigen positive. Therefore, medically, the kidney from HBs antigen positive donors who are also HBe antigen negative can be offered for transplant. We felt that the regional kidney transplant network should not have been opposed to this view unless they had a paper that could refute this view by showing new evidence – something such as an accepted paper appearing in INDEX MEDICUS. Such a paper did not exist, at least at that time.

We made contact with a university hospital outside of the area governed by the regional kidney transplant network, and the organ donation became possible. After the loss of spontaneous respiration was confirmed by an apnea test with her family present, the dopamine infusion was stopped. Blood pressure fell and the patient's pulse stopped after 10 minutes. The cardiac arrest was checked by the electrocardiogram monitor with her family present. At that point, her death was diagnosed. Then, an operation for the extraction of the kidneys was performed. The kidneys were immediately carried to the university hospital and transplanted into recipients.

The newspaper reports which followed were not so well done, I'm afraid. They were written in a way which made it easy to mistake the cancellation of treatment due to a diagnosis of brain death with the decision to cancel treatment for the purpose of organ transplantation! As a result, some doctors and citizens who read these newspaper articles accused us and prosecuted us for murder. Of course, medical staff should not make judgments regarding brain death one-sidedly and for the sole purpose of organ transplantation. On this point we are in complete agreement with our prosecutors! But shouldn't we ask ourselves whether or not there might be some basis on which life-prolonging treatment may be interrupted according to the patient's self-determination? Of course, there are various ideas regarding one's own death and none of them can be refuted by tests with experiments or observations. Therefore, science is not helpful in solving this problem. Hence, I would like to discuss these matters, not with reference to science and medical theory, but instead with reference to the classics – papers that have survived a long history of criticism.

The first thing that I would like to make reference to is something written by Albert Camus. At the beginning of Albert Camus's "The Myth of Sisyphus" he writes:

"There is but one truly serious philosophical problem and that is suicide...

Galileo who held a scientific truth of great importance abjured it with the greatest ease as soon as it endangered his life. In a certain sense, he did right. That truth was not worth the stake."

On the other hand, Tommaso Campanella defended Galileo and wrote "Apologia pro Galileo" from prison at the risk of his life. So he risked his life because he believed that there was something more important than his own life. If there is anything valuable beyond one's own life, it could be said that that is the person's religion. Such religion is necessary if one is to care for life.

Please allow me to return for a moment to the "dying with dignity" controversy that involved our hospital and the role of religion in it. At that time a television station from Vienna came to our hospital to cover the story. In Vienna, they said, passive euthanasia, or so called "dying with dignity," was forbidden by the instruction of Christianity. Since they had heard that death-with-dignity was permitted in the hospital of a Buddhist temple in Japan, they came for coverage. This raises an interesting question about the relationship between religion and dying with dignity, so I would like to talk for a moment about how the two are related. I would like to quote the first part of Schopen-

hauer's "On Suicide" which refers to this matter.

"As far as I can see, it is only the monotheistic, and hence Jewish, religions whose followers regard suicide as a crime. This is the more surprising since neither in the Old Testament nor in the New is there to be found any prohibition or even merely a definite condemnation of suicide."

Does Buddhism accept the idea of dying with dignity? Does Buddhism accept suicide? In the Buddhist scripture Buddha accepted an affair of a monk who committed suicide. Had Buddhism encouraged suicide? Allow me to quote Durkheim's "Suicide."

"Though Buddhism has often been accused of having carried this principle to its most extreme consequences and elevated suicide into a religious practice, it actually condemned it. It is true that it taught that the highest bliss was self-destruction in Nirvana; but this suspension of existence may and should be achieved even during this life without need of violent measures for its realization."

Durkheim's interpretation of Nirvana is right. To confirm the fact that Durkheim's interpretation of Nirvana is right, let's consider, for a moment, Buddha's doctrine.

It is 'the fourfold noble truths' which summarized the doctrine of Buddha. They are 'the truth of suffering', 'the truth regarding the cause of suffering', 'the truth regarding the extinction of suffering, Nirvana' and 'the truth regarding the path to Nirvana'.

'The truth of suffering' was the subject of Buddha. Here, 'suffering' is a translation of the Sanskrit word 'dukkha' that means, literally, 'to be denied what we desire.' Buddha said that there are eight sufferings. The first four are birth, aging, disease and death. These are examples of this so-called suffering, the category of things that simply are regardless of our wishes. The last suffering Buddha listed summarized all suffering. It is the attachments to oneself, which has five components. Those are, attachment to one's body, perception, conception, volition and consciousness, respectively. Attachments to the self are the fundamental sufferings.

"The truth regarding the cause of suffering" indicates that the cause of suffering is passions such as the passion for sex, the passion to live and the passion to die. These three passions correspond to the three elements of life in biology, those are: reproduction, dynamic equilibrium and death.

"The truth regarding the extinction of suffering" is the state of Nirvana where those three passions are extinguished and sufferings, i.e. attachments to self, are also extinguished.

"The truth regarding the path to Nirvana" is the way of life where one continues to control those three passions completely. Attachments to the self are also controlled completely and hence compassion for everybody appears.

Buddhist monks are those who take the oath to walk on the path to Nirvana. Therefore they neither commit suicide nor attach to living unreasonably. That is one point that they have in common with those who decide to die with dignity. However, this is the case for monks, and Buddhism does not recommend that all people choose to die with dignity. Having compassion for all people without attachment to oneself is the situation of the Buddhist who affirms the equality of all religions. It allows us to support a person's decision to die with dignity or the decision to prolong life through medical intervention.

Buddha's doctrine has no purpose in and of itself. It is but the means which bring happiness to the people. And, Buddha showed, using the metaphor of a raft, that the essence of the doctrine was to leave attachments. To help you understand the metaphor, I will tell you the story told by Buddha. Imagine a person walking down a road. He comes to a large river. The shore on his side of the river is dangerous, but the shore on the distant side is peaceful. There is neither a ship nor a bridge to take him to the other shore. Then, he makes a raft. He crosses the river using the raft and reaches the other shore. After arriving at the other shore, he considers walking on his way bringing the raft that had been useful along with him, carrying it on his head or shoulders. But, really how should he treat the raft? Should he carry the raft with him even though it has completely served its purpose? Of course not. Leaving the raft on the shore and continuing on his journey is what he should do. Thus, in order to show us how to cross from one shore to the other, leaving attachments behind, the doctrine was taught using the metaphor of a raft. And, in this case, the raft is a metaphor for Buddha's doctrine itself! Buddha's doctrine should also be left on the other shore by those who came to understand the doctrine through the metaphor of a raft.

The raft used to cross to the shore of Nirvana from this shore of suffering is Buddhism itself. The raft is a metaphor. Metaphor literally means "to carry over". And Buddhism too is just a metaphor that carries people over to the other shore of happiness. The raft will be thrown away once it crosses to the other shore. A Buddhist is not attached to Buddhism itself. The metaphor of a raft points Buddhism not being attached to itself and also non-attachment not being attached to non-attachment itself. Buddha said that what I can control freely according to my desires is mine. But that what I can not control freely according to my desire is not mine. We do not have control over our bodies as far as birth, aging, disease and dying are concerned. So, in order to control ourselves we must recognize that our bodies are not our own. There is nothing that can be said to be mine or myself because even this body does not belong to me. If a person considers himself thus, that person does not discriminate others from oneself. This is the wisdom of equality in Buddhism. And the deed or act of mercy that one would apply to the suffering of another is the same as the mercy that one would apply to oneself. Buddha's teaching is based on this principle and the purpose is to help those who are on the shore of suffering to reach the other shore of happiness.

There is no discrimination at the

arrival point of the way to non-attachment that the Buddhist monks walk. All ways of life, namely a person's religion, are affirmed equally. It is proper to give advice and help patients to make their own decisions when we, as Buddhist monks, are called on. The position of Buddhism regarding organ transplants is the same, too. We Buddhist monks should participate in donor registration on the one hand, and on the other hand support the position of those who receive an organ transplantation.

Finally I would like to quote the words of Schopenhauer and to offer them as a lesson to Buddhist monks.

"A genuine (Buddhist) monk is exceedingly venerable, but in the great majority of cases the cowl is a mere mask behind which there is just as little of the real monk as there is behind one at a masquerade."

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III Section

What Should be Done to Improve the Identity of Catholic Hospitals

MARY ANN LOU

1. Mission: Improving the Mission of Catholic Hospitals

Introduction

Taiwan is a large island nestled southeast of Mainland China. It has 11,418,174 sq.m. and a population of 22,459,000. The Catholics account for only 1.7% of the total population. The Church has one Cardinal, one Archbishop (Taipei), and 7 Bishops, caring for the 7 dioceses.

As for medical services, there are 11 hospitals scattered all over Taiwan, totaling 3272 beds, which accounts for 2.85% of all hospital beds in Taiwan. Five of the 11 hospitals are owned and operated by the diocese, while 6 are by religious orders. There are 6 nursing homes providing convalescent and skilled nursing care for the sick or elderly. Ten extended care facilities provide room and board for long term care. Twenty-nine homes of various sizes care for the mentally or physically handicapped adults and children. Nine old folks homes are for the elderly.

Health care educational institutes include 2 vocational schools of nursing, 1 junior college of nursing; the medical college in the Fu Jen Catholic University comprises of a school of nursing, a school of public health, a school of mental rehabilitation, and a new School of Medicine just going into its third year. There are also eleven health care related foundations raising funds and advocating special care for various types of needy people, such as the foundation for Dementia, for the blind etc.

Do we have an identity crisis? No!

We know we are Catholic health care; and we know we want to manifest the love of God through our medical services to those who need us. (Our Vision —> Mission)

Are we having a hard time doing this in Taiwan? Yes!

Because Taiwan is moving rapidly into the line of “developed countries”, changes are many and rapid, presenting us with tough challenges day by day, such as economic, social and cultural, political, and religious and ethical issues.

Economically, Taiwan is fortunate enough and brave enough to have had a National Health Insurance Plan for almost 97% of its population for the past 7 years. To avoid bankruptcy, many tactics are used to reduce expenses. Under the recent global budget policy, all providers must compete for the fixed amount of national health insurance dollars. The only response we can have is still to compete honestly for patients as customers by constantly improving our quality and efficiency of medical care and patient service. As economic recession worsens, more people are jobless, the middle class is shrinking, we have a harder time to solicit donations to help the needy sick who come to us.

Socially and culturally, Taiwan is changing rapidly in a western direction. Many prefer to remain unmarried and have few or no children. The birth rate is declining in half, while the aging population increases under better medical care. As family size shrinks and family bonds weaken, we see more need for non-family carers for the sick and elderly. We respond by increasing our public relation and outreach efforts, and conscientiously emphasizing our social and community services. This is a good way to show the Christian spirit also, as we encourage everyone to serve each other with love, as money profit is not in focus here.

Politically, we saw in the last election that the party that ruled for 40 years suddenly lost to a new party. The Catholic Church tried to stay neutral to politics, but is still felt by some people to be closer to the old party, therefore prejudiced against by some. But we still try to remain neutral, befriend all and

hostile to none. After all, we are only trying to serve the little common folks, as rulers come and go.

Religiously, Taiwan is much more open to freedom of worship than Mainland China. Materialism makes people too busy to attend to their spiritual needs. Evangelization without promises of material gain is not so attractive. But we continue to emphasize pastoral care in our health care ministry, striving to improve our own pastoral care skills and enthusiasm, to promote more common acceptance of our vision, and more participation by our co-workers and volunteers in "serving with love", regardless of their own religious affiliations.

It is said that the function of leadership is to catalyze a clear and shared *vision* for the company, to secure commitment to, and vigorous pursuit of it.[1] But how do we do it? That is the purpose of this project.

Material and Method

Learning from the American Catholic hospitals, we with the department heads, worked out a Mission Statement 10 years ago, as a pledge of our focus:

Cardinal Tien Hospital Mission Statement

To manifest the spirit of Jesus Christ who loves unselfishly and unconditionally, we promise with our whole heart and power to carry out the mission of a Catholic Hospital:

We promise: to practice the Gospel spirit of "Love God and people", to value and obey Catholic medical ethics, provide holistic care of the patient's physical, emotional, and psychological healing.

We promise: to care for the health needs of our society, to fulfill the duties of a teaching hospital, in cooperation with government health care policies, to improve the health care quality of all, to provide medical service with diligence and excellence.

We promise: to love our coworkers, to use well our resources, to treasure our blessings, and to develop each one's God-given talents.

But this mission statement contained 130 words and could not be recited by our employees as a slogan. So we needed to rewrite it.

Actually, for the past 3 years, the top managers of Cardinal Tien Hospital have strongly sensed an urgency to change, because: (1) We became the first teaching hospital for the Fu-Jen Catholic Medical College. I was appointed Dean concurrent with being Director of the hospital to facilitate the union. We hope to provide the medical students with a Catholic orientation throughout their 7 year medical school education, to become good doctors according to our Catholic standards. (2) We must up-grade in the next Hospital Accreditation from type B to type A teaching hospital, to accommodate our own medical students' clinical training. (3) The Budhists are building a big hospital nearby, and they have lots of money to buy things. The Budhists comprises ~60% of the population, and most of the country's charity donations go to them. This new hospital could be a source of competition.

Providentially, we obtained a grant from Taiwan JCAH to become a "learning organization", with consultants provided. Just the right thing to do, at the right time "Deo gratias" We took to task U.B. Senior Vice President Robert Wagner's proposed eight steps to transforming an organization: (1) Establish a sense of urgency. (2) Form a powerful guiding coalition. (3) Create a vision. (4) Communicate the vision. (5) Empower others to act on the vision. (6) Plan for and create short-term wins. (7) Consolidate improvements and produce more change. (8) Institutionalize new approaches.

Establishing a sense of urgency for change was easy due to the aforementioned situation. After 6 meetings, I believe there was no room for complacency among our top managers. One of the consultants was a Christian. He zealously helped the top managers of our 3 hospitals in the Cardinal Tien system to embark upon the task of re-creating our Vision. Based on the Collins-Porras Vision Framework[1], we formed a task force and proceeded. First, the consultants provided an explanation of the theory in 2 sessions. Our old Mission Statement actually included the Vision components. In the Collins-Porras theory, Vision is reconstructed in 3 parts: (1) Core values and beliefs: i.e. a system of guiding principles and tenets, a philosophy of business and life that are to be held inviolate. This should be an extension of the personal core values and belief of the leaders of the organization. (2) Purpose of the organization's existence: should be clearly expressed in words. Of course this grows out of core values. It is like a guiding star, always

being worked towards, but never fully attained. Generally, a sound purpose should serve to guide the company/organization for 100 years. (3) Mission: grows out of purpose as specific and practical action, it is a bold compelling audacious goal, with a clear finish line and a specific time frame. Once achieved, a new mission is set. It can be any of 4 common types, e.g. a target to reach, a common foe to conquer, a role model to establish, or some specific internal transformation to be accomplished in time.

After reaching a common understanding of the above, "vision statement" suggestions were requested from all our 90 functional units in the hospitals. Forty-four statements were obtained as response. Then all our employees were asked to vote for their First choice, and 16 statements were chosen to enter the final selection. After a one-day workshop where 58 top and mid-level managers participated, a consensus statement of our common Vision emerged.

Results

Our common vision, as core value and beliefs, is simply 8 words in Chinese, translated into English: Love God and people. Respect life. As the purpose of existence, we have 4 phrases in Chinese, meaning: Medical evangelization. Health promotion. Become a model of "wholistic-four" health care. Communicate Christ's loving spirit.

As for mission, many similar suggestions were summarized into these 2 categories and each subdivided into 4 strategies.

Mission I. By 2005 AD A model of "wholistic-4" health care. Strategy 1, by 2003 AD put into effective action our wholistic-4 principle in our care for our co-workers, patients, and community at large. Strategy 2, by 2003 AD intensify our medical ethics education. Strategy 3, by 2004 AD establish a Training Center for health care pastoral carers. Strategy 4, by 2005 AD strengthen our charisma in culture and management.

Mission II. By 2007 AD Achieve University Hospital (= medical center) level of medical services. Strategy 1, by 2003 AD pass class A Teaching Hospital accreditation. Strategy 2, by 2003 AD Strengthen Union with Fu Jen Medical College. Strategy 3, by 2004 AD Solidify Cardinal Tien System. Strategy 4, by 2007 AD Pass Medical Center Accreditation. Each of the strategies is subdivided into many tactics according to our current needs. Progress will be assessed at regular intervals and appropriate corrections made.

Discussion

Now that we have our vision clearly defined, we must communicate it to all our employees and coworkers. Group leadership training was given to key persons, to empower them to explain our Vision to all our 1140 employees in 10 half-day sessions. After that, each unit will be asked to develop strategy and tactics to fulfill our stated chosen mission according to their particular function in the first hospital system. Their plans will be checked and approved by the top managers, and support and encouragement given to reach accomplishment. After the appropriate time interval, results will be openly shown and acclaimed. During the process of rewriting/renewing our Mission Statement into Vision, we received from Father Michael Place a copy of "A Shared Statement of Identity for the Catholic Health Ministry" from the Catholic Health Association of the United States[2]. The content was so similar to what we are trying to do, that I felt the Holy Spirit must be behind all this activity around the world. The statement's last part stated: As the Church's ministry of health care we commit to: Promote and defend human dignity. Attend to the whole person. Care for poor and vulnerable persons. Promote the common good. Act on behalf of justice. Steward Resources. Act in communion with the church.

These sounded like the charisma of our Catholic health care in the world in general. Is it so? So I sent a questionnaire to our Catholic Hospitals in Taiwan, asking about our service to the poor and vulnerable. And obtained a very comforting picture of our ministry (Table1). We are climbing the hill to continue this ministry in the challenging world, but we are still true to our mission and the spirit of Jesus, and the spirit of those who started the healing ministry in Taiwan.

Our Vision of: "Love God and people", "respect life", truly encompasses our core values, purposes and mission. We are on the right track when we pay special attention to developing Pastoral Care, Social Service, and Community Health Service in Catholic institutions. Our respect for life is shown by providing quality professional care, with a loving spirit, be it in acute care, long term care, home care or community service. We excel in

Table 1 - Service to the Needy and Vulnerable by 9 Catholic Hospitals in Taiwan

Service Items	Offered by number of hospitals	Number of beds	Service to Persons
Hospice Care	6	42	620
Psychiatric Care	5	441	11284
Premature Babies	6	134	1054
Aboriginee	5		3056
Alien Laborers	6		4760
Lonely Elder	9		1051
Long Term Care	7	575	3482
Dementia Elders	4	256	4007
Disabled/Mentally Retarded	7	272	1044
Vegetative States	5	278	1517
Community Health Service	8		9535
Mentally Retarded	4		358

loving service to the poor and vulnerable. Few hospitals in Taiwan (in the world?) can be as comprehensive in offering a spectrum of care as Cardinal Tien Hospital.

We have been developing the "wholistic-four care principle" (in Chinese, very catchy 4 words) for our moto, i.e. care for the whole person, the whole family, the whole journey of life, with the whole team. We wish to practice this ideal in our care for our patients, our co-workers, and ourselves. Through this, we hope to achieve awareness, acceptance, and practice of Christian values by all, regardless of their religious affiliations. In our quest for excellence and competence, we remind ourselves everyday that God is our source and purpose.

Conclusion

As we strove to improve the Mission of Catholic Hospitals in Taiwan, we realized the need to form a more meaningful network, for several reasons. (1) We can share survival skills, in areas of each institutions' expertise e.g. medical, finance, joint purchasing, management, information etc. (2) We can share evangelization/pastoral care skills and training opportunities. (3) We can support/encourage each others' efforts towards our shared identity, putting our vision into action in mission strategies. Towards this end, we have officially organized the Federation of Catholic Health Care Associations of Taiwan, registered in the government in Dec. 2001. The founding members are: The Association of Catholic Hospitals, the Association of Catholic Physician, the Association of Catholic Nurses. In process is the formation of an Association of Health Care Pastoral Carers, which has its purpose to upgrade and standardize the training of pastoral carers for Taiwan. Meanwhile, efforts are being made to unite Catholic social workers in a meaningful mutually supportive way. We want to be God's good stewards, to bring forth goods old and new, aiming at doing the most beautiful thing, His will.

Sister MARY ANN LOU
Director, Cardinal Tien Hospital
President, Federation of Catholic Health Care Association of Taiwan

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LEONHARD GREGOTSCH

2. Improving Initial and On-going Training

1. Introduction

The Camillian Institute for Initial and On-going Training in the Field of Health and Health Care

The Austrian Province of the Order of the Ministers of the Infirm (Camillians) established its institute for training in the health service in 1992. The aim of this institute is to offer study courses on initial and on-going training in the field of health and health care to religious and lay workers who work in Catholic health care institutions.

The institute is guided by the Gospel as regards social service and taking care of the sick, acts according to the criteria of economic administration, and draws strength from the spirituality of the Order of St. Camillo.

Statistical data

3,400 people from Catholic health care institutions in Austria have attended the various courses of this institute since 1992. Over the last ten years 303 training courses have been organised. Initial and on-going training are an indispensable pre-condition to obtaining skill and expertise as a leading figure within Catholic social and health care institutions. To be skilled and expert increases trust in the quality of those leading figures who represent a health care institution and other leading figures who work within it. This is true of every area of an institution:

– in medical service and medical research;

– in the care and treatment of sick people and in personal assistance;

– in administration, organisation and quality assessment (controlling);

– in medical-technical assistance;

– in physiotherapy and rehabilitation;

– in technical service and welcoming.

We understand training for all the leading figures of Catholic social and health care institutions as overall training in line with the Christian image of man. Christian ethics must be in tune with professional skill and expertise at all levels of service and responsibility.

Training is connected with the medical-social and administrative sciences and increases sensitivity, which in turn ensures and develops authentic service within Catholic social and health care institutions.

Initial and on-going training opens up the road to a future for Catholic health care institutions. It is an investment to achieve operational success and is an expression of the identity of Catholic health care institutions. The high quality of work in daily and practical activity is ensured by on-going training which takes the form of training courses that transfer professional knowledge and direct personal capacities/qualities. Professional skill and expertise increases trust and ensures quality.

2. The Criteria and Guidelines for Training

2.1. The image of Christian man

Training activity is seen as the overall training of the leading figures who represent Catholic health care institutions and of collaborators at all levels of the service offered: medical service, assistance, administrative service, technical service. We want to unite professional skills and expertise with an approach that is fundamentally Christian in character.

2.2. The encouragement and promotion of collaboration must be achieved

– between the various representatives of Catholic social and health care institutions;

– between groups of professionals within Catholic health care institutions through interdisciplinary study courses;

– through participatory study courses where those taking part learn from each other and learn together.

2.3. The direction of the training of collaborators in a way that conforms to the specific identity of a Catholic institution

The programme of the study courses for the various groups of collaborators is drawn up jointly with the representatives of Catholic health care institutions.

2.4. Making the participants responsible

The participants are made a part of the creation of the environmental and organisational conditions of the training courses so as to achieve a first-rate and overall integration.

2.5. Partnership in the relationship between those who train and those who are trained

Our study courses (at the Camillian Institute for Training in the Field of Health and Health Care) are no longer called ‘educational or training courses’ but ‘learning courses’. This is to avoid the classic concept of the ‘mentor-disciple’ or ‘teacher/lecturer-listener’ relationship. The partnership between lecturers and listeners emphasises the exchange of ideas between them and the enrichment of the relationships within the training group.

2.6. Guidance to achieve personal/individual development

Every person taking part in these study courses can discover his or her own gifts and capacities and can develop them within the training community and the working group to which he or she belongs. This discovery of his or her own qualities to the benefit of the community of the Catholic health care institution creates enthusiasm and commitment in relation to the institution and professional service.

2.7. Guidance to achieve a training goal

Every Catholic institution needs its own concept of training and a programme that is suited to that institution itself. In this way, as regards the representative figures of the institution and the various groups of collaborators it is possible to achieve a first-class correspondence between the goals of that Catholic institution and the personal capacities and approaches of each individual.

2.8. Planning and implementation

People study in order to achieve results at a practical level. Implementation is a factor which works for the success of training. An attempt is made to ensure practical activity at various levels:

– at the preparatory stage;
– during the next working stage;
– during the training process;
– through the planning of new programmes during the training process and within the specific field of work of the institution;
– at the level of those taking part in the study courses;
– at the level of team work at a practical level within the Catholic health care institution.

3. The Programmes and Subjects of the Training Courses

Our social and health care institutions are in a complex situation and are subject to a growing socio-economic tension. In Europe, including post-communist Europe, as well as in America, Asia and Australia, our social and health care institutions find themselves in a position of political and socio-economic competition with government institutions and with regional and local health authorities. In these conditions how is it possible to maintain the Catholic and Christian profile and identity of our health care institutions? What are the criteria in relation to quality as regards Catholic and Christian practices?

3.1. The subject of the first training course

Spirituality and professional expertise: are these concepts a contradiction or a premise for Catholic institutions?

Those taking part in the course: the representatives of a Catholic institution are those religious and members of the laity who have positions and roles of administrative and managerial responsibility.

The aims of the course:

– reflection on the subject 'the change in ethical-religious values and new directions';
– the drawing near of the opposing concepts of ' spirituality and professional skill and expertise';
– the individual integration of spirituality and professional skill and expertise;
– the quality levels and the personal profiles of the leading figures of Catholic health care institutions;
– cultural training as a basis for professional skill and expertise and spirituality.

3.2. The subject of the second training course

The health care and social institutions of religious orders – the workshop for superiors and other high ranks

The present-day situation of the health care and social institutions of male and female religious (hospitals, rest homes, private clinics, special homes, schools) is marked by many questions:

– how can the charism of the order, the intentions of the founder of the order, and the original idea of the religious institution in health care and social works be fulfilled?
– Who will manage our initiatives in the near and distant future when religious personnel will be absent?
– How can we find a balance between economics and the specific mission of a religious institution?
– How can we harmonise the legal and economic changes in society with the specific mission of an institution?

The superiors, their respective councils and the leading figures of their order are called upon to provide an answer to these questions and these problems. They are responsible for the purpose, the culture and the structure of the activities of their orders, and for the collaborators and the men who are helped within such a framework.

The aims of the workshop

Those taking part in the course learn to translate the mission of their own institutions into works

that are entrusted to them now and in the future:

– sensitivity and an understanding of the task of guiding these works in conformity with Christian principles and values within the context of contemporary society.

– On the basis of the identity of their own institutions those taking part in the course learn discernment in the process of ascertaining the aims of their works.

– A study is carried out into the various legal forms for social and health care works and for the Catholic schools of religious institutions.

– The participants learn to find positive ways by which to discern and acquire confidence in their own tasks as owners of health care institutions.

– An investigation takes place into the genuine spirit of their institutions, and an appreciation of their religious identity is encouraged, in a way that involves confidence and skill.

The methodology of the work of training

– Work is carried out on the basis of a workshop with introductory conferences, individual and group work, assembly lectures, discussion, and implementation through practical projects.

– During the workshop, in response to papers and questions posed by the participants, the practical questions and issues raised in a religious order that administers social and health care institutions and private Catholic schools are addressed.

3.3 The subject of the third training course

Management in non-profit-institutions

Management in our works is also an indispensable question of method. However, we are now undergoing the tension and the problems/difficulties of ensuring an overall and quality service for patients, handicapped people and the elderly given the resources that we have available.

The leading figures of Catholic social and health care institutions are *the people who take part in our study courses*.

The objectives of the course:

Those taking part learn during these study courses:

– to identify the position of Catholic social and health care institutions within society and to present that position in a suitable way.

– To be clear about the task of leadership and to be confident in guiding and directing affairs in their specific field of responsibility.

– To strengthen their own effectiveness and the effectiveness of their organisation.

– To promote participatory communication which is closely directed towards the goal of a Catholic institution.

– To employ the instruments of planning and direction.

– To discern how operational effectiveness is based upon a clear accounting in relation to costs and income.

– To work with the instruments of marketing.

– To address contemporary questions and issues and organise projects within the context of Catholic health care institutions.

3.4. The subject of the fourth training course

The training of management personnel

The leadership qualities of management should be developed so as to direct personnel and staff towards the patients as the central point of our service and our work.

Professional capacity and personal and social quality to obtain the good of the patients who are entrusted to us is required to achieve responsible professional work in our institutions. In our works professional skill and expertise completed by the religious and Christian dimension is required. The ‘specific character’ and ‘specific identity’ of a Christian health care institution make themselves felt though the people who work in it and who direct and organise the service provided. The decrease in the number of religious staff is making Christian orientation and religious Christian promotion increasingly important as a base for joint work, especially as regards managers at all levels of a Catholic health care institution.

On-going training through such courses stimulates those taking part to address themselves to the professional task of leadership in a Christian sense and thus to ensuring a positive future for Catholic health care institutions.

The objectives of the study courses

Those taking part recognise the objectives of a Catholic health care institution and develop awareness and knowledge about the Catholic, Christian and added value aspect of our health care institutions:

– those taking part perceive and develop the specific strengths of a Catholic social and health care institution in their own wards and their own persons.

– They develop their professional skills and expertise, and this is done in relation to their work through such modern instruments as computers as well.

– They develop skills of leadership in relation to their staff as well as economic expertise in relation to administration.

3.5. The subject of the fifth training course

Management in rest homes and care services for elderly people

The rapid changes in society and in political and economic spheres require institutions of care to develop a new direction and orientation. Sensitivity and social competence are not enough: economic-administrative knowledge and expertise in the management of care services are also required.

As a result of these external changes there is also a need for qualified managerial staff, as well as trained collaborators, in the sphere of today’s care services.

A special course for managerial staff in rest homes for elderly people that are owned by religious institutions, by Caritas and by parishes brings out the ‘specific character’ and ‘identity’ of Catholic social and health care institutions.

The course for managers has many disciplines and is recognised by the Austrian government and certified by the European authorities in Brussels.

The objectives of the course:

Professional work in care ser-

vices for the elderly and the handicapped requires professional expertise and skill together with individual and social quality. Our work in Catholic institutions is founded upon Gospel-based and Christian doctrine.

The specific character and specific identity of care services make themselves felt through the working staff, the managers and the economic management. In essential terms, the people who work in a Catholic social and health care institution are the elements that shape its atmosphere.

The training of leading figures and the staff looking after elderly people and the handicapped stimulates them to address their professional task in a Christian spirit that ensures the identity and the future of Catholic care services.

3.6. The subject of the sixth training course

Help in moving from the hospital to the patient's home

The organisation of the hospital and care for the elderly has to address fundamental changes in society:

– the increasing number of elderly people who have more than one pathologies.

– The change in families and social structures.

– The decrease in the length of the average stay in a hospital.

– The need for care at home after being discharged from hospital.

– The need to return to hospital at short notice.

A suitable response is offered by 'transfer care' a reality constitutes a bridge for the patient between the hospital and his or her home.

3.7. The subject of the seventh training course

Assessment in Catholic health care institutions

The management of our institutions and services takes place in a spectrum that runs from qualified care to a more efficient use of human and material resources. Efficient quality assessment allows a suitable evaluation of, and is of relevance to, the planning and management of Catholic health care institutions. For quality assessment to take place in the health care field, managers are required who are sensitive to economic and administrative responsibility.

3.8. The subject of the eighth training course

The recruitment of staff – the art of choosing the right people for our social and health care institutions

The search for a collaborator who is right and suitable for a Catholic institution is matched by the need of a professional for a job that is right and suitable for him or her. The course deals with this reality and helps to bring together the requirements of the institution and the person who is looking for a job.

4. The Tasks and the Trends of the Future:

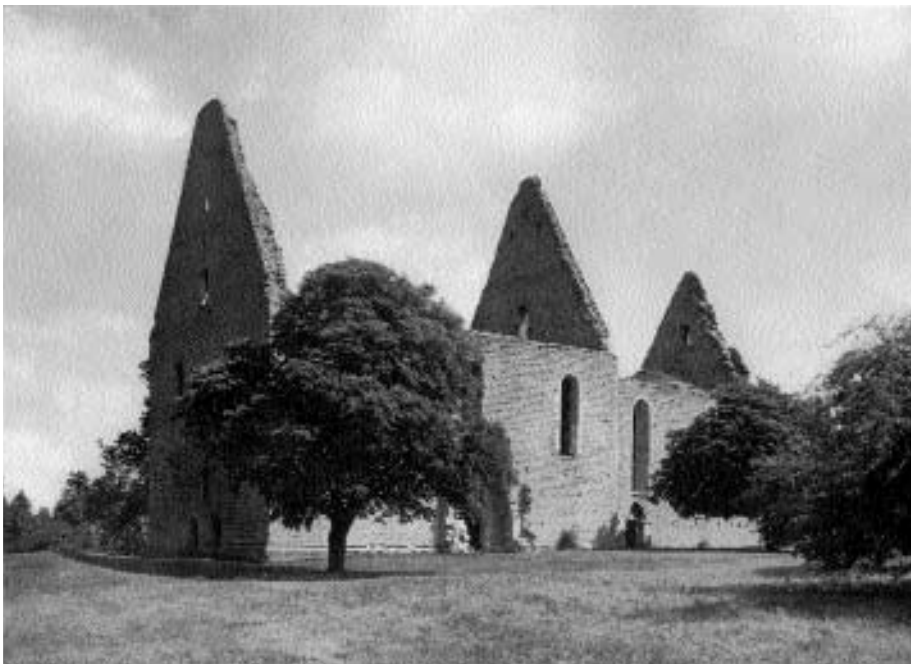
– the demand for on-going training for the leading figures and staff of institutions as a whole in the form of interdisciplinary courses is increasing rapidly.

– The same trend is to be observed in relation to specific and interdisciplinary courses for the leading figures of the various institutions of the same religious order.

– The demand for our training courses on the part of regional and local state health care institutions is also increasing.

– The Camillian Institute is recognised by the region and the state as an institute of training in the field of health and health care.

Rev. LEONHARD GREGOTSCH, M.I,
President of the Association of Catholic Hospitals of Austria



FRANCIS G. MORRISEY

3. Improving the Identity of Catholic Health Care Institutions' Structures

Introduction

It is indeed an honour and a privilege for me to have been invited to participate in the 17th International Conference sponsored by the Pontifical Council for Health Pastoral Care. I hope that what I will speak about this afternoon will be both helpful to you, and, at the same time, interesting.

I will be addressing the issue from the perspective of Canon Law, as applied in North America, looking at the various possibilities which the law of the Church provides for the future structuring of our health care institutions.

After briefly recalling the present situation, we will then move on to consider the various possibilities offered by Canon Law today, noting the challenges that arise from them, and, hopefully, seeing where they can lead us in the future.

1. Moving from the present situation to the future

The structuring of Catholic health care institutions has evolved greatly over the past quarter century.[1] In North America, we noted that governance models have moved from having the work being an integral part of a religious institute's or a diocese's mission, closely identified with the authorities in office at the time, to a more complex form of governance, usually identified with multi-tiered boards and a sharing of responsibilities. At the same time, efforts were made to give separate civil recognition to the various entities so that they would operate in the secular sphere independently of the sponsoring diocese or institution.

It was not so in the canonical world, at least at the beginning. The fact that there were separate identities – the civil and the canonical – placed the health care institution somewhere in the middle between both authorities. It did not have its own canonical identity. Therefore, in an attempt to have the two levels function jointly, Cardinal Adam Maida, who at the time was working with the Catholic Health Association of the United States, devised a system of reserved powers to enable the canonical stewards of such institutions to remain involved in the most important decisions, while leaving the day-to-day activities to others who would operate according to the civil corporate documents.[2] This system has worked very well and is now standard practice. These powers usually concerned three important areas reserved to the canonical stewards: changing the civil corporate documents, designating key personnel, and assuring the sound administration of property. They functioned in such a way that civil decisions would not be taken by the hospital boards until the canonical approvals had first been obtained.

Then, as time went on, it became evident that many stand-alone institutions could not function well and remain competitive in today's world where insurance companies and other agencies are bidding for the best service available at the lowest price. This led to the establishment of delivery systems, grouping a number of similar institutions. While originally the systems were concerned with similar entities, such as hospitals, they soon grew into integrated systems that would follow a patient from birth to death, including out-patient clinics, homes for the elderly, palliative care centres, and so forth.

But even then, this was not enough. The systems themselves found it necessary to amalgamate with other ones, so that now we have many of them which overlap the boundaries of dioceses and extend to numerous civil territories. Some even go beyond the limits of one country.[3] This often entails the pooling of financial resources of religious institutes and dioceses, something that is not directly foreseen in the Code, although canon 1274, §4 does provide for the possible pooling of inter-diocesan financial resources.

In many instances today the systems operate on behalf of a number of religious institutes, working together to further their mission. While, originally, there was a lot of concern over protection of the proper charism of each institute, it has become evident that the charisms of religious institutes are not that different one from another, and possibly what counts most is the mission. Perhaps these charisms are being refounded today. This shows the significance of Pope John Paul II's reference to a "founding charism" (something that is never complete as long as there is life) rather than to what was previously called the "Founder's charism" (which is something embedded in time).[4]

Until recently, as was the case with stand alone institutions, these health systems derived their canonical existence in the Church through a direct relationship with the sponsoring religious institute or diocese. However, using the

possibilities foreseen by the 1983 *Code of Canon Law*, the Holy See, primarily through the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life, has granted them separate and distinct juridic personality, so that their ecclesial existence is now distinct from that of the original sponsor or sponsors.[5] This is an important ecclesial development because it provides for a much greater direct involvement of the laity in the Church's health care mission.

These systems exist also in the economic world, and are major employers with thousands of persons working under each system. It is not uncommon for their annual revenues to exceed many billions of dollars, more than the gross national revenue of many countries. Thus, they play a major social role by making people more and more aware of what the Church has to offer in the field of health care and promoting its values.

2. Canonical structural possibilities

As we look to the future, using the present as our base, we see that there are many possibilities in the 1983 Code for the canonical restructuring of healthcare institutions, particularly at a time when the sponsoring religious or diocesan entities, because of a lack of personnel, are no longer in a position to operate them directly.

Interestingly enough, there is no direct reference to hospitals or to other health care institutions in the Code and so we have to proceed by analogy of law (c. 19) to examine the various possibilities.

a. Retaining present structures of direct governance

The first form would be to continue using present structures, with each work or system directly accountable to a religious or diocesan sponsor. However, there are many disadvantages in such an approach because diocesan officials and religious superiors often do not have the personal expertise nor the time to direct such works personally. Furthermore, since diocesan and congregational lines are often crossed with such systems, it is difficult to determine who is the ultimate sponsor in a particular case. Nevertheless, the largest Catholic health care system in the USA, Ascension Health, operates successfully under this model with six different canonical sponsors.

b. A private association of the faihtful

The Code provides for the existence of private associations that would be responsible for a given work in the Church, but would not operate as such in the name of the Church (see canon 321). One of the difficulties arising from this approach is that the primary focus is on the persons who comprise the association, rather than on the actual ministry. Before too long, we become involved in questions relating to the standing of the members within the Catholic Church, particularly in geographical areas where the Catholic population is not too numerous. Another factor is that the work undertaken by a private association is not a work of the Church. We must keep in mind that at the present time, the Catholic Church, through its various entities, is the largest provider of health care in the world and would want to retain this position. Because the works undertaken by a private association would not be a work of the Church, I do not see many practical possibilities arising from the use of this model.

c. A public association of the faithful

A third approach could consider using a public association of the faithful to serve as canonical sponsor of the work (see canon 313). In this instance, the health care ministry is operated directly in the name of the Church, but, again, the focus is on the persons involved. Since many of our institutions have persons who are not Catholic serving in leadership roles, this model has not proved to be too satisfactory, and leads to a dissipation of forces (something that canon 321 warns against in the case of private associations). It has been tried in the United States, but does not seem to be catching on too much.

d. A private juridic person

A fourth approach, which the Holy See has authorized on occasion, consists in granting private juridic personality to a health care system.[6] In the case of a private juridic person, its temporal goods are not considered to be ecclesiastical goods (at least according to the letter of canon 1257, §1). This would mean that if a Catholic work were to be undertaken by a private association, its temporal goods would no longer be subject to the norms of Book V of the Code, except where it is specifically mentioned.

Why should the Church give up what previous generations have strived to gather, unless there was a compelling reason to do so? The situation might be quite different when a group which has no direct connection with the Church wishes to become recognized by Church authorities. Its goods were not ecclesiastical goods, and, therefore, there is no loss of ownership rights if private juridic personality were granted.

e. Public juridic personality

The fifth approach, one which I recommend above all the others,

is for the various undertakings to obtain public juridic personality, distinct from that of the sponsoring institute or diocese.

e.1. The granting of juridic personality

The Code of Canon Law does not state specifically who can grant juridic personality. But there is no doubt that, besides the Holy See, a diocesan bishop can do so in a particular case. However, what about the provincial assembly of Bishops, or the Conference of bishops for works in their territory, or what about those major superiors in religious institutes who are Ordinaries, or those who are not? A parallel reading of canon 312, on who can establish associations of the faithful, might give us some insight; this canon speaks of three levels of approval: the Holy See, the Conference of bishops, the diocesan bishop. In the case of religious institutes, the Code provides (in canon 634) that when the major superiors establish a province or a house of the community, the law itself grants juridic personality to the new entity.

Although the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life has been actively involved in promoting the establishment of new juridical persons of pontifical right, the question can be asked: to which Congregation or dicastery would bishops address themselves if they wished to have diocesan sponsored works receive such recognition, and would these offices be ready to consider such a request?

When a work has received public juridic personality, it is relatively easy to obtain permission to alienate works to it because the goods would remain ecclesiastical goods. But, when juridic personality has not been granted, there is a legitimate reluctance on the part of the Holy See to authorize such transfers since the goods would then no longer be ecclesiastical goods.[7]

At the present time, to the best of my knowledge, no Conference of bishops has granted juridic personality to a health care system or institution. So, we are left with two possibilities: pontifical or diocesan approval. But, when a work extends over many dioceses, the diocesan bishop of the place where its headquarters are situated can be somewhat reluctant to grant juridic personality, since it affects works elsewhere. Nevertheless, such could be considered, since it is already the case with diocesan institutes of consecrated life whose members can be working in more than one diocese.

e.2. Points of particular concern

If we examine the various instances where the Holy See has granted public juridic personality to the systems, we notice a number of constant elements in the approved statutes. Three of these can be brought to our attention now, because they most likely hold the key for sound future development.

The first concerns the monitoring of the application of ethical directives as prescribed in the territory.[8] While this is obviously the responsibility of the diocesan bishop (see canons 392 and 394), the matter calls for more direct involvement on a day to day basis. Problems arise, however, when as mentioned above the system operates in a number of dioceses, since not every bishop applies these directives in the same way. Some are able to tolerate certain situations more readily, applying prudential moral norms to unforeseen situations. Others would seem to prefer an all or nothing approach, which does not always take account of circumstances affecting a moral decision. It is very frustrating for those in charge of multi-diocesan systems to keep in mind what is allowed in one place, and not in another. On a few occasions, provision was made for a Sponsors' Council to oversee the implementation of these directives.

A second point concerns the designation of members of the juridic person. Are we dealing with a self-perpetuating board, or with one which is appointed by the original religious or diocesan sponsors. The question that arises frequently is how to prepare members of the boards for their faith responsibilities. We cannot presume that simply because a person is Catholic, he or she is aware of the intricate moral teachings of the Church and the means of applying them correctly. Pope John Paul II addressed this issue in his Apostolic exhortation, "*Ecclesia in Oceania*", when he said: "Administrators and staff in Catholic institutions require formation in the application of Catholic moral principles to their professional life. This is a delicate task, since some who are involved in the work of a Catholic

hospital are not familiar with these principles or do not agree with them."[9]

The third relates to the temporal goods involved. When the goods previously owned by a religious institute or a diocese have not been legitimately turned over to the new juridic person, the original sponsor is ultimately responsible for their proper administration and, at times, their alienation. However, as more and more institutes and dioceses pool their financial resources, it becomes much harder to determine which goods belong to the original sponsors, and which are now the property of the new juridic person or jointly held assets.

There is also another factor: many buildings are not owned by the sponsors, but have been entrusted to them by secular authorities to provide health care in the area. While the sponsors have control over the works as long as they remain there, the goods are not ecclesiastical goods; rather, they are owned by the State or some other entity. We also note a change in emphasis lately in regard to lands and buildings. While formerly, they were considered to be major assets, today they can easily become liabilities as building and equipment become obsolete – and, at times, rather quickly. So, the focus is much more now on the apostolate itself, rather than on the bricks and mortar. It is perhaps here that canon 1295 comes into play: to what extent can the use of a name, or various forms of partnership jeopardize the stable patrimony of a juridic person?

These three issues become even more significant when we consider that a number of partnerships are not exclusively with Catholic partners. Other faith-based communities wish to share in the health care ministry and are willing to espouse fundamental Church teachings, particularly in relation to abortion and euthanasia. If Catholic institutions do not accept to partner with other groups, whose values perhaps do not coincide totally with Catholic ones, is there any room for negotiation and reasonable compromise? To fail to do so often means that the Church has to close its institutions because it doesn't have access to the same finances as do the public institutions, and therefore our presence in health care is seriously diminished.

This does not mean that the Church has to maintain an institution at all costs. Indeed, canon 806 (on Catholic schools) can be read in this context: if the Church offers a work, the quality of that work must be at least as outstanding as that of the other institutions in the area.

Furthermore, as canon 114 provides, we must be answering a real need. if there is no real need, or if we are wasting resources needlessly, then perhaps it might be preferable for the Church to reconsider the responsible stewardship of its time, resources and activities. This might mean concentrating our efforts in areas where real needs are not being met by society, rather than duplicating services unnecessarily in order simply to have a presence in an area. I recognize that this is a very delicate point, and one that must be carefully considered. But, we cannot overlook these two points: outstanding quality, and answering a real need. More on this later.

3. Challenges from new structures

Structures alone will not suffice to ensure the future viability of our health care institutions. We can now address a few of these, to see how they can be met in the years ahead. We will note that they correspond closely to the three points mentioned above.

a. Finding appropriate board members

Probably the most important challenge facing health care ministry as the number of available religious diminishes quite rapidly – always speaking from a North American perspective – is to find persons who are fully committed to the ministry and who are willing to carry it out. This does not always and necessarily mean that such persons must be Catholic, but they must espouse the values which the Church promotes. The Holy See has recognized that this situation does indeed exist and has sanctioned it.[10] However, it will be essential to establish sound formation programs for persons involved in top leadership positions. Otherwise, we risk losing our works from within, in the sense that there is no one involved who knows about and cares for the Catholic values that we are espousing in the ministry.

b. Application of ethical directives

A second challenge concerns the application of the ethical directives that are in place in the territory.[11] Not every Conference of Bishops has prepared directives to be applied in Catholic institutions in the region. The field is changing so rapidly that it is difficult to keep up. For instance, the principles outlined by Pope John Paul II relating to human and animal transplants have to be kept in mind.[12] As new issues relating to cloning and stem-cell research arise, they too will have to be addressed carefully. The same can be said about new medical techniques will show promising signs, but have not yet been fully tested, especially over a protracted period of time. The ethical directives would also concern the responsible use of limited resources. We have just to think for a moment of the AIDS pandemic in certain parts of the world and see how limited our resources are at the present time. It would be most important for religious institutes and dioceses to sponsor students who wish to study medical ethics and related topics, so that fully qualified persons will be available in the years ahead to help us answer delicate unresolved moral and medical questions. In this way, we are setting the base for a stronger future.

Indeed, Pope John Paul II, in his Apostolic exhortation, "*Ecclesia in Oceania*", addressed this very topic:

"On this point [i.e., the sanctity of life], the witness of Catholic health care institutions is essential, as is the role of the media in promoting the value of life. In or-

der to present the Church's position on biomedical and health issues in the public forum clearly and faithfully, bishops, priests, and experts in law and medicine need to be trained adequately".[13]

c. Responsible use of temporal goods

A third challenge arises from the responsible use of temporal goods. The sums approved by Conferences of Bishops for the region are not always realistic when it comes to multi-unit systems, with transactions in the millions of dollars. The Holy See has, once again, responded to this situation by granting indults allowing sponsoring institutes to accumulate debts up to, in some cases, a billion dollars. Much of this debt is on paper, since the various government repayment programs help manage it. Nevertheless, we must recognize that Book V of the Code was not written in the perspective of such massive transactions, such as bond issues, transfer of assets, acceptance of outside debt when new amalgamations are foreseen, closing of institutions, and so forth. It might be good to consider the possibility of preparing special legislation to facilitate the task of administrators of such works in view of the new and challenging situations faced, particularly when investments are not bringing forth the results that are necessary to enable the works to continue on their own.

d. Is health care a commodity for sale?

A fourth challenge arises from the commercial nature of the ministry today. The Church has consistently offered its services in what could be called a "not for profit" context, generously sharing the resources it has. However, today there is much pressure to partner with institutions that are investor-owned. Feelings are mixed on such issues. In general, the attitude is in the negative – Catholic works will not enter into partnerships with such groups. But, on the other hand, we have to recognize the need for partnerships. Perhaps if the owners are willing to espouse the Church's moral teachings and apply them in their institutions, this might be preferable to working with others who do not accept the moral principles operative in our institutions.

Bishop Anthony Pilla, of Cleveland, Ohio, addressed the same issue recently.

A lot of those involved in health care no longer agree on any universal principles or on the appropriate way to put those principles into practice. Even the most conscientious practitioners are often perplexed as to how they should act when they are caught up in a web of economic forces, politics, business practices and social responsibilities. The result is that health care sometimes seems to lack a sure and accurate sense of how to find its way through difficult times.[14]

e. Are we answering real needs?

A fifth challenge arises from the necessity of determining whether we are indeed answering a real need. Of course, we must recognize that Church entities have assumed a number of long-term commitments and must honour them accordingly. But, as medical techniques extend more and more to out-patient services, we might have to ask ourselves whether our large institutions are really necessary everywhere. This is extremely delicate. Furthermore, since patients are in the hospital or clinic for only a very short period of time, often not overnight, there is less opportunity for direct pastoral care in such circumstances. Perhaps we should be directing some of our interests more to extended care and to home assistance for the sick and elderly. Indeed, the President of the Pontifical Council for Health Pastoral Care raised the same issue in an address to the Second World Assembly on Aging, when he said that "too many older people are left alone or are forced to take up responsibility of caring for children abandoned or separated from parents and homes."[15]

f. Uniformity in pastoral practices

A sixth challenge that I see is bringing about some uniformity in our pastoral practices in relation to health care, without necessarily adopting the strictest or narrowest possible position. At the present time, we cannot help but notice a polarization within the Church on a number of issues affecting health care. Usually, truth is not found in the extremes, particularly when dealing with new and unresolved issues. For

instance, who would dare say that the Church has today the final answer on issues related to cloning, when the questions themselves haven't even yet been raised?

g. Relations with the medical world

A seventh challenge will be to find a more balanced approach to the medical world, as well as to the world of science. Just as the Church during Vatican II decided to speak of "the world" as that which is waiting to be evangelized, rather than considering it to be a source of evil, so too today we might need to show a greater willingness to consider advances in medical techniques in a positive light. I find it very disappointing to see that a number of our Catholic hospitals have had to close their maternity departments because they cannot apply the medical techniques which doctors say are now necessary but which certain Church authorities say are not allowed. The Church's stand in favour of human life is so unwavering that there must be some way in which a sound dialogue can be carried out with representatives of the medical world so that we can continue to offer such important services.

4. Catholic health care in the future

a. The consequences of separate juridic personality

If the various institutions, or at least the systems receive distinct juridic personality, their temporal goods belong to them. The system is then free to use these goods for the best advantage of the ministry, without having a number of outside pressures to face.

Of course, if the system doesn't own its goods, but simply administers the ones put at its disposal, this advantage will not be felt.

In view of the fact that the systems are extending beyond diocesan and even beyond national boundaries, their having a distinct identity strengthens the work of the Church. Like religious institutes which operate in many dioceses and countries, a system with its own juridic personality would be able to imprint its own characteristics of the work carried out.

It can be asked whether it is premature to think of the possibility that a system which has acquired juridic personality to carry on the mission could have a charism of its own. The idea is not too far-fetched and could be addressed in the future.

b. The increased role of the laity

Given the demographics of the Church in North America, we must consider that the increased involvement of the laity in the healthcare ministry of the future will be a special grace given to us.

As people live out their baptismal and confirmation commitment, and assume a very active role in the mission of the Church, they will be able to animate the temporal order with a Christian spirit (see canon 298), perhaps in ways that were hidden to clerics and religious. As I noted above, the challenge will be for us to unite their work with a mission, so that we are not dealing merely with employment opportunities.

c. A new social role

It is quite possible that, as the health care ministry evolves, new methods will be put in place to provide service to those in need. Extensive use of the Internet to provide quick and accurate information would enable us to offer competent services in a much more user-friendly fashion. The Church's health systems should already be working at providing unified and uniform information relating to a patient no matter where that person is at a given moment. Of course, there are privacy issues at stake here, but they can be easily overcome with proper identification.

d. A new political role

Since so many of the Church's interventions are centered on the dignity of the human person, it will be important to maintain what is now a particular concern for each individual who avails himself or herself of the Church's saving care. In this way, a strong message is sent to Society, so that it too can eventually come to realize what is at stake here for the future of humanity.

I am not necessarily referring to activism, but am thinking more of example, since actions speak louder than words.

e. A new organizational role

As health care institutions groups together more and more, we have to realize that the day of the small independent clinic is fast drawing to a close. We are now literally in the global village. It is not a question of centralizing for the sake of uniformity, but in order to present a more coherent approach to new medical and health care techniques.

Cardinal Anthony Bevilacqua, of Philadelphia, set out five principles that he thought should be at the base of any new organizational approach. These can constitute a realistic goal for all of us, no matter where we are in the world:

1. We aim to see that accessible and affordable health care is available for everyone. This entails quality care at reasonable cost.
2. Ethical integrity must be supported and preserved by the health care environment.
3. There should be an equitable payment policy, responding at the same time to the needs of individuals and their communities.
4. The services offered must be appropriate, compassionate and of the highest quality, respecting the rights of patients.
5. Nonprofit health care should be promoted so that health care in not viewed merely as a commodity which is exchanged for profit.[16]

There is much wisdom and experience underlying these points and they could be used as a checklist when new structures are being considered.

Conclusion

I do not think that there is much new in what I have said. Rather,

my goal was to gather together different trends that we find in the organization of health care today.

The Church's heritage in the field of health care is something to be very proud of. It cannot be let slip away simply because of new challenges. New canonical structures are certainly a step in the right direction to give this apostolate a strong basis in which to face the future with security and freedom, but much depends on the persons involved and their individual commitment to the saving mission of Christ as lived out in the Church.

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Notes

[1] On this topic, see F.G. MORRISEY, "Toward Juridic Personality", in *Health Progress*, 82(2001), pp. 27-31, 51.

[2] See A.J. MAIDA and N. CAFARDI, *Church Property, Church Finances, and Church-related Corporations*, St. Louis, The Catholic Health Association, 1984, xxii-339p., at pp. 155-163.

[3] For instance, "Catholic Health East" based in the Archdiocese of Philadelphia, has extensive activities in the Carribean region.

[4] See JOHN PAUL II, Apostolic exhortation, "*Vita consecrata*", March 25, 1996, No. 36.

[5] Examples of such pontifical juridic persons in the USA are: "Catholic Health Care Federation" (1991), "Covenant Health System" (1996), "Peace Health" (1997), "Catholic Health Ministries" (2000), "Hope Ministries" (2000). In Canada, the following systems have received pontifical approval: "Catholic Health Sponsors of Ontario" (1997), "Catholic Health Sponsors of Manitoba" (1999), and "Catholic Health Sponsors of New Brunswick" (2001).

[6] As was the case with "Peace Health" in 1997.

[7] See, for instance, CICLSAL, Prot. No. 15050/2000, February 3, 2000: "Enclosed with this letter is the rescript authorizing the requested alienation of certain health care works and supporting foundations of N.N. to the new canonical public juridic person, AA.BB. [However,] since the CC.DD. has not yet been granted canonical public juridic personality, we prefer to wait before issuing the requested rescript for those works and their respective foundations. When juridic personality has been granted, it will be sufficient to inform us of that fact, making reference to this letter and protocol number. Unless significant information has changed, it would not be necessary to repeat that which we have here on file..."

[8] Ethical directives concern much more than prohibitions against certain medical techniques. They also concern the correct application of the Church's social teachings. See, for instance, "Agreement Outlines Guidelines for Union Organizing Campaign", April 6, 2001, between "Catholic Health West" and "Service Employees International Union", in *Origins*, 30(2000-2001), pp. 728-732.

[9] JOHN PAUL II, Apostolic exhortation, "*Ecclesia in Oceania*", November 22, 2001, in *Origins*, 31(2001-2002), pp. 573, 575-596, at p. 589.

[10] For instance, the approved statutes for "Catholic Health Ministries" recognize that a majority of the members must be Catholic, but they do not require that all be Catholic.

[11] For instance, see "Ethical and Religious Directives for Catholic Health Care Services". approved June 15, 2001, for the USA; *Origins*, 31(2001-2002), pp. 153, 155-163. For Canada, CATHOLIC HEALTH ASSOCIATION OF CANADA, *Health Ethics Guide*, approved by the Permanent Council of the CCCB, March 2000; Ottawa, CHAC, 2000, x-120p.

[12] JOHN PAUL II, Address to the 18th International Congress on Transplants, August 29th 2000. French text, "Transplantation d'organe: les limites à ne pas dépasser", in *La Documentation catholique*, 97(2000), pp. 852-854.

[13] *"Ecclesia in Oceania", p.* 587.

[14] Bishop A. PILLA, "The Practice of Faith in the Practice of Medicine", October 18, 2000, in *Origins*, 30(2000-2001), pp. 364-369, at p. 364.

[15] Archbishop J. LOZANO BARRAGÁN, April 8, 2002, address to the Second World Assembly on Aging, Madrid, as reported in *Origins*, 31(2001-2002), p. 726.

[16] See Cardinal A. BEVILACQUA, "Assuring the Future of Catholic Health Care", October 18, 2000, in *Origins*, 30(2000-2001), pp. 369-372, at p. 371.

MICHAEL D. PLACE

4. How to improve the International Association of Catholic Health Care Institutes (AISAC)

Over the last few days we have been informed by the reflections of many experts. These reflections, in part, have reminded us of the complexity of our ecclesial service. As daunting as that complexity may be, we cannot allow it to distract us from our foundation, which is the healing ministry of the Lord Jesus. Jesus' stories – whether that of the woman with the hemorrhage, or the leper, or the blind men, or the Good Samaritan – are about healing. They remind us of God's active presence in the world, a presence that reveals to us the fact that the Reign of God is in our midst. The Gospel stories also witness to the inclusivity of God's love. This is an inclusivity that pays special attention to the poor, the weak, and the vulnerable. Most important, however, these stories are about faith, the invitation to "let go" and trust completely in the unmerited generosity of God's love, which is the source of all healing.

It is this healing mission of Jesus that has been entrusted to the Church to carry forward under the guidance of the Holy Father and the bishops. The manner in which the mission is fulfilled has changed over the centuries. In recent years, with the scientific and technological advances in the practice of medicine, Jesus' healing mission has more and more come to be carried on in institutional settings. However, whether that setting be a dispensary in India, a rural clinic in Mexico, or a large urban hospital in Taiwan, the soul of Catholic health care remains the same – the healing touch of Jesus.

When His Holiness John Paul II visited the United States in 1987, he spoke of Catholic health care and provided us with several foundational observations concerning our ministry.

Vital Apostolate: "Your healthcare ministry, pioneered and developed by congregations of women religious and by congregations of brothers, is," the Pope noted, "one of the most vital apostolates of the ecclesial community and one of the most significant services which the Catholic Church offers to society in the name of Jesus Christ."[1]

Witness: "All concern for the sick and suffering is part of the Church's life and mission. The Church has always understood herself to be charged by Christ with the care of the poor, the weak, the defenseless, the suffering, and those who mourn. This means that, as you alleviate suffering and seek to heal, you also bear witness to the Christian view of suffering and to the meaning of life and death as taught by your Christian faith."

Dignity of the Human Person: "Similarly, the love with which Catholic healthcare is performed and its professional excellence have the value of a sign testifying to the Christian view of the human person. The inalienable dignity of every human being is, of course, fundamental to all Catholic healthcare."

Mission of Truth: "Your ministry, therefore, must also reflect the mission of the Church as the teacher of moral truth, especially in regard to the new frontiers of scientific research and technological achievement."

Just Society: "As you give the best of yourselves in fulfilling your Christian responsibilities, you will also be aware of the important contribution you must make to building a society based on truth and justice. Your service to the sick enables you with great credibility to proclaim to the world the demands and values of the Gospel of Jesus Christ and to foster hope and renewal of heart."

Ecclesial Communion: "You must always see yourselves and your work as part of the Church's life and mission. You are indeed a very special part of the people of God. You and your institutions have precise responsibilities toward the ecclesial community, just as that community has responsibilities toward you."

Last year, Archbishop Javier Lozano Barragán, the President of the Pontifical Council, provided another valuable insight into what makes Catholic health care distinctive. The world, he reminded us, "needs the Gospel to enter the very heart of health and health care and ...root itself in it, so that the world of health and health care becomes

transformed by the Gospel. This pre-supposes *a new evangelisation* [emphasis added] of the world of health, that is to say the transformation of health care into Christian health care. This inculturalisation of health and health care consti-

tutes authentic pastoral care in health. We must enter the fundamental values of the world of health and health care in order to transform them and make them every time more in accord with the Gospel."[2]

It is in this ecclesial context that we look at the face of Catholic health care across the world. The sheer number of ministry institutions – including hospitals, nursing homes, health centers for the aged, homes for long-term patients, medical facilities for the disabled, rehabilitation centers, day hospitals, outpatient units (mobile clinics, first aid stations, and others), consulting rooms, and centers for the care of lepers – is astounding.

Ministry Institutions around the World

According to the Pontifical Council of Health Pastoral Care, there are 21,757 Catholic health care institutions – including acute care hospitals, nursing homes, clinics, rehabilitation centers, and other facilities – around the world. The total breaks down as follows:

Africa	3,665 (17% of all ministry facilities)
Americas	4,363 (20%)
Asia	3,905 (18%)
Europe	9,500 (43.5%)
Oceania	324 (1.5%)
Oceania	324 (1,5%)

The number reminds us how truly universal are the apostolic efforts of Catholic health care. These efforts are extremely diverse, of course. However, this diversity exists in the context of the family of faith that is the one Church of Jesus Christ, a Church with a Supreme Pastor who has solicitude for the well-being of all the church and all those who labor to carry on its mission. For those of us in Catholic health care, that papal solicitude is expressed, in part, through the dicastery that sponsors this conference, the Pontifical Council and its president, Archbishop Lozano.

History

We know that, with the apostolic letter *Dolentium Hominum* of February 11, 1985, John Paul II instituted the Pontifical Commission for Pastoral Assistance to Health Care Workers, which, with the Apostolic Constitution in 1988, became the Pontifical Council for Pastoral Assistance to Health Care Workers (now known as the Pontifical Council for Health Pastoral Care).

One responsibility of this dicastery is to stimulate and promote the work, formation, study, and action carried out by the diverse Catholic international organizations in the health care field, as well as that of other groups and associations that work in this sector on different levels and in different ways.

In fulfilling the responsibilities given to it by the Holy Father, the Pontifical Council has paid particular attention to several constitutive elements of Catholic health care: physicians, nurses, pharmacists, and health care institutions. One dimension of the Council's pastoral service to these realities has been the fostering of a sense of international solidarity within these pastoral realities in the hope that this solidarity can provide both support and context for local efforts. One way of providing this support and context has been nurturing the work of international federations of physicians, nurses, pharmacists, and health care institutions. As a result, there currently exist the following federations:

– The International Federation of Catholic Pharmacists.

– The International Catholic Committee of Nurses and Medical-Social Assistants.

– The International Federation of Associations of Catholic Doctors.

– The International Federation of Catholic Health Care Associations (AISAC).

In a meeting whose focus is sustaining the identity of Catholic hospitals, it is appropriate that we reflect on the history of the fourth entity.

Originally AISAC was called the Confederation of Health Care Catholic Institutes. Founded with the encouragement of Pope John Paul II in 1984, it was refounded in July 1999 during a world symposium. As we know, "Catholic health care institutions" are more than acute care hospitals; they are health care institutions that are recognized by the local Church bishops (see canons 216, 300, 312, and 807-814) and accept the teaching of the Church's magisterium. Over the years, much energy was expended in trying to realize the dream of AISAC becoming a vibrant organization. As noble as these efforts were, AISAC, unlike some of its sister federations and for a variety of reasons, experienced great difficulty in maintaining its (as we would say in the United States) momentum.

In light of these difficulties**,** but convinced of the organization's importance, Archbishop Lozano has worked diligently in recent years to revive AISAC. In 1999, after consulting with conferences of bishops across the world, he convened representatives from many nations to discuss the future of AISAC.

In May 2000, there was another gathering, the result of which was the selection of continental dele-

gates who could continue the dialogue about the future of AISAC. Those delegates have come together on several occasions over the past years to discuss how AISAC could find a renewed sense of vitality. Those discussions were guided by the parameters given by Archbishop Lozano**,** as well as by his encouragement and that of the secretary of the council, Bishop Jose Luis Redrado Machite. And, in a very special way, they were nur-

tured by one of the recent heroes of Catholic health care, Br. Pierluigi Marchesi, former Prior General of the *Fatebenefratelli*, who had been appointed by the Pontifical Council as director of AISAC. Even as we mourn his passing (in March 2002), we thank God for the tireless dedication Br. Marchesi brought to AISAC, beginning with its founding in 1984. We also are appreciative of the support of Monsignor James P. Cassidy, President Emeritus of AISAC. We also have been aided by the efforts of many others who assist the work of the Pontifical Council – especially Isabella Biondi and Pietro Quattrocchi.

Over time, the gathering of the continental delegates was recognized as constituting an "interim board" that could assist the Pontifical Council as it sought new vitality for AISAC. It was this interim board that recommended that AISAC should, while remaining dependent on the council, become a federation of Catholic health associations in order to stimulate the creation of new national associations and to reinforce the initiatives of existing national associations. Another example of the assistance the interim board provided the council is the observations it prepared on the composition of this **i**nternational conference. The board also suggested that the convening of the **c**onference would provide a welcome opportunity for another programmatic meeting of AISAC, one that could apply the fruits of these deliberations to the federation's future work. These deliberations will be guided by AISAC's statement of purpose:

– To strengthen the identity of Catholic healthcare.

– To exchange information about the condition of Catholic healthcare around the world and the challenges facing it.

– To encourage the formation of Catholic health care, especially in ethical and pastoral matters.

– To maintain information/documentation about Catholic health care to support the work of the Pontifical Council for Health Pastoral Care and the international association.

Challenges

Those deliberations also will be informed by some of the critical challenges that confront Catholic health care across the world. Several have been discussed in previous AISAC meetings.

Culture of Death. Whether it be threats to the life of the unborn, the movement to legalize euthanasia, or the modern tendency to reduce human worth to its so-called productive or relational capacity, the sacred dignity of human life made in the image and likeness of its Creator is threatened by a culture of death. Because Catholic health care serves the mother and her unborn baby, cares for those who are terminally ill or dying, and reaches out to all who experience physical or emotional diminishment**,** it can often find itself as an essential participant in promoting a culture of life by proposing what Pope John Paul II has called a "consistent life ethic."

Technological/Scientific Imperative. One of the last century's great contributions to the advancement of the human family was the incredible scientific and technological developments that have transformed the landscape of health care delivery. The discovery of penicillin and antibiotics, the introduction of vaccinations, advances in radiology and imaging, and the development of non-invasive surgery and pharmacological treatment – these have transformed all health care**,** albeit unevenly because of global inequities. The downside of these advances is that they have deluded some into believing that the God of Abraham, Isaac**,** and Jacob has been replaced by a new imperative: namely, if a therapy is scientifically or technologically feasible, then it *must* be pursued. An autonomous understanding of the nature of science is being proposed as an alternative to human nature fully and adequately considered. For Catholic health care, the critical challenge lies in preserving the primacy of human touch that mediates God's saving love and guided by immutable truths while honoring the legitimate role of scientific inquiry.

Health Care as a Commodity. A third challenge faced by Catholic health care across the world is the movement to consider health care as an economic commodity. This stands in stark contrast to the teaching of Blessed John XXIII**,** who in *Pacem in Terris* wrote:

"But first We must speak of man's rights. Man has the right to live. He has the right to bodily integrity and to the means necessary for the proper development of life, particularly food, clothing, shelter, medical care, rest, and, finally, the necessary social services. In consequence, he has the right to be looked after in the event of ill health; disability stemming from his work; widowhood; old age; enforced unemployment; or whenever through no fault of his own he is deprived of the means of livelihood."[3]

Obviously, the manner in which this statement of principle has been put into action has varied in significant ways**,** depending on how the right of access to health care is understood in the local social, economic, and political environment. For example, the way in which the provision of health care was provided and paid for in the middle of the last century was done in one way in a capitalist economy**,** such as the United States', and in another in a more socialist structure**,** such as Great Britain's. Within this heterogeneity, however, there was, by and large, at least an implicit recognition within the so-called First World that the provision of health care was, like public safety and education, so important for the well-being of society that it must be protected from the competitive forces of marketplace economics.

In recent years, for reasons too complex to analyze here, the special nature of health care has been challenged. Both government and the private sector have increasingly come to view it as a commodity to be managed like any other product intended to generate a profit. In the past, the service to patient and community that is the heart of health care was both a means and end**;** today that service is more often viewed as a means to the end of a positive return on investment. In more developed nations, this movement has been partially responsible for an increased rationing of access based on economic status

as well as for a retreat of government support. In underdeveloped parts of the world, it has enhanced already existing injustices. It is in this economic jungle of conflicting and shifting pressures that we continue the healing mission of Jesus, knowing our call cannot be defined by economic or political theory.

AISAC Programmatic Meeting

How are we to respond to these and other challenges? This question leads us to the four themes of the AISAC programmatic meeting. After extended reflection, the federation's continental delegates have proposed four areas of reflection that could well serve as the basis for national, regional, and international activity.

Catholic Mission and Identity. First, in light of these three challenges and others, how can we better sustain the mission and identity of Catholic health care institutions? When external pressures are so strong, how do we, for example, ensure that the interior life of our institutions really reflects a culture of life? Our witness is not just about what we avoid but**,** more important, about what we actively promote. For example, if our patients do not experience our commitment to life in the way they and their families are treated, then ours is a hollow witness. Archbishop Lozano regularly reminds us that ours is a work of charity, not of benevolence. How do we ensure that *amor Christi* is the soul of every institution?

Leadership. Second, given the increasing specialization and expertise needed to lead health care, on one hand, and the reduction of the number of religious women and men available to serve in and lead Catholic health care, on the other, how do we ensure that there will be for the future faith-filled leaders who are deeply committed to the Church and its teaching? How do we, without the advantage of the years of formation associated with religious and priestly life, provide the initial and ongoing training of today's and tomorrow's lay leaders?

Ecclesial Structures. Third, what are the ecclesial structures that will ground Catholic health care institutions as true works of the Church if and when those institutions are no longer identified with a religious community? The revised Code of Canon Law offers several opportunities. Have we adequately explored them? Are there other ecclesial options we ought to explore? Critical to these discussions is the fact that Catholic health care cannot be a work of the church carried on in the name of the church unless it is formally tied to the pastoral ministry of the Pope and the bishops. As some aspects of the mission of health care are increasingly the responsibility of the *Christi fidelis,* how do we ensure this essential connection?

Justice. Finally, how do we work in pursuit of justice in the delivery of health care as a social good nationally and internationally? There is no more powerful witness for the cause of justice than the Holy Father and the Apostolic See. But the work of justice is an essential component of all ecclesial life. For those of us in Catholic health care, it is not enough just to provide care for those who are marginalized. We also are compelled to make sure there is room at the table of health care for all God's children.

Solidarity in Communio. Although the future of AISAC is yet to be written, I am confident it will not be written well unless those of us who are gifted with the opportunity to serve in Catholic health care make this motto our own: "solidarity *in communio."* The Holy Father has taught us well about the "communion" that is the Church. Catholic health care is an essential aspect of the inner and exterior life of that *communio.* Although ultimately the strength of that *communio* is the Holy Spirit, its human bonds flow from a spirit of solidarity. Unfortunately, at times, Catholic health care seems to have adopted what in the United States we would describe as a "lone ranger" mentality. Because we are so aware of the immediate needs of those we serve**,** or of the distinctive charism of the religious community of which we are a part, we tend to think and act as if our apostolic work or our religious community were the center of all reality. Consequently, it can be difficult to find the time or the motivation to pursue effective ecclesial collaboration.

Attending a conference such as this should remind us of the inadequacy of such a perspective, at the practical level, if not at the theological level. Neither the challenges nor the opportunities we face will be met successfully by individual efforts. Nor can the more successful **(**in worldly terms**)** institutions ignore their responsibility to assist those that are struggling as well as to learn from their successes. By pursuing a path of "solidarity *in communio***,**" we will be able to achieve more than others would think possible. If we pursue true solidarity within Catholic health care, the entire world will experience – in a new way – the healing touch of Jesus.

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Notes

[1] JOHN PAUL II, "Address to the Catholic Healthcare Ministry," *Health Progress,* November, 1987, pp. 10-17.

[2] JAVIER LOZANO BARRAGAN, "Introduction," *Dolentium Hominum: Church and Health in the World,* n.46 p. 10, Vatican City, 2001,.

[3] JOHN XXIII, *Pacem in Terris,* 1963, para. 11.

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ANGELO BRUSCO

5. Improving the Catholic Religious Aspect of Hospitals

Introduction

A lion opened his jaws under the nose of a sheep and asked the sheep if she found his breath bad. The sheep answered: "Yes". '"Stupid", answered the lion and bit off her head with a powerful bite. Then he asked a wolf the same question. "No", answered the wolf. "Flatterer", replied the lion, and tore him to pieces. Then the lion went to a fox and asked him the same question. "To tell the truth, Sire", answered the fox, "I have such a bad cold that really I can't smell the smell…" This anecdote seems to me to well illustrate the position of those who are asked to point out directions for the achievement of growth to a person, to a group or to an institution. Indeed, what answer should be given to a question such as the following: 'Do Catholic health care institutions really match their purpose of being 'a gift of God, a 'sign' of His care' and constitute a 'response of fidelity to Christ who, in the specific commandment to evangelise and heal the sick given to his disciples, makes the whole Church share in his evangelising mission'?[1] Should we provide the answer of the sheep, the wolf or the fox?

The best position perhaps lies in capturing in one answer all three, affirming that as is the case with all sectors of living and acting, in that of Catholic health care institutions, as well, the Church, both in the past and today, is both a saint and a sinner. A *saint* because she has known how to reveal the merciful face of Christ through the witness of so many people who, working in these health care institutions, have achieved the perfection of charity and have made a significant contribution to the promotion of health. A *sinner* because often the communication of the redemptive love of the Lord has been slowed down and hindered by many obstacles generated by selfishness, a narrowness of vision, resistance to change, low levels of religious fervour, and the influence of the cultural context of which they necessarily form a part.

This is understandable when one thinks that a Catholic health care institution is not extraneous to the vast world of health and health care, and is thus susceptible to being influenced in a negative way by the principles and the models of behaviour that reign in that context. The world of health and health care which has been formed in recent decades tends to be:

– A *secularised* world, that is to say dominated by an awareness of its autonomy as regards the sacred and by the development of a series of forms of knowledge and technology directed towards meeting the problems raised by mankind in that area of human life made up of living, suffering, and dying. The question about the meaning of health and illness has moved from the sphere of religion to the sphere of technology; mystery has been reduced to a *problem*.[2]

– A world *in search of humanity*. The humanisation of medicine and care for the sick is one of the problems that most worries the world of health and health care. Indeed, the advance of science and technology is not always matched by an equally positive evolution in the human quality of health care.

– A world where *technical logic and ethical logic* are in contrast, giving rise to serious conflicts.

– A world *full of contradictions*, where wonderful altruistic impulses live side by side with strong feelings of indifference.

If Catholic health care institutions are subject to the often negative influences of the world of health and health care of which they form a part, this does not mean that they must necessarily be their victims. On the contrary: they are called upon to be agents of a counter-culture by offering a valid contribution to caring for the sick and the promotion of health and by proposing new ways of approaching suffering and those who suffer based upon authentic humanity and the Gospel.[3]

A Clear Identity

In order to achieve this goal, Catholic hospitals must find their own identity. If we look at history we realise that the question of the identity of Catholic health care institutions has emerged periodically within the framework of the ecclesial community. In some epochs this has taken place in a climate of serene security, in others this question has been lived out in a way marked by conflict and has generated major disturbances.

One can well understand this if one thinks of what happens at a personal level. Each of us during the process of growth slowly puts together the various pieces of ourselves until we form a more or less satisfying self-image. This image, however, during the course of our lives will be continuously put to the test by the arrival of new situations. An illness, the passing of years, an interior search…can shake or cloud our self-perception, creating an impression of insecurity and dismay, whose consequences can be either a painful dissipation of identity or a richer reassembling of our identity.

The often keenly felt debates

that have arisen have helped to deepen reflection on Catholic health care institutions.

Various initiatives have been taken by Popes, bishops and Church bodies. From these it appears that whereas the progressive secularisation of health care institutions has freed the Church from the task of providing back-up support, it has not deprived her either of the right or the wish to be involved in taking care of sick people through her own structures. To employ a phrase used by Paul VI, spoken shortly after Vatican Council II, the Christian institutions created in the educational, cultural, charitable and social field 'remain indispensable for the radiation of the Gospel'.[4]

This concept was repeated by a recent Italian Church document,[5] in which it is stated that 'Catholic health care institutions are a specific modality by which the ecclesial community puts into practice the mandate to 'heal the sick'. For this reason, they should be seen not only as useful but also as necessary to the mission of the Church, providing consistency and continuity to the charitable action and the human promotion of the Christian community'.[6]

Although they can have a social value, they 'first and foremost have a religious and prophetic value because they offer themselves as a fact of salvation: the expression of the freely-given love of God who looks for man'.[7] It follows from this that Catholic health care institutions 'are never for the Church a matter of providing back-up support',[8] even though they can be such for the state. Their reason for existing, in fact, lies in being original expressions of God's love for man.

Keeping the Quality of the Religious Aspect at a High Level

The upholding of the legitimacy of Catholic health care institutions and a clarification of their identity would have little efficacy if such initiatives were not accompanied by a commitment to keep such institutions up to the level of their mission by constantly improving them.

Amongst the dimensions in which such an improvement should be implemented, the religious dimension occupies a very special place. Although it is not separate from the other aspects of Catholic health care institutions – the health care, economic and administrative aspects – it is, nonetheless, distinct from them and should be understood not in a general sense but in terms of its specific character, which it derives from the special context in which it is realised.

Hospitals, in fact, including Catholic hospitals, are the place where the sick person could respond to those who invite him to praise the Lord with the words of the psalm: 'How can I sing the praises of the Lord in a foreign land?' (Psalm 137:4). During the exile of illness, when one's fundamental certainties are severely put to the test and the meaning of personal identity grows weaker, it is not easy to convert one's own experience of pain into a place of celebration. It follows from this that he who offers the sick person the possibility of being touched by the words and the actions of merciful Christ must be aware that he is moving in a territory full of difficulties, without forgetting, at the same time, that where there seems to be arid silence there can in fact echo, through the healing experience of God, the serene notes of hope, and the opportunity for salvation can also present itself.

An Instrument of Salvation

The religious dimension of Catholic hospitals is primarily expressed in evangelisation. Being *works of the Church*, Catholic health care institutions are called to take part in her evangelising mission, and to be, therefore, authentic instruments through which the Gospel is proclaimed.

It is important to observe that the term 'evangelisation' is employed by the documents issued by and after Vatican Council II with a notable variety of meanings, oscillating between a restricted meaning limited to the sphere of service of the Word or the first proclaiming of the Word, and a broader meaning which is not limited to an aspect of the action of the Church, but includes the whole of her mission.

Evangelisation expresses in the preaching of the Word, actuates in the sacraments and bears witness to in life, that salvation that Jesus Christ, who died and rose again, communicates to men.[9]

Adhering to this meaning of the term 'evangelisation', we can state that Catholic health care institutions are called to proclaim the Good News by becoming *healing* communities, 'an effective sign (sacrament) of an overall salvation that the Lord works through the power of his Spirit of healing' [10]

There are very many ways in which Catholic hospitals can carry out their task of evangelisation.

Merciful Charity

The first such way is admirably illustrated by the figure of the *Good Samaritan*. Three groups of people drew near to the man who was coming down to Jericho from Jerusalem. First of all there were the thieves. Perhaps with words, and certainly with their behaviour, they said to him: " what you have is ours". This is the approach of violence, of abuse, of blackmail and of manipulation. Then there arrive the priest and the Levite. The message that they send to the wounded man is the following: "what is ours is ours". This message expresses indifference, closure within one's own world, and attachment to prescribed customs that prevent one from leaving one's own world. Finally, there is the Samaritan, who is a representative of a third category of people. His way of being and of doing things is expressed in the following phrase: "what I have is yours". This is the approach of altruism which, although it is present in every form of altruism, finds its highest expression in Christian charity.

That the approach expressed by the Good Samaritan is one of evangelisation is explained in a clear and meaningful way by a passage from the apostolic exhortation *Evangelii Nuntiandi*, paraphrased in the following way by one authority: 'when the actions of concern are informed with charity,

translated into generous dedication, a warm drawing near, careful sensitivity, humble and freely-given presence, they have a strong internal charge that transcends them: they raise irresistible questions (*EN*, 21), they expand the spaces of comprehension and shared understanding, they constitute a kind of platform leading on to further achievements, they open the hearts and minds of men to new horizons, they become a silent but very strong and effective proclamation of the Good News, and they are the first form of evangelisation'.[11]

It follows from this that those who work in Catholic health care institutions can engage in a salvific mission through their professional or voluntary activity. In-

deed, in practicing their profession they carry out their salvific mission without having to add any further words about Christ or religion. If this is the case, then that word as well can be pronounced, without, however, forgetting that their healing action is in itself salvific because their specific way of evangelising does not take place through the pathway of the word but through that of the healing action. Their evangelising action takes place not through 'your heard it' but through 'you saw it' (Lk 7:22).

From this it follows that offering one's own contribution to taking care of sick people and the promotion of health does not only open the door to evangelisation but is already in itself evangelising activity. The actions carried out to contribute with one's own professional skill to a human improvement of the atmosphere of Catholic health care institutions in order to defend the rights of sick people and to improve the relationships between the staff and the patients are an integral part of the apostolic mission of Catholic health care institutions. These actions, in fact, proclaim that man, even in a condition of mental and physical illness, conserves his value as a son of God and deserves to be treated as a person and helped to recover his *health* in the overall sense of the term.

Is the ecclesial community sufficiently conscious of this evangelising dimension to Catholic health care institutions? A careful analysis of the situation leads one to think that so many forms of neglect, so many attitudes of renunciation on the part of Catholic hospitals, so many drops in enthusiasm, are the result of an inadequate awareness of the nexus that exists between service provided to sick people and evangelisation.

Is the phenomenon of people appreciating the services offered by the Church without grasping the roots from which they come not, perhaps, something that is rather widespread? People should not only take services from the Church: they should also gain reasons for living. This implies, for example, that the socio-health care services offered by the ecclesial community should not be directed only towards the achievement of practical objectives but should be also directed towards changing a mentality about what power, money, health, suffering, life, death, sociality and so forth are.

As Cardinal Martini has stated: 'Today more than ever before the charity of the Church must demonstrate something that is unique, original, irreducible to all the works of charity, something that is beyond, mystery, something that is not contained in the efforts of the programmes of civil society. It is precisely because it comes from mystery and stewards difference that it is able to confer upon human programmes direction, horizons, reserves of energy and critical observations, where this is necessary'. If works of charity are not evangelised, that is to say not made authentic by faith, there is the risk that we will have a socially 'bustling Church' which tends to become in the world of health and health care a 'figure now parallel, now in competition with, now living with, other forces'.

The presence and the effect of this evangelising movement help us to read the situation of health care institutions not only from the economic and socio-psychological point of view but also from a theological-spiritual approach. This means, foe example, that the negative aspects that characterise an institution are not only seen as the result of external factors, such as political and economic interests, the excessive bureaucratisation of the health system, inadequate administrative efficiency, conflicts as regards work contracts, the deterioration in the scale of values which makes it harder to see the patient as a person and so forth, but also as a consequence of sin, with the conclusion that at the roots of every reform a conversion of hearts is needed even before a change in structures'.[12]

From Health to Salvation

Seen from this point of view, care for the sick becomes a place where truly human and thus overall health is promoted, which becomes transformed into an open and nostalgic sign of the 'salvation constituted of an existence that is successful in its wholeness and fullness', a gift of God.[13] Indeed, the alliance established with the sick person through care that is competent from both a human and a technical point of view, speaks 'within the sign of the alliance with God, whose presence, whatever happens, does not disappear'.[14] Healing and health are not seen as the ultimate and global reality of the destiny of man but are placed in the process of salvation because every authentic human liberation, partial or sectorial, is a moment, a proclaiming sign, a demonstration of this deep liberation that Christ achieved in his paschal mystery.

This also applies in the case of

that movement towards absolute well-being that is proposed by one school of contemporary medicine, namely the so-called *medicine of desires*. This movement, in fact, conceals that yearning for salvation that finds its satisfaction in the words of Jesus: 'I have come so that they may have life, and have it more abundantly' (Jn 10:10). The prospect of salvation, understood as the establishment of a relationship of love between God and man, does not eliminate the movement towards full health and well-being, but directs its path on the basis of values that are rooted in the real condition of man and the project that God has for the human person.

Interventions

How can we reawaken in the person who wishes for healing and health that yearning for *salvation* which is present in the heart of every individual? The answer to this question leads us to identify the other modalities by which Catholic hospitals can exercise their evangelising mission and thus improve their religious dimension: the Word, the sacraments, and service.

The Word

A word of God has already been spoken on everything that takes place in a hospital: medical science, health care practice, suffering, interpersonal relationships. A word revealed in a special way through Holy Scripture, the Magisterium of the Church, theology…This word of God needs to be used so that it can:

Act to vivify the philosophy of Catholic hospitals, showing that everything that takes place within a health care institution corresponds to a design in which is reflected the wish to communicate the healing and redemptive lone of Christ to all those who suffer and their families.

Nourish the process of the relationship of help with patients and their family relatives. In the accompanying of the sick there must transpire the wish that 'sick people who are believers live out their lives in Jesus Christ and achieve the holiness to which they are called. This means helping them in the light of the Gospel and in ways suited to our times to find an answer to the persistent questions about the meaning of their present and future lives and their mutual relationship, on the meaning of pain, evil and death, to be near to them especially during moments of darkness and vulnerability, so as to become for them a sign of hope. In the exercise of this particular ministry of accompanying, dialogue must be human, fraternal, open to everyone and must correspond to the needs and the characteristics of sick people.[15]

Co-operate in the drawing up of ethical principles which should not only to be applied to the questions and issues connected with the beginning or the end of life or the use of new technologies, but which should also be introduced into the whole of the tissue of the action of a health care institution in order to govern – in a way that conforms to justice and charity – the work relationships, the interpersonal relationships, the choice of means and instruments, and the conditions for gaining access to that institution.

The Sacraments

Another way by which Catholic hospitals evangelise is through sacraments. 'To be Christian is not to adhere to an idea but to adhere to a person. Through the liturgical celebrations of the Church, the Lord Jesus, who was crucified and rose again, comes to us personally according to our historical condition, He communicates to us the paschal gift of his Spirit and new life, which sanctifies our existence in the various situations we experience, to the praise of God the Father'.[16]

When we refer to sacraments in the hospital context, that reference immediately goes to the sick, almost as though they were the only recipients of these 'actions' which manifest the totality and the fullness of the salvation given to us in the risen Christ and say that this salvation is underway today in our lives and in the situations that characterise human existence.

Within the context of a Catholic hospital, that concept should be left behind. In the celebration of the sacraments, in fact, the saving practice of Christ continues to be actuated: his liberating love for people in that context, his attention towards, and care for, the sick and the suffering, and his giving of hope and life to the full. It is from the sacraments that the strength is drawn to achieve an authentic realisation of the mission of Catholic hospitals.

This applies above all to the Eucharist. The service rendered to man through the role of a Catholic health care institution takes on its meaning and its style from the Eucharist; it finds in the Eucharist its source and also its guiding rule. It is no accident that Jesus closely connected service to the Eucharist (Jn 13:2-16): he asked his disciples to perpetuate in his memory both the *Lord's Supper* and the washing of the feet. In the celebration of the Eucharist the Christian encounters the Christ, the divine Samaritan of souls and bodies, the Crucified One, the highest expression of the love of God, the Risen One. From such an encounter, the Christian draws the capacity to make of his own existence, taking Christ as his example, a *pro-existence,* an authentic tale of the love of God.

The Sacraments and Service

The celebration of the sacraments – reconciliation, the Eucharist and the anointing of the sick – can adequately render tangible, reveal, proclaim and celebrate the healing encounter between Christ and the sick person only when the services provided by the health care institution to those who suffer are characterised by professional skill and warm humanity, and when the light of the word of God and theological reflection illuminate the sacramental signs, bringing out their deep meaning. If it is true that a sacrament acts *ex opere operato*, this does not remove the fact that the receiving of sacramental grace depends in a relevant way also on the approach of who administers the sacrament

and who receives it, and on the quality of the context in which the celebration takes place.

The symbolism of the anointing of the sick loses its wealth and its incisiveness if the environment in which the sacrament is celebrated is full of 'diabolical' elements, that is to say disintegrating elements. How can one affirm, proclaim and celebrate the present of the Lord, the divine healer of bodies and souls, in a context where the sick person is ignored, left alone, and not seen as an active subject? In these cases, the sacraments for the sick run the risk of becoming routine, matters of habit that in some cases can even be alienating. The light and the grace of the Lord

channelled by the anointing of the sick, although obeying divine freedom and free-giving, take on and transform every action intended to bring relief to the patient. The new Ritual states that 'all the attempts of science to prolong biological longevity and all the forms of care for the sick, whoever has them or uses them, can be seen as a preparation for receiving the Gospel and taking part in the ministry of Christ who comforts the sick' (n. 32). One authority has the same approach: 'The art of knowing how to give, of knowing how to serve, of listening, makes the sick see… that the sacraments are located in this movement of mercy that inspires those who work for him and sacrifice themselves… The action of he who draws near to the sick person is a symbol of an action which is greater and more total, an action that comes from God to envelop man and transform him'.

Is it not perhaps one of the tasks of the religious assistants to help staff and family relatives to see this continuity between the service that they provide and the supernatural therapeutic action effected by the sacrament?

What has been said also applies to the celebration of the sacraments. To celebrate means to identify the values present in an experience and to proclaim them, thanking the Lord. The values present in the experience undergone by a patient who receives the sacrament of the anointing of the sick are many in number: the presence of Christ who heals and saves; communitarian solidarity; the value of life at the very moment when it is threatened by evil.

So that these values can be made the subject of experience, the celebration of the anointing of the sick should bring them out and make them evident. This is not an easy task, above all else in the hospital context. But this is a task which should carried out with constancy and creativity, fostering those factors which, as a document of the Italian Bishops' Conference observes[17] and which has been quoted previously in this paper, 'helps to make the celebration of the sacraments in families, parishes and health care institutions meaningful: favourable environmental conditions, a serene relationship between the patients and those who treat them, the choice of appropriate liturgical texts and reflections suitable to the situation which is being experienced by the patient'.

From Theory to Practice

What has been pointed out above can have an effect on the improvement of the religious aspect of Catholic hospitals according to the extent to which suitable strategies are implemented.

– First of all, the religious dimension of the hospital should be a subject of attention on the part of those managing the hospital, and should not be confined to the entity providing pastoral service.

– The religious-pastoral service should not be limited to accompanying the sick – a role which is nonetheless very important – but should also have an effective impact on the philosophy and the programmes of the institution. To this end, both the quantitative and the qualitative aspects of that service should be strengthened.

– The creation of bodies involving communion also becomes important, bodies such as a mixed chaplaincy or the hospital pastoral council. All those lay ministries that are rooted in baptism should be made active.

– The importance of training. What has been argued hitherto in this paper cannot have positive consequences without an adequate investment in the training of the staff of Catholic health care institutions. Many people believe that it is specifically because of the inadequacy of this training role that various questions and issues such as the relationship between religious and the members of the laity, the humanisation of health care contexts, and the culture of health, encounter difficulty in achieving effective results at an operational level. It is thus necessary to draw up valid training programmes that embrace both the technical areas

and the relational areas, and the areas of values derived from the charism of merciful charity, the gift of God to His Church. What often arises in informing and training staff will turn out to be of use to health care institutions, providing them with freshness and creativity.

– Given that many Catholic health care institutions work in territories where the local population adheres to non-Christian religions, it becomes necessary to take into account the cultures in which the Gospel-based message is transmitted both through the word and through charitable activity.

Conclusion

The attempt to improve the religious aspect of Catholic hospitals cannot but have a positive effect both on the quality of care for the sick and on the quality of management of hospitals. It will co-operate in a decisive way in transforming hospitals into a home where a pound of precious oil – merciful charity – is poured at the feet of Jesus present in the suffering, so that the whole of the home, that is to say the Church and society, is filled with its scent.

Rev. ANGELO BRUSCO, M.I.
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Notes

[1] Ufficio Nazionale della CEI per la Pastorale della Sanità, *Le istituzioni sanitarie cattoliche in Italia. Identità e ruolo* (EDB, Bologna, 2000), n. 15.

[2] A. BRUSCO, *Umanità per gli ospedali* (Salcom, Varese, 1983), p. 78.

[3] *PSCI*, 12.

[4] '*Message à la France*', 31 May 1964. Vatican Council II repeatedly affirmed that 'works of charity are the duty and inalienable right of the Church' (*AA* n. 8), making clear that 'where this is necessary, according to the circumstances of time and place, she can, indeed she must, generate works intended to serve everyone, but especially those most in need' (*GS* n. 42).

[5] Consulta Nazionale per la Pastorale della Salute, *La Pastorale della salute nella Chiesa italiana* (PSCI) (Rome, 1989).

[6] *Ibidem*, n. 54.

[7] Vescovi dell'Emilia-Romagna, *Impegno comunitario a servizio dei fratelli*, 24 December 1973, n. 12.

[8] G. GIROLLA, 'Carità, strutture e organizzazioni di servizio sul territorio', in AAVV, *Diaconia della carità nella pastorale della Chiesa locale* (Gregoriana, Padua, 1986). The words of John Paul II should be read in this sense: 'Charitable works are not mere back-up support for temporary failings of the state, nor do they amount to competition in relation to the state. They are an original and creative expression of the fertility of Christian love' ('Discorso a Loreto', 11 April 1985).

[9] Cf. B. PAPA, 'Perché la comunità cristiana deve evangelizzare a svolgere opera di promozione umana nel mondo socio-sanitario', *Anime e Corpi* 94 (1981), 145-161; A. Brusco, *Umanità per gli ospedali* (Salcom, Varese, 1983), pp. 46-49.

[10] L. SANDRIN, 'Nuova evangelizzazione per il terzo millennio e istituzioni sanitarie cattoliche', *Dolentium Hominum* 3 (1999), p. 83.

[11] F. Alvarez, 'La nuova evangelizzazione nel mondo della salute. Prospettive teologico-pastorali', in AAVV, La vita consacrata nel mondo della salute', *Quaderni del "Camillianum"* n. 4 (1993), p. 54.

[12] Ufficio Nazionale della CEI per la Pastorale della Sanità, *Le Istituzioni sanitarie cattoliche in Italia. Identità e ruolo* (EDB, Bologna, 2000).

[13] Cf. L. SANDRIN, *op. cit.*, p. 83.

[14] L. SANDRIN, *op. cit.*, pp. 80-85.

[15] Cf. *Costituzione dei Ministri degli Infermi* (Rome, 1988), n.47

[16] CEI, *La Verità vi farà liberi* (Ed. Vaticana, Rome, 1995), p. 304, n. 633.

[17] *La pastorale della salute*, n. 21.