DOLENTIUM HOMINUM

N. 53 – Year XVIII – No. 2, 2003

JOURNAL OF THE PONTIFICAL COUNCIL
FOR HEALTH PASTORAL CARE

Editorial and Business Offices: PONTIFICAL COUNCIL FOR HEALTH PASTORAL CARE
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Published three times a year. Subscription rate: 32 € for Europe, 30 $ for countries outside Europe, postage included

Printed by Editrice VELAR, Gorle (BG)

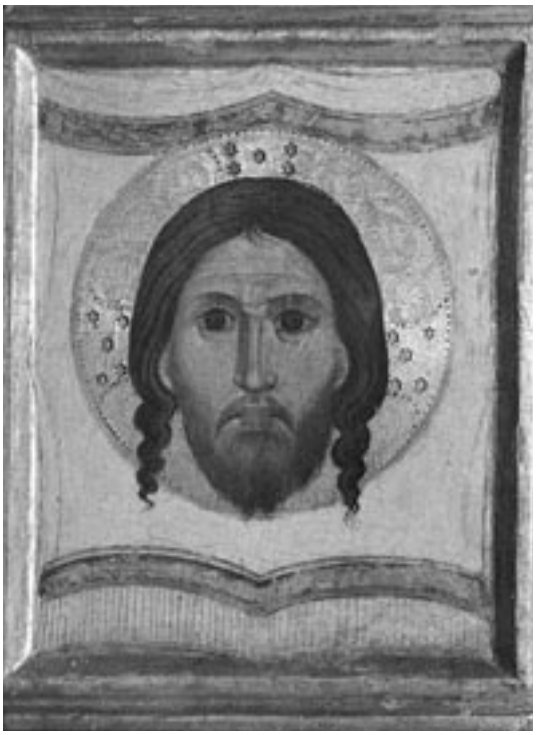
Cover: Glass window Rev. Costantino Ruggeri

Spedizione in a.p. - art. 2, comma 20/c, legge 662/96 - Roma

Contents

The illustrations in this edition are taken from the book
'Veronica il mistero del Volto
itinerari iconografici memoria e rappresentazione'
by Tiziana Maria Di Blasio,
Edited by Città Nuova, Rome, 2000

XI World Day of the Sick



National Shrine of the Immaculate Conception, Washington, D.C. United States of America 11 February 2003

Letter of the Holy Father

ON 25 JANUARY 2003 THE HOLY FATHER JOHN PAUL II APPOINTED H.E. MSGR. JAVIER LOZANO BARRAGÁN HIS SPECIAL ENVOY TO THE CELEBRATION OF THE ELEVENTH WORLD DAY OF THE SICK

To Our Venerable Brother
JAVIER LOZANO BARRAGÁN
President of the Pontifical Council for Health Pastoral Care

We certainly have before our eyes those most gentle and completely comforting words of Christ: 'Come to me, all you who labor and are overburdened, and I will give you rest' (Mt 11: 28).

We are convinced that in these words people who are tried in various ways by the difficulties of life can find a celestial strength for their hearts and a desired relief for their suffering.

But our thoughts go spontaneously first and foremost to the sick people of the whole world. With the affection and love of Jesus of Nazareth we feel compassion for them, as it is right that all men of good will and even higher benevolence should do.

We are already thinking with very great emotion of the Eleventh World Day of the Sick, which will be solemnly celebrated in Washington on the next feast of Our Lady of Lourdes, namely February 11.

We have already sent Our greetings and our exhortation to the Assembly. However, we wish not only that someone should represent our person there openly and publicly but also that he should bear witness to our very close union with the infirm and the sick of this world of ours.

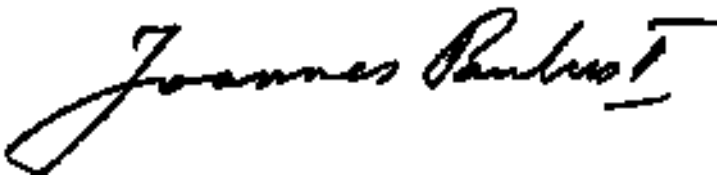
Venerable Brother, you yourself will be that person, precisely because by our will you head the Pontifical Council for Health Pastoral Care.

By this letter, having trust in your work, we appoint you OUR SPECIAL ENVOY to that meeting animated by the greatest solicitude, participating at the same time with the feelings of suffering Christ in the condition of so many sick people.

For us, who will truly share in and follow what will be deliberated and proposed at that distinguished meeting, You, Venerable Brother, will be present, you will read our special message, and on this occasion you will also confirm our concern for, and our union with, the infirm and the sick; you will convey our Apostolic Blessing which is with great love imparted to all those present.

We in the meantime accompany you with our prayers in this very important and valuable mission of yours, and we are already truly happy because of your zeal.

From the Vatican Palaces, 25 January 2003,
in the twenty-fifth year of our Pontificate



Account of the Eleventh World Day of the Sick

The Eleventh World day of the Sick was solemnly celebrated in the Basilica of the National Shrine of the Immaculate Conception in Washington, the capital of the District of Colombia and the capital of the United States of America. Promoted by the Pontifical Council for Health Pastoral Care, in collaboration with the Bishops of the United States of America, the Eleventh World Day of the Sick had as its principal theme: 'the life of solidarity: the vocation of pastoral care in health in America'.

In his special message sent by the Holy Father for this occasion, the Pope hoped and wished that with the celebration in Washington 'the Gospel of life and love will sound out with vigour especially in America where more than a half of all Catholics live'. The Pope entrusted the unfolding and success of the celebration to Our Lady of Guadalupe, the patron saint of the continent of America, venerated in one of the chapels of the Basilica of the Immaculate Conception as well.

The Holy Father was represented at the Eleventh World Day of the Sick by the pontifical mission, which was made up of his Special Envoy, H.E. Msgr. Javier Lozano Barragán, the President of the Pontifical Council for Health Pastoral Care, accompanied by Msgr. Michael J. Bransfield, Rector of the Basilica of the National Shrine of the Immaculate Conception, and Rev. Michael Place, the Co-ordinator of the Catholic Health Association of the United States of America. The organised group of our dicastery which went to Washington was made up, in addition to the President of the Pontifical Council, of twenty-seven people, amongst whom the Bishop-Secretary, H.E. Msgr José Luis Redrado OH, certain Officials of the dicastery, and collaborators who are priests, religious or members of the laity and involved in pastoral care in health in various countries of the world.

PREPARATIONS PRIOR TO THE ELEVENTH WORLD DAY OF THE SICK

Announced and convoked by the Message of the Holy Father, the celebration of the Eleventh World Day of the Sick was the subject of numerous preparatory initiatives. The Pontifical Council for Health Pastoral Care was responsible for the dissemination of the Pope's Message through the mass media. Vatican Radio made live broadcasts of the principal initiatives connected with the celebration. A poster for the World Day, as well as various other support materials, were prepared by the Episcopal Commission for Pastoral Care in Health of the United States of America. In addition, in September 2002, the President of the dicastery, H.E. Msgr. Javier Lozano Barragán, went to Washington to encourage the organisers and to follow from close at hand the work on the preparations for this important international event.

THE CELEBRATION OF THE ELEVENTH WORLD DAY OF THE SICK

As has been the case every year, the celebration of the World Day of the Sick in 2003 had three main characteristics: liturgy, theology and pastoral care.

The Moments of Prayer

1. The Inaugural Holy Mass, Sunday, 9 February 2003

At 9 am, on Sunday 9 February, the President of the United States Conference of Catholic Bishops, H.E. Msgr. Wilton D. Gregory, the Bishop of Belleville, officiated over the inaugural solemn concelebration of the Eucharist of the Eleventh World Day of the Sick in the Basilica of the National Shrine of the Immaculate Conception. With the President of the American Bishops, those also celebrating the Eucharist included Cardinal Theodore McCarrick, the Archbishop of Washington; Cardinal Miguel Obando Bravo, the Archbishop of Managua (Nicaragua); Cardinal Oscar Andrés Rodriguez Maradiaga, the Archbishop of Tegucigalpa (the Honduras); Archbishop Javier Lozano Barragán; Bishop José Redrado Marchite OH; Paul S. Loverde, the Bishop of Arlington; the President of Pastoral Care in Health of the United States of America, Robert Morlino, the Bishop of Helena; other bishops from the United States of America, Canada, Mexico, Santa Domingo, Haiti, Porto Rico, Salvador; and priests and religious who work in hospitals, clinics, and nursing and rest homes.

A very evocative image was provided by the Archbishop Emeritus of Washington, Cardinal James Aloysius Hickey, an invalid in a wheelchair, who celebrated Holy Mass at the altar together with the members of the mission of the Pontifical Council for Health Pastoral Care.

Cardinal McCarrick, after greeting the concelebrants and the whole of the assembly, thanked the Holy Father for choosing the Archdiocese of Washington as the location for the celebration of the Eleventh World Day of the Sick.

During his homily, the Bishop of Belleville, H.E. Msgr. Wilton Gregory, the President of the United States Conference of Catholic Bishops, after welcoming all the participants, dwelt upon the subject of the substantial mission of the Church which, following

Christ, must dedicate herself to taking care of the sick. 'The celebration of the Eucharist is a special occasion to praise the Lord who 'takes care of' every man and every woman. We proclaim the presence of Christ amongst us, an authentic sign of his design of love'. This prelate then outlined the three urgent requirements that spring from the words of the Gospel regarding Christ 'he healed many that were afflicted by various illnesses', namely the vision of Christ the Physician Healer; the need for those who suffer to feel that they are linked to Christ; and the ministry of the Church in relation to the world of the sick and the suffering. 'The actions and miracles of Christ sought not only to heal man in a physical sense but also to touch him internally and to convert him. The salvific healings of Christ were directed towards the advent of the Kingdom of God'.

In conclusion, Bishop Wilton Gregory emphasised that the Eucharist is the soul of pastoral care in health and that service and the proclamation of the Word of God together heal the wounds of every suffering person.

At the end of the solemn concelebration of the Eucharist, Rev. Michael Place, made very happy by the choral singing of the joyful assembly, read out, amidst applause, the Message of John Paul II for this World Day of the Sick, which had been opened – as the Pope had observed a few hours previously at the Sunday Angelus – in the Marian Shrine of the Immaculate Conception 'at a time of international concern'.

Everyone present implored the Virgin Mother for the great and inestimable gift of peace.

2. The Solemn Concelebration of the Eucharist of 11 February and the Sacrament of the Anointing of the Sick

Five thousand people took part in the solemn concelebration of the Eucharist in liturgical memory of the Blessed Virgin of Lourdes which took place in the Basilica of the National Shrine of the Immaculate Conception. The Special Envoy of the Pope, Archbishop Javier Lozano Barragán, officiated over the liturgy, and he was joined in this concelebration by Cardinal Theodore McCarrick, the Archbishop of Washington; Cardinal James Hickey, the Archbishop Emeritus of Washington; Cardinal Miguel Obando Bravo, the Archbishop of Managua (Nicaragua); Cardinal Oscar Andrés Rodriguez Maradiaga, the Archbishop of Tegucigalpa (the Honduras), and twenty-two Archbishops and Bishops from dioceses of the United States of America, Canada, Mexico, Santo Domingo, Porto Rico and Haiti, as well as about a hundred priests.

At the opening of the liturgy, Rev. Michael Place, the co-ordinator of the Catholic Health Association of the United States of America, read out the letter appointing Archbishop Javier Lozano Barragán the Special Envoy of the Pope to the celebrations of the Eleventh World Day of the Sick.

During his homily, the President of the Pontifical Council for Health Pastoral Care thanked the Holy Father for appointing him as his Special Envoy and greeted those present. He then dwelt upon the following observations: pastoral care in health involves leading Christians to defeat death through the conversion of death into the resurrection of Christ. Such pastoral care must involve, therefore, emphasising the virtue of hope. This action must characterise Catholic health care centres, which should also remember that health is a tension towards harmony. Pastoral care in health is a path by which to acquire such harmony. For this reason, the guiding rule of such pastoral care is the construction of the person: 'what builds up man is good; what destroys him is bad'. Such is the criterion of medicine and biogenetics as well. The Blessed Virgin Mary, the immaculate conception to which this shrine is dedicated, is the model of harmony, of the construction of man, and thus of health. To her the Special Envoy of the Holy Father then entrusted the Eleventh World Day of the Sick.

Subsequently, the sacrament of the anointing of the sick was administered to five hundred sick people at the foot of the altar who were accompanied by many women religious and volunteers. This sacrament was administered, as well as by the Special Envoy of the Holy Father, Archbishop Javier Lozano Barragán, by Cardinal McCarrick, Cardinal Miguel Obando Bravo, Cardinal Oscar Andrés Rodriguez Maradiaga, and other bishops. The first person to be anointed by holy oil was the infirm Cardinal James Hickey, who was sitting next to the altar.

Before finishing the solemn and august liturgy, the Cardinal-Archbishop McCarrick thanked Archbishop Javier Lozano Barragán, the Special Envoy of the Pope, the Cardinals, the Archbishops and the bishops, the priests and all the sick people present, for all having celebrated together 'this day of grace'.

The Cardinal then expressed his deep gratitude to the Holy Father for this gesture of affection and favour towards the Church in Washington. 'May this moment of grace celebrated in faith and praise', declared Cardinal McCarrick, 'heal America of all her maladies'.

The liturgy ended with the solemn blessing, after which the singing of 'Ave Maria' of Lourdes took place. On the faces of the sick people present in the Basilica could be encountered the truth of the words of Jesus which the deacon had proclaimed during the Holy Mass: 'Come to me all you labour and are heavy laden, and I will give you rest… For my yoke is easy, and my burden is light' (Mt 11:28-30).

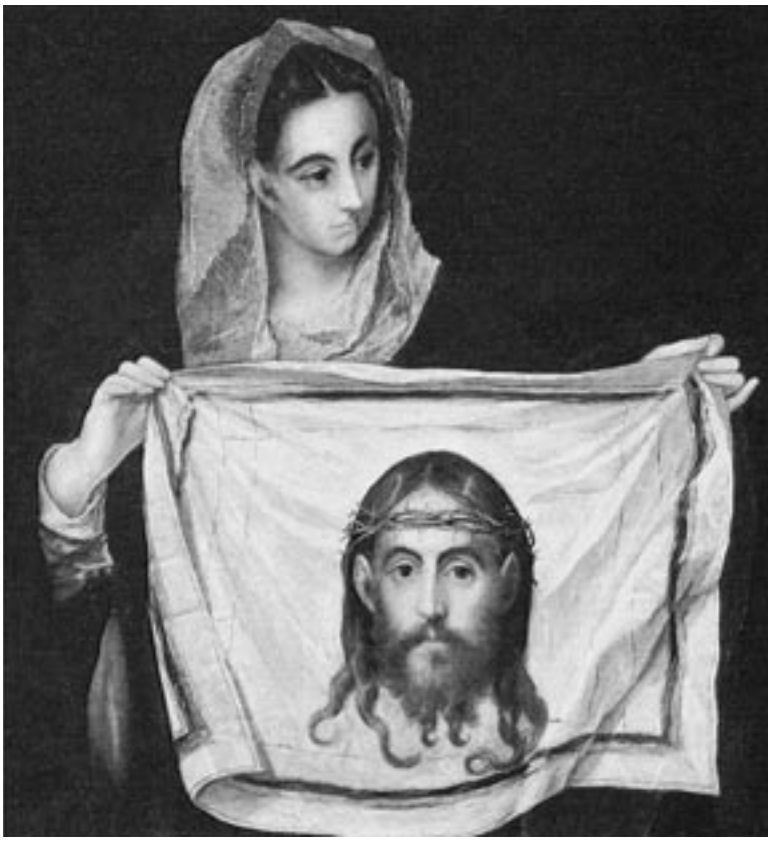
The Moments of Study

1. The Meeting of Bishops at the Headquarters of the United States Conference of Catholic Bishops

On Sunday, 9 February, in the modern headquarters of the United States Conference of Catholic Bishops, there took place the meeting of bishops who were delegates of the various Bishops' Conferences of

the American continent and those responsible for pastoral care in health within those conferences. Cardinal Theodore McCarrick welcomed those present and once again thanked the Holy Father and the President of the Pontifical Council for Health Pastoral Care for having chosen, for the first time, the United States of America as the place to celebrate the World Day of the Sick.

The round table of bishops was dedicated to the subject of pastoral care in health in America. At a more specific level, two subjects derived from the



slogan of the World Day of Health were considered: 'the path of solidarity: the perspective of pastoral care in health' and 'health care in America: an appeal to justice'.

An introduction to the proceedings was offered by Archbishop Javier Lozano Barragán who recalled the gospel bases of pastoral care in health, as well as explaining the contemporary situation to the Cardinals, the bishops of the United States of America and the bishops who had come from Canada, Mexico, Honduras, Nicaragua, Salvador, Santo Domingo, Haiti, and Porto Rico.

Then the President of the Pontifical Council for Health Pastoral Care dwelt upon three points: what is the situation of pastoral care in health in the world; what is pastoral care in health; and what should we do? Speaking about the contemporary situation of pastoral care in health, H.E. Msgr. Javier Lozano Barragán referred to the positive points and to the negative points; in discussing pastoral care in health he outlined what the Gospel proposed, what the Pope proposed, and lastly what our dicastery proposed; and in turning to the practical side of the question he referred to the challenges, the proposals and the answers to be encountered in the field of pastoral care in health.

After this speech by the President of the Pontifical Council for Health Pastoral Care, each representative of the various countries represented spoke about the situation of pastoral care in health in their own specific nations.

The situation in Bolivia, where the number of poor people and of marginalised people was on the increase and where a high level of infant mortality was to be found, was described by Dr. German Erico Loza Monroy Lawyar, the envoy of the Bishops' Conference of Bolivia.

Bishop James W. Wingle spoke on the Church and health care in Canada, and he drew attention to the large number of ethical problems, such as a weak political will in relation to the dramatic reality of abortion.

The President of the Bishops' Conference of the Dominican Republic, Bishop Ramón B. De la Rosa y Caprio, stressed the problem of the extreme poverty in which a quarter of the inhabitants of his country found themselves and the very high costs of medicines and drugs.

The Archbishop of San Salvador, Ferdinando Sáenz Lacalle, described the situation in Salvador where, in addition to the high cost of medicines and drugs, there was also a grave shortage of food and satisfactory nutrition.

The situation described by Cardinal Oscar Andrés Rodriguez Maradiaga, the Archbishop of Tegucigalpa in Honduras, was even more dramatic. The Cardinal emphasised that 79% of the population lived on a dollar a day and 49% of the population could not pay for urgent and necessary medicines and drugs.

Other countries of South America are in a similar state. This was confirmed by Cardinal Miguel Obando Bravo of Nicaragua and by Bishop Héctor Riviera of Porto Rico. Both these prelates, in full agreement with each other, spoke about the poverty of people in their countries, of the high cost of medicines and drugs, of the high cost of medical care and treatment, and of inadequate health services.

In conclusion, Bishop Robert C. Morlino, Bishop Joseph L. Charron and Bishop William Murphy, prelates who were responsible for pastoral care in health within the United States Conference of Catholic Bishops, illustrated the situation as it stood in their country: although on the one hand the situation of Catholic health care structures was good (634

Catholic hospitals and 1,359 long term services), on the other hand, there were the great risks provoked by secularisation and the 'new age' movement, which encouraged ethical relativism and the culture of death.

The debate brought out the following urgent needs in the field of pastoral care in health in the continent of America: to provide strong ethical responses, to construct new pastoral care in relation to evangelisation, and to 'care for' the world of pain and suffering with the same feelings of Christ and the spiritual motivations of the Church. In this context, a great deal of emphasis was placed on the need for closer co-operation between the Bishops' Conferences of the Americas. The word 'solidarity' emerged as a key concept of the meeting, and the phrase of John Paul II, 'the globalisation of solidarity', emerged as the sole plausible programme for the future of Catholic Americans.

2. The Day of Study at the Pope John Paul II Cultural Center

On Monday, 10 February, a day of study was held at the Pope John Paul II Cultural Center. The subjects that were discussed revolved around two principal questions: 'globalisation and Catholic health care in America: an appeal to justice' and 'the problems of bioethics and Catholic health care: an appeal to faithfulness'.

Opening the deliberations of the meeting, Bishop W. Gregory and Bishop R. Morlino placed emphasis on the urgent need for the protection of Christian values in Catholic hospitals and health care institutions.

Msgr. Ricard, the Bishop of Pensacola-Tallahassee in Florida and the President of the Foreign Affairs Committee of his Bishops' Conference, spoke about the health care situation in the United States of America within the context of globalisation.

These questions and issues were also addressed in two round tables. The first round table was dedicated to globalisation and Mr. Aedo and Mr. Baeza of Chile, the Canadian Jesuit Rev. Mercier, and the American religious Patricia Smith, were the participants. In examining the situation in North America and Latin America, the speakers agreed that globalisation should be guided and directed for the good of all men and not only for a part of the family of nations. The only possible way to escape from the tunnels and blind alleys that shut down the future of peoples was the globalisation of solidarity.

During the debate on questions and issues connected with bioethics, the Bishop of New Ulm in Minnesota, Msgr. John C. Nienstedt, was joined as a participant by such incontestable authorities as Kevin T. Fitzgerald, Edmund D. Pelligrino, M. Therese Lysanght, and the prelate Russel E. Smith.

The President of the Pontifical Council for Health Pastoral Care, Javier Lozano Barragán, addressed the subject of global ethics: the 'new paradigm' and open bioethics. In his introduction, the Archbishop spoke about globalisation, the framework of the 'new paradigm', and its authors. Archbishop Javier Lozano Barragán then dwelt upon three subjects: the 'new paradigm', open bioethics, and its applications. He made special reference to *in vitro* fertilisation, to cloning, to stem cells, to the manipulation of embryos, to organ transplants, to euthanasia, and to forms of pain killing treatment.

At the end of the proceedings of the Eleventh World Day of Health, Cardinal Theodore McCarrick officiated over the solemn concelebration of the Eucharist at the Pope John Paul II Cultural Center. 'Touch me, Lord, and I will be saved' – such was the theme of his reflection during his homily (based upon the Gospel According to St. Mark 5:53-56).

The Visit to the Sick

A visit to a hospital, that is to say to a health care centre, to meet sick people and patients, forms a part of the tradition of the celebrations of the World Day of the Sick. In Washington, this meeting took place at the Holy Cross Hospital of Sil-

ver Spring, Maryland, to which, on the morning of 11 February, the Special Envoy of the Holy Father, H.E. Msgr. Javier Lozano Barragán, paid a visit.

Accompanied by Rev. Michael Place, Archbishop Javier Lozano Barragán was welcomed by the President of the hospital, Dr. Kevin J. Sexton, and by the chaplains, by the religious, by the medical doctors, by the paramedics and by the nurses of this health care centre.

The Holy Cross Hospital is a hospital administered by the Sisters of the Holy Cross and the Sisters of Mercy. These two religious institutes united to form a 'single juridical person' in order to respond in a more effective way to the challenges of pastoral care in health. One of these challenges lies in the fact that forty-three million people in the United States of America do not have social insurance and 60% of these are cared for thanks to the funds of the Catholic Church.

A special problem encountered by the Holy Cross Hospital is that the patients cared for and treated in this hospital come from almost a hundred countries and thus speak a variety of languages. At times difficulties at the level of communication arise from this fact and good interpreters are thus required.

The pastoral care provided by the hospital is entrusted to three chaplains, who are priests, and their team is made up of sixteen people - religious and women members of the laity. H. E. Msgr. Javier Lozano Barragán encouraged these people to live, and make live, to the full the mission of a Catholic hospital, namely to preach life, to propose the pathway of the sacraments, and to preach Christ who died and rose again for all of us. 'In a multicultural context', declared the Archbishop, 'our identity cannot be betrayed or weakened. We must proclaim to everyone that Jesus Christ died and rose again for man. He is the real life that saves'.

The President of the Pontifical Council for Health Pastoral Care then asked the medical doctors and paramedics 'to harmonise technology and charity, to unite joy and pain, and to make people understand the gift of life and the meaning of death. May you rise to this great task'.

A very touching moment was the visit of the Special Envoy of the Holy Father to the ward for newly born children, babies who are in precarious situations of health. Thanks to the sophisticated instruments of high technology in this ward, at that time, amongst other things, a struggle was going on to defend the life of a baby weighing only four hundred grams who had been born during the fifth month of pregnancy.

Other Important Moments

1. The Reception at Georgetown University

Almost a hundred delegates and guests of the Eleventh World Day of Health met on Sunday, 9 February, at Georgetown University in Washington, one of the most prestigious and esteemed seats of learning in the United States of America. The Secretary of the Department of Health and Human Resources of the United States of America, Tommy G. Thompson, and the Mayor of Washington City, Mr. Anthony Williams, honoured the ceremony with their presence.

The Rector of Georgetown University, John J. Di Gioia, gave a warm welcome to those present. Secretary Thompson then spoke and in his speech, beginning with the Gospel commandment of love, made clear that he was ready to cooperate with the Catholic Church in the field of health and health care in the United States of America and the whole of the world, paying special attention to those most in need, the poor, and the vulnerable. After him, Mayor Williams expressed his gratitude at the fact that the city of Washington had been chosen for the celebration of the Eleventh World Day of the Sick. Rev. Place then spoke on behalf of the organisation committee and emphasised that care and treatment for sick people should be a priority for everyone because only in this way could one speak about real solidarity towards those who are in need in our world.

The evening at Georgetown University ended with a ceremony to award the medals of the Pontifical Council for Health Pastoral Care, medals by which Archbishop Javier Lozano Barragán rendered homage to Secretary Thompson, Mayor Williams, and Rector Di Gioia.

2. The Reception at the Apostolic Nuncio's Residence

On Monday evening, 10 February, the Cardinals, Archbishops and bishops who had taken part in the Eleventh World Day of the Sick, together with the group of the Pontifical Council for Health Pastoral Care and other authorities of the city of Washington, were invited to a reception at the Apostolic Nuncio's Residence. The official part of the meeting, which was marked by important speeches, was begun by Mayor Williams who expressed deeply-felt gratitude to the Pontifical Council for Health Pastoral Care, and in particular to its President, H.E. Msgr. Javier Lozano Barragán. By a special document handed over to the Special Envoy of the Pope, the mayor proclaimed 11 February 2003 the 'World Day of the Sick' in Washington.

Archbishop Javier Lozano Barragán then thanked the mayor for this very meaningful action and for the hospitality with which the city of Washington had welcomed this initiative and those taking part in this World Day.

At the end the Apostolic Nuncio to the United States of America, H.E. Msgr. Gabriel Montalvo, expressed his joy at the honour of being able to receive the Special Envoy of the Holy Father, and all the distinguished guests, in his own home.

Don DARIUSZ GIERS,
Official of the Pontifical Council for Health Pastoral Care, the Holy See.

Pray the Rosary Insistently for the Great Gift of Peace

JOHN PAUL II DURING THE ANGELUS OF 9 FEBRUARY REFLECTED ON THE ELEVENTH WORLD DAY OF THE SICK THAT WAS CELEBRATED ON 11 FEBRUARY 2003

Dear Brothers and Sisters,

1. On 11 February, the liturgical memorial of Our Lady of Lourdes, the *World Day of the Sick will* be observed. It is an important occasion, that helps the ecclesial communities to keep alive their concern for their sick and suffering brothers and sisters, and encourages health care workers to perform their professional service with unfailing dedication.

Our Lady of Lourdes

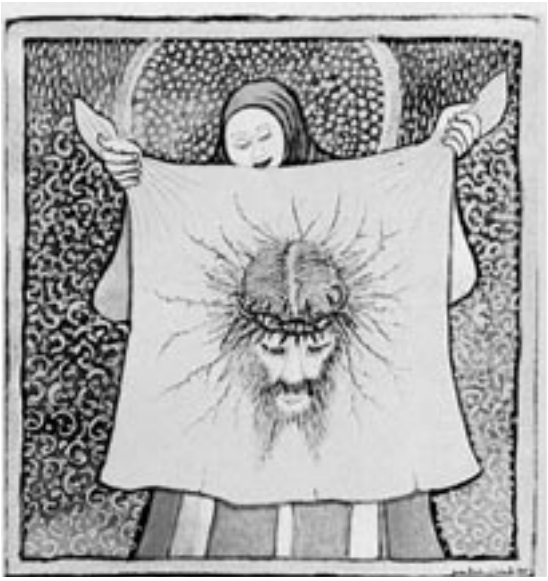
The fact that this observance coincides with the date of the apparition of Our Lady at *Lourdes* makes that place consecrated by the presence of Mary, *the constant reference point for the Day of the Sick.* From the grotto of Massabielle, Mary does not fail to direct to the world of the suffering a consoling message of confidence and hope.

2. As is well known, the main celebrations of the Day will take place in the National Shrine of the Immaculate Conception in Washington, capital of the United States of America. I express heartfelt gratitude to those who have organized the different events of this important ecclesial realization.

I express my appreciation to the *doctors* and *nurses, social assistants, volunteers, priests, men and women religious* who work in the vast field of assistance to the sick. May the Day of the Sick renew in each one the desire to serve with dedication those who suffer; imitating Jesus, the Good Samaritan of humanity.

Implore the great gift of peace from the Lord

3. At this time of international concern, we all feel the need to turn to the Lord to *implore the great gift of peace*. As I pointed out in the Apostolic Letter, *On the Most Holy Rosary,* "the grave challenges confronting the world at the start of this new millennium lead us to think that only an intervention from on high ... can give reason to hope for a brighter future" (n. 40). Many prayer initiatives are taking place these days all over the world. While I endorse them wholeheartedly, I invite all to take up the Rosary to ask the infercession of the Blessed Virgin Mary: "One cannot recite the Rosary without feeling caught up in a clear commitment to advancing peace" (n. 6).



Lourdes, Rome, Washington: 'Crossroads' of a Rosary Choir for Peace in the World

ON THE EVENING OF 11 FEBRUARY AT THE END OF MASS FOR THE SICK, CELEBRATED IN ST. PETER'S BASILICA BY CARDINAL VICAR CAMILLO RUINI, THE HOLY FATHER JOHN PAUL II GAVE THE FOLLOWING ADDRESS

Dear Brothers and Sisters,

1. I meet you with great joy, as I do every year, at the end of this celebration dedicated especially to you, dear sick people.

Greeting to the sick, to those who take care of them, to the Italian National Union

My first greeting is for you, the primary participants in today's *World Day of the Sick*. I greet all who are close to you, relatives, friends and volunteers, and the members of the Italian National Union for Transporting the Sick to Shrines (UNITALSI). I greet the Cardinal Vicar, and the bishops and priests present, the men and women religious and those who in various ways place themselves at the service of the sick and the suffering.

I also greet the members of the "Opera Romana Pellegrinaggi" (the Roman Work for Pilgrimages to Lourdes), and those who take part in the national theological-pastoral convention held in Rome on the theme: "the Pilgrimage, Path of Peace". This reminds me of the Holy Land. I express the hope and the prayer that as soon as possible those places sanctified by Christ's presence may recover a stable peace that will allow the return of the groups of pilgrims.

Pray the Rosary on World Day of the Sick, a landmark in the Year of the Rosary

2. Today we celebrate the 11th World Day of the Sick, placed *under the protection of the Immaculate Virgin Mary*. In a little while, the hymns and prayers will take us in spirit to Lourdes, a place blessed by God and dear to you. At the same time, we join the faithful who have thronged the National Shrine in Washington, also dedicated to the Immaculate Virgin, where this year the principal celebrations of the World Day of the Sick take place.

As we look to the revered image of our Lady of Lourdes, our eyes are drawn to the *Rosary* that hangs from her joined hands. The Virgin in prayer seems to want *to renew her invitation* to young Bernadette *to recite the Rosary confidently*. With great joy we accept this exhortation on the World Day of the Sick, an important date in the Year of the Rosary! Today Lourdes, Rome and Washington form a providential "crossroads" in a concerted invocation to the God of life that he instil confidence, comfort and hope in those who are suffering all over the world.

The Rosary offers the Christian response to suffering

3. Dear sick people, *the Rosary offers the Christian response to the problem of suffering,* drawing it from the Easter mystery of Christ. Those who pray follow, with Mary, the whole itinerary of life and faith, an itinerary that has as an integral part human suffering, that in Christ becomes divine – human suffering, the saving Passion.

In the sorrowful mysteries we contemplate Christ who takes upon himself, we can say, all the "sickness" of the human person and of the human race. As the Lamb of God, he not only bears the burden of their consequences, but of their profound cause, that is, not just *the evils,* but *the radical evil of sin*. His strug-

gle is not superficial but radical; his cure is not palliative but definitive.

The power through which Christ overcame the dominion of evil and healed the human person is his *confident abandonment* in an attitude of filial submission to the Father's will. This same attitude operates in us, thanks to the Holy Spirit, when, in the experience of sickness, we travel with Mary the way of the sorrowful mysteries.

Those who carry the cross with Jesus offer a witness to those who cannot hope

4. Dear Brothers and Sisters, the heart of the Virgin Mary that was pierced by the sword teaches us to "learn Christ", to be conformed to him and to pray to him (cf. Apostolic Letter *On the Most Holy Rosary,* nn. 13-16). She guides us to proclaim his love (cf. *ibid.,* n. 17); those who carry the cross with Jesus also offer an eloquent witness to those who are unable to believe or to hope.

Special intentions for the Rosary: the family and peace

In this year, troubled by such great anxiety for the future of humanity, I wished the prayer of the Rosary to have as specific intentions the cause of *peace* and of the *family* (*ibid.,* nn. 6; 40-42). Dear sick brothers and sisters, you are "on the front line" to intercede for these two great designs.

May your life, marked by trial, instil in everyone that hope and serenity which can only be experienced in meeting Christ. Let us entrust this hope and all our special intentions to Mary Immaculate, Health of the Sick.

To you who are here, and to your loved ones, I affectionately impart my Apostolic Blessing.

Homily of H.E. Msgr. Javier Lozano Barragán

BASILICA OF THE NATIONAL SHRINE OF THE IMMACULATE CONCEPTION, WASHINGTON, D.C.11 FEBRUARY 2003.
HOMILY GIVEN DURING THE HOLY MASS AT THE END OF THE ELEVENTH WORLD DAY OF SICK (I JN. 4,14-16)

Your Eminences,
Excellences, Dear Priests
and religious sisters,
brothers and sisters

It is for me a great honor to represent the Holy Father John Paul the Second at this XI World Day of the Sick. It is my duty to bring to you his blessings and greetings. His living testimony of pain and joy reflect the painful and joyful face of Christ and give us the courage to overcome illness and as well as death, through the solid hope of the resurrection, and to proclaim together with the Pope the Gospel of Life.

May I extend my cordial greetings to the Catholic Bishops' Conference of the United States, and to the other 23 Conferences of Bishops of the American Countries, represented here at this memorable Celebration of the XIth World Day of the Sick. The World Day of the Sick obviously concerns the whole world, but the choice to celebrate it in America, corresponds to the expressed desire of the Pope to have it every year in a different Continent. This year, it was America's turn, and it marks the second celebration in America, since the first one was seven years ago at the Shrine of Our Lady of Guadalupe, in Mexico City.

In agreement with the Holy Father, we had proposed to celebrate it either in Argentina or in the United States. The Catholic Bishops' Conference of the United States warmly accepted the proposal and made all the necessary arrangements for the celebration. We particularly thank Bishop Fiorenza, former President of the Catholic Bishops' Conference of the United States, and Bishop Gregory the current President, both of whom worked with great enthusiasm for the realization of this event. Our greetings and very special thanks go to the Archdiocese of Washington and her worthy and dynamic pastor, Cardinal Theodore McCarrick. Together with his team, under the direction of Father Michael Place, president of Catholic Health Association of the United States of America, and Dr. Jane Belford, Chancellor of the Archdiocese, they shouldered the great and hard work of making the project of the XI World Day of the Sick a reality. I would like to convey to Your Eminence and your team, sincere and heartfelt thanks, both from the Holy Father and the Pontifical Council for Health Pastoral Care.

May I also cordially greet all of you, priests, religious sisters, who are particularly involved in the health care ministry, all health professionals, workers, volunteers of all America, and all of you my dear sisters and brothers present at this National Shrine of the Immaculate Conception. It is a great honor to be with you working together for the good of our brothers and sisters, who are suffering under all kinds of sorrow, and for the good of the entire world plagued by suffering and pain, which often remind us of the reality of death. You, as an active part of the Church, are always engaged in finding adequate answers to the great and important problems of mankind, namely: illness, pain, suffering, all kinds of evil, and death. Our world often neglects those problems and wishes to cover them up with a smokescreen, or simply hide them. We are here to face them courageously and offer effective solutions. This is the Ministry of the Church; this is the meaning of redemption and salvation. The Pontifical Council looks at the core of the problem and offers its collaboration in the effort of finding lasting solutions, through its specific task of pastoral health care.

In this year's message for the World Day of the Sick, the Pope opens with a quotation from the first Letter of St. John, where the Apostle tells us that: "We ourselves have seen and testify that the Father sent His Son, as Savior of the World… *and we have recognized ourselves and believe in the Love* God has for us".

We are therefore celebrating the World Day of the Sick under the sign of Love. However, this celebration is not only a commemoration or an occasion to remember that all people must be compassionate towards the suffering world; that would be good, but still wanting. We have the power, not only to be compassionate, but also effectively to take away the sorrow and the anguish of this World. This is exactly our task in the liturgical celebration of the XI World Day of the Sick. In the Holy Mass we have the experience of the whole salvation.

According to our Faith, here, in the holy sacrifice we offer to the world the only true solution to evil; in a word, the only solution to death. We do not hide

death or minimize it; we know it as the greatest evil there is; but in the reality of the Mass as Memorial of the Lord's Death and Resurrection, death becomes a fountain of life and happiness.

Today we often speak of the quality of life. In the Eucharist our life receives its true quality; here we find the authentic quality of life. Our quality of life consists in breaking through the dark limits of death and acquiring a life forever. The true quality of life ensues from our participation in the mystery of Christ, enabling us to be a reflection of the face of Christ, joyful and sorrowful at the same time. It is the victory of the paradox: victory over death through the same death. In the Easter Liturgy we sing: "Death and life have contended in that combat stupendous: The Prince of life, who died, reigns immortal" *(Sequence of the Easter Sunday and the Octave)*.

In the mystery of faith and charity, Christ takes our sorrows and converts them into happiness; but the condition is that we must fervently awaken the virtue of hope. In this way, we become members of the Body of Christ, and the whole Church with her Head, Christ, assumes the death of mankind and converts it into resurrection. This exactly constitutes health pastoral care. This is the all-powerful Love of God that from the "guilty nothing" of humanity on the cross creates again the new humanity in the full life of the resurrection of Christ.

If we ask ourselves for the identity of Catholic health pastoral care, this paradox is the distinguishing mark for the Institutions and people that wish to be considered as Catholic health professionals or workers.

The last hurdle is death, which causes trouble and disharmony. If death is destroyed we will have harmony and peace. By destroying death we will foster Life and Health. We will have life because harmony builds unity, and life is unity while death is disintegration. This is the reason why health is a tension towards harmony. So health pastoral care or ministry is a way of achieving harmony, unity, peace, life and Health.

The way that leads to harmony is a long one. It means following the footsteps of Christ in building the human person. Therefore, the rule of health care ministry is the continuous building of the person. In this way we can enunciate the main principle of Christian ethics: What builds man is good, what destroys him is bad. As I said before, the paradox is that the only way by which death can build the human person is by accepting it and being with Christ on the cross. This is the only way, through which death can be converted into a fountain of life and resurrection.

Therefore, because through this Eucharistic Memorial on the XI World Day of the Sick, we are in communion with Christ who died and rose again, we are gathered here not just to awaken in us sentiments of compassion for suffering mankind, but to give the world the only way to overcome her sorrows, pains and sufferings. This is the mystery we are celebrating in the Eucharist and in the anointing of the sick that we will soon celebrate.

We are celebrating the World Day of the Sick on the commemoration day for the apparitions of Our Lady in Lourdes; in those apparitions she said, she was the Immaculate Conception ("Soy era la Inmaculada Concepción"). And we are gathered here at the national Shrine of the United States, dedicated to the Immaculate Conception of Mary. This is a very appropriate setting for the meaning of our celebration.

In fact, the Immaculate Conception means the beginning of the creation of the perfect woman, Mary, whom God had in His eternal Plan. In virtue of the grace of Christ, She is the model of human harmony, unity, life and health. Because of Her immaculate conception, Her harmony is due to the full reception of the Love of the Holy Spirit. May She pray for us, so that we may receive the Holy Spirit. The Holy Spirit is the strength of the resurrection of Christ. The Love of the Holy Spirit gives us the unique capacity to believe, to overcome the paradox of death and to communicate with Christ, the only way to obtain the true Health. So we ask Mary, because of Her Immaculate Conception, to pray for us, that we may lavishly receive the Holy Spirit, to help us give to the World a credible testimony of how to overcome death and obtain the true Health. With the Love of the Spirit and the intercession of Mary we will understand better that only with faith, charity and hope can we overcome death and obtain true Health. In this way, we can arrive at the root of all life and have the solid conviction that only love is credible.

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

Addresses of H.E. Msgr. Javier Lozano Barragán

XLVI Sessio
of the Committee
on Drugs and Narcotics
of the United Nations
Vienna, 16-17 April 2003

LVI Plenary Assembly
of the World Health
Organisation
Geneva, 20-21 May 2003

Education and Drug Abuse

ADDRESS TO THE XLVI SESSIO OF THE COMMITTEE ON DRUGS AND NARCOTICS OF THE UNITED NATIONS, VIENNA, 16-17 APRIL 2003.

The purpose that has brought us together in this ministerial part of the regular session n. 46 of the committee on drugs and narcotics is to assess the progress that has been made and to see the difficulties that have been encountered in order to achieve the goals and objectives outlined in the policy declaration adopted by the General Assembly of the United Nations at its twentieth session.

As regards the progress made by the Holy See, we can refer to the educational work that the Catholic Church is constantly engaged in throughout the world to avoid drug abuse. Indeed, amongst other initiatives we have published the pastoral handbook *Church: Drugs and Drug Addiction* as a practical guide to educate and to respond to the most common questions that are usually raised in the field of prevention and accompanying in the sphere of the phenomenon of drugs. This handbook has been published in seven of the main modern languages and we shall make it available to this committee. We have also organised and held many congresses, conferences and study sessions, and developed rehabilitation centres in various countries of the world, accompanying and encouraging therapeutic communities.

Regarding the difficulties that have been encountered, we have observed the absence of a global education of the new generations which centres in particular around the ineluctable dignity of the human person and the values that constitute him: this is the greatest prevention that we can offer because it goes to the root of the problem.

As an answer to this difficulty, we present our position on it by suggesting that the role played by global education in the fight against drug abuse be given greater emphasis.

In fact, the phenomenon of drugs has spread like a wild fire all over the world and has generated terrorism and death. In the fight against drug abuse a serious policy on the part of the state in relation to life, and in relation to respect for the human person, is required, as well as an employment of the mass media and a positive use of freedom. The heads of governments must be made aware of the need to improve the legislation in this sphere in the light of the experience that has been gained. The legal authorisation in some parts of the world that is given to the selling and consumption of drugs has only increased their use. Drugs cannot be defeated by drugs. Repression is not sufficient. However, we must absolutely fight criminal organisations, denounce them and pursue drug-traffickers. Those who are involved in the production and sale of drugs are traffickers in death; they kill, they destroy, and they create a human sub-class.

Another very important point is the cultivation and production of drugs by poor countries. It is true that such cultivation has to be replaced. However, being realists, we observe that there are countries where the cultivation of drugs is the only resource they have available to them to escape from their poverty. For this fight to be effective, these countries must be helped to replace such forms of cultivation with other, licit crops, which provide them with the means to support themselves, with all the economic requirements that this involves.

All this is very necessary, but it is not enough: we have to go to the root of the problem of drugs, namely the loss of ethical and spiritual values and consequent moral degeneration: dissatisfaction produced by the contemporary social structures and by a dominant human and religious scepticism, in a permissive and depersonalised society, causes a lack of hope and an emptiness as regards wanting to live. We are dealing here with a pathology of the spirit that kills life, which is itself communion and giving. In a particular way the values of life, love, sexuality, solidarity and transcendence have been obscured. In order to address this loss of values the only solution is education in such values, emphasising them basing ourselves upon the dignity of the human person and stressing the love of God, awareness of one's own immortality, and the integration of the family.

As a result, the drug-addict will rediscover his dignity; he will be able to encounter the Gospel, be sober and chaste, and be certain that he can defeat his addiction. This education involves an overall dynamism because the human person is a global project to be realised so as to overcome every limit. He is a project of physical growth, but at the same time, and also simultaneously, of mental, social, environmental and spiritual growth. The person is a tension towards harmony.

In his *demand for drugs* the drug-addict seeks new sensations that bring new physical and mental experiences of pleasure, but in doing this he totally breaks human harmony. Pleasure as an ultimate and exclusive framework destroys. Emphasis is placed solely on physical well-being or at the most on mental well-being, and the person as a whole is destroyed, as well as the social fabric and the environment itself.

In his *supply of drugs* the producer, the trafficker, is after money and power; as an ultimate end he is searching for well-being, which he thinks he can obtain through both. But this is only an illusion: the search for well-being is dis-

* On the subject of drug abuse, H.E. Msgr. Lozano Barragán also gave an address to the Ministerial Conference on 'The Drug Route from Central Asia to Europe', held in Paris on 22 May 2003.

turbed because he has destroyed himself, leaving behind a total social, environmental and spiritual void.

This partial perspective must be changed into a *global vision* of man. This vision is physical, mental, social, environmental and spiritual. In this fight against drug abuse we cannot be satisfied any longer with imperfect visions which are confined to one or the other of these aspects of the whole or which exclude one of them. Either man is constructed as a whole or he is destroyed. Free will is what constructs but it must have a stable orientation in which is rooted an authentic human project that is not contradicted by formal or informal, systematic or unsystematic education, which, indeed, is what people so often wish to impart. Models for behaviour are required, but it is evident that 'models' that destroy the human project, such as pansexualistic or economicistic proposals or ones involving power and violence, which are presented by most of the mass media today, must not be accepted. Nobody has the right to destroy other people or themselves. There is a crisis of the inner man in the contemporary generations and they try to fill this void with a whole series of sensations. Their slogan could be: 'I feel, therefore I exist'. Many television programmes and videogames foster this crisis by presenting an imaginary world of pleasure, violence and power. Drugs are presented as an easy key that enables people to enter this world.

As regards global education, *objective global ethics* rooted in the construction of human person should be the point of departure. The basic principle is '*what constructs man is good, what destroys him is bad*'. This is the principle of beneficence or non maleficence, which is accepted by the whole of the world – '*primum non nocere*' ('first of all do no harm'). From this objectivity, the principal features of the model will conform to the other two well-known principles of justice and autonomy.

We may indicate certain important steps for overall education based upon ethics for the fight against drug abuse: learning how to reflect on ourselves, to distinguish between well-being and happiness, to discover the value of life; to address life and its difficulties; to understand the authentic meaning of life, pleasure and sexuality; to cultivate responsible attitudes in relation to life, to know how to proceed by stages; to practice the virtue of temperance, self-control, and to know the limits of one's own behaviour, to know how to choose and how to say '*no*' when this is necessary, to learn to respect the law; to know how to wait, employ one's will, reason, freedom and responsibility in a correct way, to respect the specific right of not harming oneself; and to learn how to live for others.

We suggest that educators welcome the drug addict and accompany him in the fight against his addiction, that they listen to him, that they choose a suitable way to speak to those who are immersed in this problem, that they help them to restore their dignity in the face of life, and that they support their families in particular during this difficult process of re-education.

This is a rather complex educational effort, which must as such come from an overall effort. This is an irreplaceable task for parents, to whom other agents of education must be added: the family, schools, the Church, the state, the international community, a healthy social environment, the mass media, etc. National re-education projects are required in which the whole of society feels involved. In this collective effort the therapeutic communities play a very important role and without doubt because of their experience and devotion they amount to a priceless contribution from which we should never depart.

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

Address to the LVI Plenary Assembly of the World Health Organisation

GENEVA, 20-21 MAY 2003

Mr. President,
Illustrious Ministers,
Distinguished Participants,

I extend to you all my cordial greetings and I congratulate the President, in particular, on his wise and successful guidance of this Assembly.

Over the last decade, more than two million children have been killed in armed conflicts, six million children have suffered disabilities, and tens of thousands of children have been mutilated as a result of anti-personnel mines. During the course of 2002 three hundred thousand children were recruited as soldiers. Over four million three hundred thousand children have died in recent years of AIDS. Every day, seven thousand children fall sick with AIDS, and in Africa alone over fourteen million children have been made orphans because of this disease. Poverty continues to be the principal cause of sickness during childhood. One thousand two hundred million people live on less than a dollar a day. Even in the

richest countries one child in every six lives under the poverty threshold. The gap between the rich and the poor is growing greater. 30% of children under the age of five suffer from hunger or malnutrition, and 50% of the whole of the Sub-Saharan population of Africa does not have access to drinking water.

Two hundred and fifty million minors of the age of fifteen work, and fifty to sixty million of them work in dangerous conditions. According to the World Labour Organisation, one hundred and twenty million boys and girls between the ages of five and fourteen work full time, most of them for six days a week. The rest work for seven days a week without a rest period. Most of the time they are forced to do so in places that lack ventilation and have bad lighting and are watched over by armed guards who are there to stop them from running away.

Today, most children and adolescents are abandoned to themselves and their own impulses. Internet and the television are their company. Everywhere we encounter the widespread presence of stereo compact disk players, computers, playstations, digital telecameras, and cellular telephones. There is no control over television programmes or over Internet, in which children and adolescents browse without any kind of moral guidance. The sex trade, paedophilia, violence in schools, crimes, gangs and so on have all increased. According to data provided by ISTAT, during his school years a child will have watched fifteen thousand hours of television and 'witnessed' eighteen thousand murders in a context full of violence, drugs and sex.

Many families have abandoned their specific task of bringing up their children. Fathers and mothers work and do not have time for their children. They do not give them love, care, personal communication or a formation of their moral conscience, teaching them to distinguish between right and wrong. The situation is even worse when the families are divided and the children themselves are 'divided'. It is often the case that due to the prevailing norm of 'non directivity', the education provided by schools is reduced to mere information and authentic education is abandoned because it is believed that this would damage the right of children to self-determination.

In the face of the worrying situation that now besets children, the seven guidelines for the future proposed by the World Health Organisation seem to me very suitable. I believe, in fact, that priority should be given to mother-child health, that infectious diseases afflicting children should be prevented, that accidents should be avoided, and that the physical environment should be improved, in particular in relation to water, hygiene, environmental pollution, the ways in which diseases are spread, the dangers generated by chemicals, accidents, and the behaviour of children and adolescents, their psycho-social development, and looking after them in special high risk situations such as that of 'street children'.

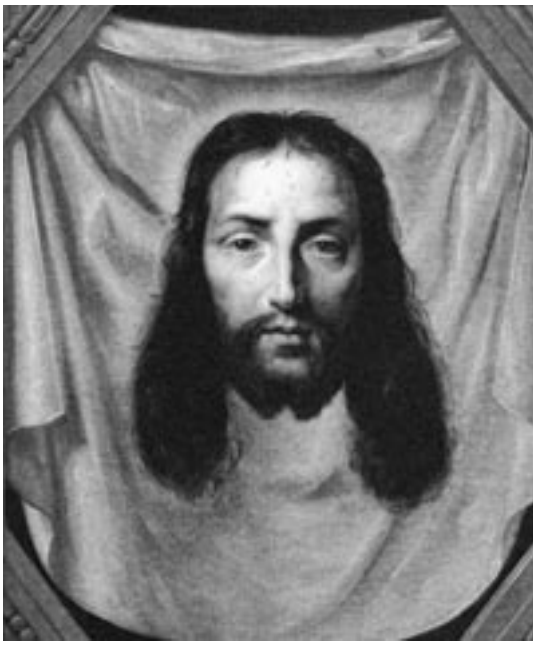
For our part, in recognising the urgency of the guidelines that have been presented, we lay emphasis on two points for the creation of an environment suitable for children. First of all, combating poverty with adequate measures within the present-day globalised economy. An economy that is an end in itself cannot but generate forms of injustice on a broad scale. An economy, whether globalised or otherwise, is for the person and not *vice versa*. The time has come to consider seriously the need for the international common good, which we could now define as an international 'global' good. The injustice that exists between industrialised countries and developing countries is not in the least sustainable.

The other equally important point mentioned by the WHO concerns the behaviour and the psycho-social development of the child. As a human person, the child is a very complex being, whose physical, sexual, psychic, mental, economic, social, political and spiritual aspects intertwine. These aspects act as communicating vases and require a holistic and not a departmentalised environment. It is the whole person that is developed and not only one of his aspects. The behaviour of the child is the self-development of his own life project. For this reason, he must know who he is, what he wants, what constructs him and what destroys him, and in this complex situation he needs a clear and solid orientation.

The affection and the love of his parents and of all of his family is what is primarily needed for his own self-understanding. When these are absent the development of other elements becomes difficult and, at times, becomes harmful. The environment to be favoured, therefore, is a healthy family environment made up of a stable and well anchored family in which all the aspects of the growth of the human person find their balance. Within the educational community, schools that really educate the child must be an extension and a broadening of the family itself. There should be a continuity and a mutual synergy between the family and the school institution at all levels, which in a thoughtful and reflective way will introduce the child into, and locate him within, a complete social environment. In conclusion, to improve the child's environment we must first of all effectively fight the poverty within his own country and at the international level, then also strengthen the family and ensure authentic school formation**.**

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

Topics



Being a Health Care Professional in a Changing World: Gospel-based Approaches

The Chaplain as Seen by Health Care Workers

Schools and Health: a Pastoral Perspective

The Effect of a Thoughtful Reading of the New Testament on the Hyperalgesic Area and in the Perception of Pain in Patients with the Lumbar Algic syndrome

The History of Monastic Medicine in the Christian West

Being a Health Care Professional in a Changing World: Gospel-based Approaches

PAPER GIVEN AT THE EL ESCORIAL (MADRID) ON 29 MARCH 2003 DURING THE CONFERENCE TO CELEBRATE THE TENTH ANNIVERSARY OF PROSAC

'We are to follow the truth, in a spirit of charity, and so grow up, in everything, into a due proportion with Christ, who is our head' (Eph 4:15)

Introduction

This paper is organised into three parts. In the first part I would like to locate the health care professional in the social context in which he has to work. I think that this framework is important, even though it is presented in summarising form and even though other speakers have already analysed it in greater detail. This element is of interest to me because one can then better understand the second and third parts of the paper, that is to say the human and Gospel aspects of my subject. I will lay emphasis on these last above all else in order to strengthen and stimulate within the Christian health care worker those values that should characterise his profession, something that goes beyond his being a mere technician.

I. THE SECULARISATION OF MEDICINE OR LOST VALUES

1. We live in a world in a state of constant change[1]

The situation of our world is explosive. We are undergoing a great revolution, the replacement of man by the computer, the mechanisation of work, and the standardisation of people's lives.

Today, man dominates – or tries to dominate – nature. Man is dynamic and open to doing things, and he is proud to belong to this epoch, made up as it is of technology and great advances:

– Communication satellites.
– Motorways.
– Organ transplants.
– Revolutions at the level of information technology, bioengineering (the defeat of diseases, hereditary genetic alterations); a quantum revolution (molecular machines, a worldwide civilisation).

This is a world where professional skill and expertise are very highly valued and living is a wager.

The principal characteristics of our society

a) Rapid economic, political, scientific and urban advance.

b) A technical mentality which leads man to do everything that is possible without asking himself if he needs to do it, and which at the same time forces him to produce and to be effective.

c) Our society is a large social conflict that manifests itself at an international, national and local level. This conflict places ideas, systems and ways of living in a state of crisis, and as a consequence produces change in all fields – the political, the economic, the religious…

d) As a result, these changes have given rise to:

– a transitory sense of life which is translated into the following slogans: death to permanence, discard after use, the era of what is useless;

– a new meaning to life: we are in a new society, this is a revolution that destroys institutions and power relationships (kidnappings, forms of violence, strikes);

– in essential terms these changes give rise to a very broad range of lives marked by a multiplicity of choices: things, services, lifestyles;

e) Here we are dealing with a cultural change in which certain characteristics dominate and at the same time create a new kind of man – *'techno sapiens'*, who has taken the place of *homo sapiens*. The whole of information technology is changing life, philosophy, language and mentalities. Man believes that he is able to change man. Here we are dealing with the digital revolution. The acronym 'PC' does not stand for the Communist Party in Spanish but for 'personal computer'.

2. How these Changes Affect Man

Disorientation: we are face to face with a phenomenon termed 'the acceleration of history' and the changes of recent years have been more rapid and more profound than during previous centuries. 'And this early arrival of the future', observes Tofler, 'can be transformed into the most important illness of tomorrow'.

Difficulties in adaptation because of speed and instability: you cannot lean on the past but at the same time the future is experienced in a state of insecurity.

The loss of identity and a multiplicity of roles: contemporary man is an extrovert and one can feel emptier and more alienated even while having more things.

A feeling of confusion and loneliness: man is constantly asking himself: where am I going? Who am I?

Contemporary man becomes abandoned when the world no longer needs him. Here we encounter the whole problem of marginalisation, a phenomenon which is so characteristic of our society.

3. How can Technology be Placed at the Service of Man?[2]

We have a great responsibility towards future generations:

– The power of man that is conferred on him by technology can influence his body and his spirit (Romano Guardini, *Il Potere*).

– 'But he seems to be threatened by what he produces' (*Redemptor hominis*, 15).

– Hence the need for a balance between technical development and ethical values (*RH*, 15).

– It is important to search out the sapiential horizon, which is the final and overall meaning of life (*Fides et Ratio*, 81); the sapiential horizon 'within which scientific and technological achievements are wedded to… philosophical and ethical values' (*Fides et Ratio*, 106).

– As Vatican Council II says (*Gaudium et Spes*, 15): 'Our era needs such wisdom more than bygone ages if the discoveries made by man are to be further humanized. For the future of the world stands in peril unless wiser men are forthcoming.'

– An upright and good task must be assigned to technology and this should be at the service of man.

We cannot forget that lordship in the world is based upon the *supremacy*

– of the spirit over matter;

– of the person over things;

– of morality over technology (cf. John Paul II, *Redemptor Hominis*, 16).

4. We have a more Effective form of Medicine but is it more Human?

We have left behind us the old wizard-priest approaches to medicine, and we have done the same as regards the hospital as stewardship, hearth or Hôtel-Dieu, and the approaches involving charitable and beneficial care. The simple criteria of medicine involving the view that it restores health are also behind us.

Our health and our medical practice are today more complex. They have other characteristics, which are as follows:

– community forms of medical practice *take precedence* over hospital forms of medical practice; medical practice connected with the environment prevails over medical practice centred around the person;

– prevention and promotion come before care and treatment;

– quality of life;

– programmes that seek to reach everyone (this is a central idea of the World Health Organisation);

– medicine is all-embracing and is not only concerned with the body;

– we are dealing with a practice of medicine where the word 'rights' is the order of the day, together with the word 'business', organisation, objectives, management, and assessment;

– we have before us a practice of medicine which is more technological: because of its instruments, its equipment, its people…

I believe that we have achieved many advances, and those that are about to arrive are much more numerous and much more spectacular. It is for this reason that we must be very careful and ensure that they work for the good of man.

At the present time we have not grown sufficiently, or in parallel with, technology as regards values, and hence we see its negative effects: the new problems and challenges that are present, for example in the field of human and technical questions:

– dehumanisation;

– a lack of training of professionals to direct them towards the achievement of overall care and treatment;

– a lack of ethical training for professionals;

– the lack of a detailed study of the new challenges raised by medicine in relation to such subjects as genetics, euthanasia, experimentation, organ transplants, abortion, family planning, cloning, AIDS, and

all forms of mental illness…

The lack of training and ethical criteria of professionals in relation to these subjects leads to great violations and the manipulation of the human person.

5. The Place of the Sick Person in such Progress

The techniques that bring about healing should be well received. But we should not forget that at the centre of things there is a man who is ill.

Is the patient really at the centre of medicine? Is the sick person at the centre of legislation? Is he at the centre of all the projects we engage in?

– He is not when we have a higher regard for being efficient and producing than for people.

– He is not when technology engenders disproportionate expectations.

– He is not when professional interests (money, prestige, success) are present in the approach to the needs of the patient.

– Our *disloyalty* to the sick person is an obstacle that involves a lack of knowledge about that person – his age, culture, role, environment, and biography.

– For this reason we engage in flight and take refuge in our role, the job that we do.

– But in addition to this obstacle we discover:

a) that the patient is *worried* about his illness, which for him is *an insult, a threat, an evil* which makes him insecure and forces him to ask for help;

b) after overcoming the obstacle the sick person asks himself whether the medical doctors will be able to cure him and take care of him.

The place of health, as Rev. Marchesi used to say, is not a bar or a cinema, but a place of care where I may die.[3]

II. TOWARDS A HOLISTIC APPROACH TO HEALTH

1. Human and overall care

The health care staff (medical doctors, nurses) must be able through their profession to offer the patient more than certain technical means – they are also called to safeguard everything that the sick person needs for his cure. Hence the best answer that we can give to the patient is overall care. All this pre-supposes knowledge of his real needs. We should thus know his biography, his reactions (because each person suffers from his illness in his own way); and we should be very respectful of his person and individualise the care and treatment that we provide.

If we act in this way, at a practical level we will recognise that we are engaging in a form of overall care that is really such and that our health care environment is human.

In particular, with reference to hospitals, as Rev. Marchesi said: 'a human hospital is an open hospital, it has a very precise and transparent map of power, it believes in team work, it provides on-going training, and it is a family home'.[4]

All of this is, or should be, because we are with people and not with things and because the treatment of these sick people requires intense meetings and repeated dialogue. Treatment is not merely a matter of administering drugs and medicines, or of shallow meetings. Hence our patients ask from us care which every time is more human and personal, understanding, and near. We do not treat illnesses – we treat sick people. What distinguishes the health care profession from most other professions is that it is exercised with living beings who in addition to having rights also suffer. What matters is not so much what we do to them but how we do it.

We do not have before us a mere professional action, an occupation, but something that must go beyond this – our service to suffering man requires a vocation that is the same as dedication, devotion, harmony, collaboration, respect and love.

'The most important foundation of medicine', wrote the physician Paracelso of the sixteenth century, 'is love. If our love is great, the fruit that medicine obtains will be great; and if our love is small, then our fruits will be small'.

The sick must be loved if we want to serve them and to serve them in a human and overall way.[5]

2. Overall Care: an Urgent Collective Need

Care for the sick is becoming increasingly complex in nature. We are a moving towards a form of medicine along team lines where there are new categories of professionals, medical doctors, psychologists, social assistants, and priests, to cover the four dimensions of man: the somatic, the psychological, the social and the religious. If we do not retrieve these dimensions in man we will not cure man.

In an interview Rev. Pierluigi Marchesi declared as follows: 'under the pressure of technology and of secularisation as well, medicine is faced with a critical dilemma, and debate takes place between two extremes: whether to have an in-

creasingly 'scientific' form of medicine, or whether to have an increasingly human form of medicine'.

We could be satisfied if medicine was increasingly 'medicine'. And I mean by 'medicine' what is always beyond the increasingly technological nature of science and the mass-scale and state character of care – a form of medicine which down the ages has rested on support being given at an emotional, social and human level; a form of medicine whose origins were the Hellenic concept of 'philanthropy' or the Christian concept of 'charity', i.e. of love for man.

How can I make the way in which I live out my service authentic, if to begin with I have not studied with reference to myself the need for hope and service itself? I would hand over something akin to a counterfeit coin, an action that is imposed on me by work, by a contract, or by a law that prescribes it.

It would lead to my hands being placed on a sick person as though he was a piece of damp paper, and it would end up by killing him because I would be looking for something outside him, a pay cheque, a prize, a small amount of happiness. But instead I should absorb this piece of damp paper, be transformed into a single thing but remaining mysteriously both myself and him, continuing to be him'.

3. Health Care Professionals: Love your Profession, be Ministers of Life

You have before you a great task: a technical task, certainly, but your profession at the service of man presents you with a challenge: are you able to care for a patient with humanity and in an overall way?

Through your welcoming you will be a 'new home' for the patient, the new home he needs. You will build a suitable place directed towards the sick person. He is, and must be, the centre. Go deep inside what he is; try to do good to the patient; and you will see that relationships, forms of communication, and power will change.

Try to do good to the patient and you will see that you will put more science into your profession, more readiness to help, more dialogue, less discrimination and more presence.

Cardinal Tarancón used to say when speaking about the health care profession: 'medicine, education, and the priesthood require something more than technical help, although this last is necessary. They need the human warmth of those who provide care. For this reason, they have a special greatness and a human fullness'.[6]

These health care professionals have a greatness, and our Pontifical Council for Health Pastoral Care does not hesitate to call them 'ministers of life'.[7]

The Spanish episcopate, in one of its documents, provides the following reflections on 'Catholics and professions': 'A profession acquires…a really vocational and even spiritual dimension. But this will be the case only if the practice of a profession is internally animated by the spirit and supported in its development by the moral criteria of the Gospel and by an imitation of Jesus Christ. These requirements must not be confined solely to economic matters, for example the rightness of salaries or fees. The Christian life and Christian morality have wider requirements. Respect for life, loyalty to truth, responsibility and sound training, hard work and honesty, the rejection of any kind of fraud, a social sense, and even generosity, must always inspire the Christian in the practice of his work and professional activity'.[8]

III. GOSPEL-BASED APPROACHES SO AS TO LIVE AS A CHRISTIAN HEALTH CARE WORKER

This third part of my paper is specifically concerned with the purpose of my talk: to emphasise those values that are of determining importance for all health care professionals, but which must in particular inspire the Christian health care worker because they have to deal with human persons in such difficult situations as weakness, illness and death.

And it is here that the Gospel engenders life in the experience of every day and in contact with the man who is suffering.

I will point out certain approaches, aware of the fact that others are not being listed. I have chosen the following: the experience of being loved; chosen to be witnesses to the compassion, mercy and the tenderness of God who forgives, loves and sends people do the same, i.e. they are called to narrate the parable of the Good Samaritan: go, then, and do likewise. Yes: you do the same in the crowd, in an aggressive and hostile world, but knowing that strength comes from on high, and hence the need to be united like the branches of the vine, to grow united and to be witnesses to light, joy and hope.

1. The Experience of Being Loved, Called and Sent

The divine plan of salvation:

'Blessed be the God and Father of our Lord Jesus Christ, who has blessed us in Christ with every spiritual blessing in the heavenly places, even as he chose us in him before the foundations of the world, that

we should be holy and blameless before him. He destined us in love to be his sons through Jesus Christ, according to the purpose of his will, to the praise of his glorious grace which he freely bestowed on us in the Beloved. In him we have redemption through his blood,

the forgiveness of our trespasses, according to the riches of his grace which he lavished upon us. For he has made known to us in all wisdom and insight the mystery of his will, according to his purpose which he set forth in Christ as a plan for the fullness of time, to unite all things in him, things in heaven and things on earth.

In him, according to the purpose of him who accomplishes all things according to the counsel of his will, we who first hoped in Christ have been destined and appointed to live for the praise of his glory. In him you also, who have heard the word of truth, the gospel of your salvation, and have believed in him, were sealed with the promised Holy Spirit, who is the guarantee of our inheritance until we acquire possession of it, to the praise of his glory' (Eph 1:3-14).

This is a wonderful text by St. Paul to the Ephesians, who were a trading people. They lived in a large city, the capital of the Roman province of Asia. Here St. Paul was engaged in a great mission, which, indeed, he carried out with great success. He begins with a blessing of God the Father and then goes on to outline the plan of redemption in Jesus Christ. Beloved, 'chosen before the creation of the world', destined and marked freely by love. Yes: from love, because 'God is love', as St. John declares (1 Jn 4:8). 'God alone can love', observed St. Isaac of Ninive, the Christian thinker of the seventh century. 'In this the love of God was made manifest among us, that God sent his only Son into the world, so that we might live through him' (1 Jn 4:8). 'He loved sinners but took away their sin; he loved the sick and thus visited them to heal them' (St. Augustine, 'Tract on the First Letter of John', VII 1.7.9).

My being, my life, depends on this love; I am the fruit of an infinite love, higher than that of my parents and brothers, the love of God in me. God loves me. Only the experience of being loved, of feeling that someone – God – loves me, knowing it and experiencing it, implementing it in life, only this experience can convert our lives.

'The love of God poured into our hearts ought to inspire and transform who we are and what we do. Christians must not think that they can seek the true good of their brothers and sisters without embodying the charity of Christ. Even in those cases where they might succeed in improving important aspects of social or political life, without charity every change would remain short-lived. The possibility of giving oneself to others is itself a gift which comes from the grace of God. As Saint Paul teaches: 'God is at work in you, both to will and to work for his good pleasure' (Phil 2:13) (John Paul II, *Message for Lent 2003*, n. 4).

The experience of human love, for example within the married couple, is a creative force, it is passion, it is tenderness, it is giving, it is a source of life, faithfulness, welcome, a source of happiness. In authentic human love all of this is experienced because a person loves and feels that he is loved. Love moves, realises all of this; it is an engine that guarantees a new life, a full life. 'Love moves the son and the other stars', (Dante, *The Divine Comedy*). 'Love and do as you wish', said St. Augustine. Do what you wish because love will always be its engine. 'Love and do as you wish'. Love. One cannot live without loving and without feeling loved. To love, to hear one's heartbeat, beyond what is physiological, beyond what is instinctual. To love and allow oneself to be loved. To love is to allow space for another person, it is to break down barriers, it is to feel the heart grow as life grows, it is to increase the wish to live. To love is to be born again.

God does all of this in us because God is love and allows us to experience these feelings. God is love. For this reason, He loves us before we love him: he loves each one of us: He loves me, He loves you, He loves us. 'I have loved you with an everlasting love' (Jer 31:3). Always loved, from the womb onwards, the Lord loved me, chose me, and sent me. 'Before I formed you in the womb I knew you, and before you were born I consecrated you; I appointed you a prophet to the nations' (Jer 1:5).

This is a dynamic love, made life giving; a love to love. A love sent to love. 'As the Father has loved me, so have I loved you; abide in my love…This is my commandment, that you love one another as I have loved you…You did not choose me, but I chose you and appointed you that you should go and bear fruit and that your fruit should abide… This I command you, to love one another (Jn 15:9-17).

The witness of our faith is love. Only he who loves knows God and he who follows Jesus, the model of love, bears much fruit.

From this experience of love – the Father loves us, we answer with love – is also born a response of mutual love: love one another. A love translated into works: welcome, service, joy, and peace. A love translated into enthusiasm, free giving, a love that grows through commitment, that becomes strong in trials and matures with the contrasts of life.

2. Being Witnesses to the Compassion, Mercy, and Tenderness of God

This is the second approach that I would like to discuss and analyse. It is connected to the approach just outlined. The person who feels that he is loved must answer by loving; this love becomes life, is translated into being an example, a model, witness to another love, that of God, who is compassion, mercy, forgiveness, and tenderness. God is all of this and the health care professional is called to live it and express it; he is called to be a witness. 'Be merciful as your Father is merciful' (Lk 6:36).

God is compassion, mercy, and forgiveness

Jesus was rich in compassion and taught compassion to men, but above all else he practiced it intensely with those who needed his welcoming and his forgiveness (Lk 15:3-32; 19:1-10; 7:36-50; Jn 8:1-11).

Compassion, mercy and forgiveness in Jesus are surprising in their intensity: 'The Spirit of the Lord is upon me, because he has anointed me to preach good news to the poor' (Lk 4:18); the blind receive their sight, the lame walk, lepers are cleansed, the dead are raised up (Lk 7:22).

Jesus heals, but in doing so he *shares*, he *reintegrates* the sick person, he enables him to find his place once again (Mk 1:40-45). The whole of healing involves Jesus because it is a manifestation of his love and his mercy (Mt 11:28; Jn 5:5-9). Such healings are the *sign of the coming of the Kingdom*, they express the message; they are in essential terms a prefiguring of total liberation, of the era without illness (Rev 21:3-41).

Jesus does not only care for sick people, he also cares *for their families*. 'Do not weep' he says to the mother of the dead young man (Lk 7:13). And to Giairus, faced with the illness of his daughter, he said: 'Do not fear; only believe, and she shall be well' (Lk 8:50). 'For this saying you may go your way; the demon has left your daughter' he said to the woman from Canaan (Mk 7:29). And to the question asked of him by Martha and Maria on the death of their brother he answered: 'Where have you laid him?' (Jn 11-34).

Many words and actions of Jesus bear witness to this merciful love. The Gospel is full of these facts. If we wanted to narrate them all, the list would be endless. As regards the message that is being conveyed in this paper, I would like to focus in on three icons: the healing of the paralytic, the prodigal son, and the Good Samaritan.

The healing of the paralytic (Mk 2:2-12)

The following is the scene in this parable: Jesus is in Capernaum surrounded by many people. A paralytic has been carried there by four volunteers who do not manage to enter the house with the paralytic because of the crowd. They open a hole in the roof and lower him down in front of Jesus. Having seen their faith, Christ says to the paralytic: 'My son, your sons have been forgiven', and then: rise up and walk! Jesus provokes surprise and scandal because first he forgives sins and then he heals the body; first he absolves and then he cures.

Jesus frees the person from the physical malady; he cures, and this is a sign of a richer liberation: your sins are forgiven (Mk 2:5); I remove your misdeeds; as far as I am concerned I no longer remember your sins (Is 43:25).

This is the forgiveness of God which takes place through charity. The paralytic is helped by four men, by four volunteers (Mk 2:3). This is the forgiveness of God which the Church practices in the sacrament of reconciliation; it is the forgiveness of God, whom we call on in the Lord's Prayer every day. Forgive us our trespasses, Father, as we forgive them that trespass against us.

God forgives us. There are other experiences: being listened to, forgiven, freed. A person who does not pass through such experiences will encounter difficulty in being forgiven because our hearts are small, narrow, and limited. To know how to forgive we need to recognise that we are sinners, to recognise that we are guilty, sinners, and ready to forgive. Forgiven, reconciled, we can become instruments of mercy and forgiveness.

The Prodigal Son (Lk 15:1-32)

The scene is the following in this parable: a son has gone off from the paternal home and does not want to have anything to do with his family…There is a father who hopes, who does not tire of hoping to regain his son. In the end he embraces him and gives a party for him.

The parable of the prodigal son is more the parable of the merciful father, of the father who goes out of his house and looks into the distance, who listens, who waits, without getting tired, for the return of his son. And the father recognises him from afar, goes to meet him, embraces him, puts a ring on his finger, invites him to the celebrations, places him to the full within his home; not as a servant but as a son who is embraced, kissed, forgiven, celebrated, rejoiced, because he was lost and now he is found; he is forgiven and a party is to be held for him.

The parable of mercy presents us with a great merciful father who forgives freely, who rejoices at the return of his son, and invites us to the following: a great and merciful love, slow to anger and rich in forgive-

ness; forgiveness that is celebrated with joy, with a party banquet. We also remember the cases of Matthew (9:9-17) and Zacchaeus (Lk 19:1-10). This is the greatness of a Father who opens his arms, always, totally, because he is filled with mercy.

'Go on your way and do you likewise' (Lk 10:37)

This is the end of the parable of the Good Samaritan, the phrase by which Christ wanted to teach us what our love for our neighbour should be: a merciful love, a love of welcome, an effective love. The Samaritan sees the man thrown on the ground half dead and goes over to the him, looks at him, is moved by him, draws close to him, treats his wounds, takes him to an inn and pays for him.

He engages in a good deed of mercy, a good deed of love. It is for this reason that Jesus asks: 'Which of these three – the priest, the Levite, or the Samaritan – seemed to you to be most a neighbour to the man who fell in with thieves? The answer is obvious: the man who had compassion on him. Because of this Jesus said to the lawyer: 'go on your way and do you likewise'.

Go on your way and do you likewise, the Lord repeats this to each one of us, we Christian health care professionals. Do the same as the Samaritan: draw near, have compassion, care, give of your life, share your good, your learning and expertise, your money…do what the Good Samaritan did. Do you likewise: love God and your neighbour: God with all your heart, with all your soul, with all your mind; and love your neighbour as yourself (Mt 22:37). In doing what the Good Samaritan did, the Christian health care worker will be a witness to this love of God, this mercy, and this forgiveness and reconciliation.

Should we pass by on the other side as the priest and the Levite did or should we draw near as the Samaritan did? To draw near a person in need and do so with ability, with expertise, with technical skill, with efficiency, but above all else to draw near with love.

Witnesses to a merciful love, the reflection of a greater love, the love of Christ, who passed by doing good. Witnesses to this are the saints of charity, especially John of God, Camillo de Lellis, Vincenzo de' Paoli and an immense army of merciful women. Their example leads us today to do the same: to have charity and to walk in charity. This is the cry of Pope John Paul II in the final document of the Holy Year – *Novo Millennio Ineunte*: to contemplate in the cross the cry of love, a face of resurrection, a face of life with an invitation to express it in everyday life, both in one's family and in one's profession.

To walk in charity (nn. 49-50) so that our love bears fruit; this is the hour of the creativity of charity, the Pope also says. 'Charity is the heart of the Church' said St. Theresa of the Child Jesus.

Through the anointment of charity we are signs of concord and peace, and this is pleasing in God's sight; as St. Paul declares: 'we are the aroma of Christ' (II Cor 2:15). The Church, society, and health care centres need this aroma of Christ. The health care professional is called to this, to be a witness to these values.

3. Joined to the Vines

a. Are all the limbs of the body active?[10]

By its very nature the Christian vocation is a vocation to an apostolate. In a body all the limbs behave in an active way – this is true of the Mystical Body as well.

A layman lives in the world and exercises his apostolate in it like a yeast (*AA*, 2)

Christians have a right to an apostolate through union with Christ the Head; inserted through baptism and reinvigorated by first communion (*AA*, 3).

Everybody has to work to ensure that the message of salvation reaches everyone. To practice this apostolate the Holy Spirit also grants special gifts as he so wishes (I Cor 12:11).

The apostolic life of a layman requires the constant exercise of faith (meditation on the Word of God), of hope (remembering the death and resurrection of Christ), and of charity (doing good to everyone).

This is not only a matter of proclaiming the message of Christ but also of filling and improving the whole of the temporal order with the gospel spirit. This proclaiming must be done through words and works (*AA*, 4 and 5).

b. Grafted onto Christ to give fruit

Christ is a vine with solid branches; we are the branches of this vine. I am the true vine and my Father is the vineyard keeper. Just as a branch cannot bear fruit if there is no vine, so also if you do not remain in me…because without me you cannot do anything (Jn 15:5), says the Lord. Through faith and the sacraments we join ourselves to Christ and he communicates divine life to us, in the same way as the vine and its branches make up a single plant. For this reason, without this union no fruit will come from this apostolate. To bear this fruit we must rely upon the Holy Spirit, who is light, strength, the leader of evangelisation. He is the protagonist of the mission of the Church.

In *Evangeli nuntiandi*, Paul VI says: 'Evangelisation will not be possible without the action of the Holy Spirit' (n. 75).

The following are phrases of Ignatius IV Hazim, the Patriarch of the Greek Orthodox Church of Antioch: 'Without the Holy Spirit, God is far

away, Christ remains in the past, the Gospel is a dead letter, the Church is a mere organisation, authority is dominion, mission is propaganda…But in the Spirit the cosmos is raised up and blooms in the trials of the Kingdom. The risen Christ is present, the Gospel is the force of life, the Church is Trinitarian communion, authority is service that frees, and mission is Pentecost'.

I believe that these phrases are a real practical translation of the gospel quotation: 'without me you can do nothing' (Jn 15:5).

Baptised, confirmed and sent to evangelise, to bear the fruits of the spirit that St. Paul points out to the Galatians: 'love, joy, peace, patience, kindness, goodness, faithfulness, gentleness, self-control' (Gal 5:22-23).

If we want to bear fruit within the Church, in our pastoral work, in our profession, in our bear fruit: the same is true of the Christian, grafted through baptism onto the real vine – Jesus; and the Christian is called to bear fruit, not on his own but joined to the vine. For this reason Jesus adds: 'Every branch of mine that bears no fruit, he takes away, and every branch that does bear fruit he prunes that it may bear more fruit' (Jn 15:2).

In the action of pruning the Father intervenes in personal life, the life of the community, and the life of the Church herself. These actions, this pruning, which at times make us suffer, are nonetheless guided by a great love because we bear more fruit in order to grow.

With regard to the vine and its branches, the Church stimulates us frequently to engage in this union, as we are reminded in particular in various sections of the *Catechism of the Catholic Church* (nn. 308, 755, 787, 1108, 2074).

lives as committed lay people, we have to make space, and I repeat the point, for the Spirit. With his force and his aroma we will certainly be more ready to help, more open to the needs of the Church and of our society, and more enthusiastic in our apostolate with the sick.

We have received the Holy Spirit to bear fruit and be witnesses to mercy, welcome and healing. If the Holy Spirit is in us, flames, vivacity and apostolic welcoming will certainly be lit inside us.

Jesus reminds us that a tree by its very nature is made to

And Pope John Paul II observes that taking everything into account there is the primary importance of grace and holiness. These are his words: 'There is a temptation which perennially besets every spiritual journey and pastoral work: that of thinking that the results depend on our ability to act and to plan. God of course asks us to really co-operate with his grace, and therefore invites us to invest all of our resources of intelligence and energy in serving the cause of the Kingdom. But it is fatal to forget that "without Christ we can do nothing" (cf. Jn 15:5).

It is prayer which roots us in this truth. It constantly reminds us of the primacy of Christ and, in union with him, the primacy of the interior life and of holiness. When this principle is not respected, is it any wonder that pastoral plans come to nothing and leave us with a disheartening sense of frustration? We then share the experience of the disciples in the Gospel story of the miraculous catch of fish: "We have toiled all night and caught nothing" (Lk 5:5). This is the moment of faith, of prayer, of conversation with God, in order to open our hearts to the tide of grace and allow the word of Christ to pass through us in all its power: *Duc in altum*!' (*Novo Millennio Ineunte*, n. 38).

4. Joined Together to Grow, to be the Salt of the Earth and the Light of the World. Called to be Witnesses to Joy and Hope

'We are to grow up every way into him who is the head, into Christ' (Eph 4:15); 'rejoice in your hope' (Rom 12:12). The Association of Christian Health Care Workers was created with the aim of growing together, as is to be read in the preamble to the statutes, which were approved ten years ago. This very spirit of union and communion is taken up in article 4 of the statutes, as are the other Christian dimensions – faith, hope, love, service to life, training, the sacraments - everything that the Christian health care worker is called to live in order to be a witness.

Called to be the salt of the earth and the light of the world (Mt 5:13-14)

What characterises salt is that it imparts taste, conserves, and makes food pleasant. What characterises light and is specific to it is that it illuminates; light is made for us to see, and it is for this reason that it is put in a high place. Salt and light remind us of the obligation to be witnesses. How? Through our simple lifestyle, which is luminous, pleasant, and healthy

– witnesses in our professional life, in our good works; they indeed must be the aroma of Christ, that is to say holiness.

'Let your light so shine before men, that they may see your good works and give glory to your Father who is in heaven' (Mt 5:16).

Called to be witnesses to joy and hope

In a world of tensions, of depression, in a world where many people are tired of struggling – because it is not worthwhile they say in a health care world in which many advances have really been made but where illness and death are still an enigma, in a world of so many lost hopes, the health care professional must be a sign, a witness to a rich struggle in hope, a prophet and witness who says with his life, with his consistency, with his joy and his simplicity, with his enthusiasm, that life has a meaning, that it is necessary to struggle, to generate life, to put oneself on the road of hope.

Hope is another one of the great positive dimensions of life. To hope is to live with an open window through which there enter rays of light, of enthusiasm, of a wish to carry on the fight. To hope is a tiring exercise. It is to believe in tomorrow, it is to make an effort today, it means not eliminating our good and fine wishes.

Hope is like blood: you cannot see it but it has to be there. Blood is life, and so is hope: something that circulates within you; if you don't have it you are dead.

The Letter of Taizé of 2003 has as its title 'God alone can love'. As regards hope it declares: 'Many aspire to live a time of trust and hope. In the Bible hope is not a creation of the imagination, it is rooted in the presence of God, who is never absent. 'For I know the plans I have for you, says the Lord, plans for welfare and not for evil, to give you a future and a hope' (Jer 29:11). This hope is a certainty - 'surely there is a future, and your hope will not be cut off' (Prov 23). The New Testament goes further by understanding hope as a reality which is already in movement: 'hope does not disappoint us, because God's love has been poured into our hearts through the Holy Spirit who has been given to us' (Rm 5:5).[11]

The life of man is hope. Two thousand years of hope and the courage to go on spreading hope in the world. Let us light our lamps of hope and what we think impossible will become possible.

Duc in altum! Have courage, it is me, do not be afraid! It is me, the Risen One. It is me, I am not a ghost! How often, when we have lost hope, there happens to us what happened to the apostles when they saw Christ walking on the water and thought that he was a ghost (Mk 6:45-52). The same thing happens to us when we are alone, with so many difficulties and so much wind blowing in our faces, we cannot see well, everything is dark, we lose the will to go on fighting…And so, is everything that I have in my hands a ghost? My family, my professional life, the Church, Jesus himself, are they all ghosts? Now, we need urgently to activate hope, to set sail, even if we vacillate, even if we see that the light is far off in the distance…We will find a door open, the door of hope; we will find Jesus when we least expect him, perhaps when we feel distant – but he is no ghost, he accompanies us, and the wind against us stops blowing. Hope is born.

The health care professional is called to be a witness to the hope that does not disappoint, a witness to, and a bearer of, a joyful message. Joy, happiness, Easter; a joy that spreads happiness, a joy that lasts, a joy which is the fruit of the Risen One, in opposition to the joy which is the fruit of noise and industry. Christian joy is born from the death and resurrection of Jesus. Health care professionals: listen to the song of joy, the Gospel of joy: glory to you Christ, who has illuminated the day of this new millennium; glory to you, Christ, who has filled our young millennium with joy and celebration. You are our hope, you are our joy, and you are our celebration. The Christian is born from the Easter of celebration, the victory of Christ, and he is called to celebrate it by making of it his experience and by communicating it, by being a witness to it.

Christ has risen: this is the paschal song that the Church proclaims every year. And everybody in a chorus answers: we are the witnesses to this resurrection. Christ has really risen; we proclaim this with our words and our lives.

I will conclude my paper with a page entitled 'Witness' that I found when reading a book by José M. Alimbau entitled 'Words for Difficult Moments'.(12) I believe that it sums up the Gospel-based approaches that I have attempted to describe in this paper very well: this identification of the Christian health care worker with Christ, who bears fruit and manifests it in his life as a witness:

'Your Life, the Only Gospel that they will Read'

The Barcelona poet J.V. Foix wrote a poem entitled 'new proof on the identity of Jesus'.

'Jesus does not speak: he says;
he does not write: he does;
he does not argue: he provokes;
he does not enslave: he emancipates;
he does not wound: he gives;
he does not fall in love: he loves'

– The Christian, in his ideal as the imitation of Jesus Christ:

– does not prejudge: he is kindly in outlook;
– does not oppress: he frees;
– is not insensitive: he consoles;
– does not sink: he raises up;
– does not defeat: he convinces;
– is not proud: he is humble;
– does not do evil: he does good;
– does not use power: he serves.

'When I look at his hands I remember that they are yours;/when I read his eyes they reflect your gaze; /there are not 'men' but the multiplied 'You', wrote my friend Martin Descalzo.

As Msgr. Helder Cámara said: 'do not forget that your life as a Christian is the only gospel that many people will read'

H.E. Msgr. JOSÉ L. REDRADO OH,
Titular Bishop of Ofena,
Secretary of the Pontifical Council for Health Pastoral Care,
The Holy See.

Notes

[1] J.L. REDRADO, 'Derecho del hombre a la salud', *Labor Hospitalaria*, n. 186.
[2] Cf. K.G. DOIG, *El ombre de la tecnologia* (Asociación Vida y Espiritualidad, Lima, 2000).
[3] Cf. P. MARCHESI, 'Umanizziamo l'ospedale', in AAVV, *Per un ospedale più umano* (Paoline, 1985).
[4] P. MARCHESI, *op. cit.*
[5] J.L. REDRADO, *op. cit.*
[6] Card. ENRIQUE TARANCÓN, 'La profesión sanitaria', *Humanizar*, February 1994.
[7] Pontificio Consejo para la Pastoral de los Agentes Sanitaros, *Carta de los Agentes Sanitarios* (nn. 1-10).
[8] Comision Permanente de la Conferencia Epsicopal Española, Inst. Past. *Los católicos en la vida pública*, 22-IV-1986, nn. 113-114.
[9] Cf. The Brothers of St. John of God, Secretariato Internazionale di P.S., Curia Generalizia, 'Pastoral de endermos en el hospital y en la parroquia', pp. 7-11
[10] Hermanos de S. Juan de Dios – Secretariado Internacional de Pastoral Sanitaria, *¿Qué es la Pastoral Sanitaria?* (Ed. Claret, Barcelona, 1980).
[11] Cf. *Ecclesia*, n. 3, 134-135, January 2002.
[12] Ediciones STJ, Barcelona, 1998.

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The Chaplain as Seen by Health Care Workers

The aim of the research was to gather data on the attitudes and opinions of a specific group of people with reference to the phenomenon subjected to study.

A 'sample' was used which reflected, on a lower scale, the population to be investigated in order to understand the tendencies or opinions of that population. In order to be valid the sample was stratified so as to represent the variables of the universe that was investigated.

Pastoral care, as an action of the presence of the Church in the world of health and health care, also uses scientific instruments such as research inquiries in order to assess the quality of service to the sick person, to his family relatives, to and health care workers.

The contextual location of this research was the hospital, the place where vulnerability and questions in the face of pain are experienced.

The objects of the inquiry were health care workers, and the subject of the inquiry was their perceptions of hospital chaplains.

The Stages of the Research

The International Institute of Health Care Pastoral Theology 'Camillianum' of Rome, in cooperation with the National Office of the CEI (the Italian Bishops' Conference) and the AIPAS (the Italian Association of Pastoral Care in Health) organised this study, the aim of which was to learn about perceptions of chaplains and expectations about them on the part of health care workers.

The inquiry was organised around the four following stages:

1. The preparatory stage: the identification of the objectives of the research and those people it was aimed at; the preparation of the instrument by which this inquiry would to be carried out.

2. The organisational stage: the identification of the distributors of the questionnaire; instructions for its use, taking into account the criteria of its representativeness and the best ways by which to compile it. The distribution of the questionnaire was entrusted to hospital voluntary workers in order to ensure its objectivity.

3. The analytical stage: the gathering and analysis of the data; intersections between the different variables (sex, age, profession, etc.) in order to assess elements of uniformity and differences, trends and/or counter-trends, and summarising tables.

4. The application stage: the indications that emerged from the inquiry were transmitted to the institutions that had promoted the initiative so that they could be borne in mind at an academic/educational level (Camillianum), at an organisational level (the Office of the CEI), and at a pastoral level (the AIPAS).

The data that were analysed offer precise guidelines for the training of chaplains and for the achievement of more effective witness and the planning of pastoral care.

The Sample of the Respondents

1,717 health care workers from almost all of the regions of Italy took part in this research project. For this reason, the sample was representative, both from a qualitative and a quantitative level, of the national reality.

The variables of the investigated sample were as follows:

– *Sex*: 60% females (1,024 respondents) and 40% males (693 respondents).

– *Marital status*: almost three quarters of the sample were married (1,200 respondents), there were 391 bachelors or spinsters, 60 divorced or separated people, 25 widows, and the rest were undeclared.

– *Age*: of the whole sample about two-thirds were of between the ages of thirty and forty (1,099 respondents), 390 were in their fifties, 137 were in their thirties, and the others were over sixty years of age.

– *Profession*: (Table 1) 848 of those interviewed (about a half of the sample) were nurses and/or ward sisters, 558 were medical doctors, 61 were physiotherapists, 54 were social workers, and the rest were psychologists or other kinds of professionals.

– *Religious faith*: 845 of the respondents said that they were practicing Catholics, 553 said they were non-practicing Catholics, 234 said they were believers, 53 said they were atheists, and a minority belonged to other religions.

– *Hospitals investigated*: 554 of the respondents worked in hospitals with over 500 beds, 564 worked in hospitals with between 250 and 500 beds, and 505 worked in health care structures with less than 250 beds. Of the whole sample, 1,613 respondents (almost all of them) worked in public hospitals and 97 worked in private hospitals or hospitals administered by religious bodies.

– *Geographical areas:* 42% of the respondents came from the regions of northern Italy, 18% of the respondents came from the regions of central Italy, and 40% of the respondents came from the regions of southern Italy.

An X-Ray of the Answers

The research was characterised by a nucleus of questions accompanied by different possible answers to be chosen in terms of priority or importance. These questions were preceded by a question about the frequency of contacts that those interviewed had with a chaplain, and this helped us to understand the subsequently described perceptions in a clearer way.

From the answers to the questionnaire it emerged that 659 of the respondents had had irregular contacts with their chaplain, 578 had had rare contacts, 367 had had frequent contacts and 195 had never had contacts.

This first survey does not provide a very favourable picture of chaplains, who, indeed, do not appear to be very present or visible in the eyes of the health care workers.

The reasons for the low level of contacts could be due to: different work schedules, the non-presence of chaplains in the staff of the institutions concerned, and the confidential character of pastoral agents or their tendency to confine their pastoral work to the essential.

However, the message is clear: one cannot build a team that honours the spiritual dimension of the patient if the protagonists of this framework are not actually present.

Table 1

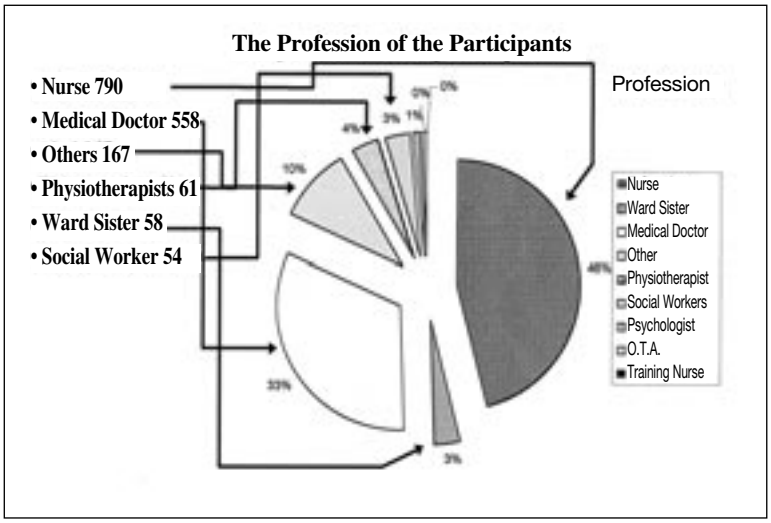


Table 2

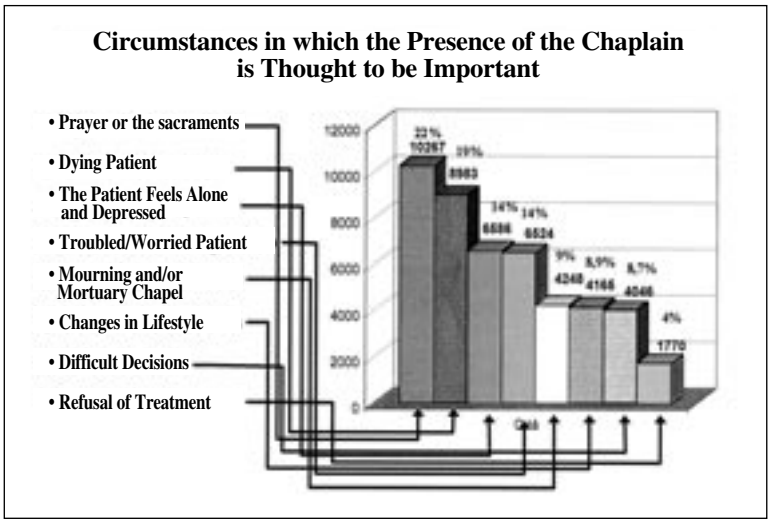
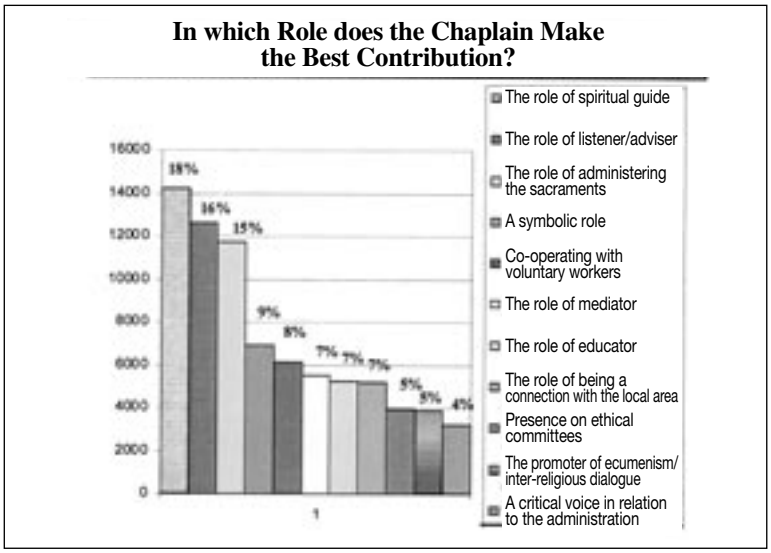


Table 3



Perceptions Derived from the Other Questions

1. The circumstances in which it was believed the presence of the chaplain was important.

The answers (Table 2) confirmed orientations established by long tradition. There stand out, in order of importance, circumstances in which the patient wished to receive the sacraments or the comfort of prayer; and, secondly, circumstances involving the accompanying of the dying.

The occasions involving pastoral comfort when the patient is alone and depressed, feels troubled and worried, or finds himself in circumstances involving mourning or death, were mentioned quite a lot.

Of less importance was the need for a chaplain when the patient has to address ethically sensitive decisions, rejects a treatment, or experiences difficult changes in his lifestyle.

2. Roles in which a Chaplain Can Offer his Best Contribution (Table 3)

The importance of his contribution as a spiritual guide stood out, followed by his role as a listener or adviser, followed by his role in administering the sacraments.

Mentioned quite often were his role in co-operating with voluntary workers, his role in educating people within his institution, and his role as a connecting agent with the local area.

Of less relevance or significance were his presence in ethical committees, his promotion of ecumenism or inter-religious dialogue, and his role as a critical voice in relation to the administration of the hospital structure.

3. Attitudes that Can Damage the Credibility of a Chaplain (Table 4)

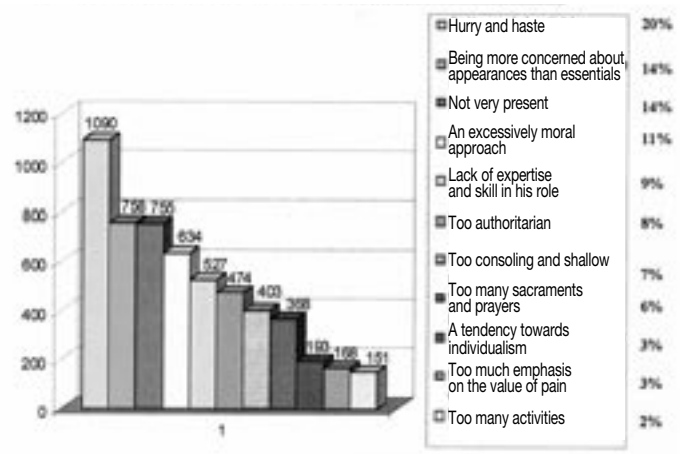
The attitude that was indicated as being the most damaging by the majority of respondents was hurry and haste on the part of the chaplain. This was followed, at almost the same level, by the perception that the chaplain tended to care more about appearances that the essentials and that he was not very present.

Mentioned quite a lot was the perception that the chaplain manifested an excess of moralist thinking, that he was incompetent as regards his role, or that he was too authoritarian.

Of lesser importance were the perceptions that he was involved in too many activities overall and that he placed too much emphasis on the value of pain.

Table 4

Potentially Harmful Approaches



4. The Qualities to be Wished for in a Chaplain (Table 5)

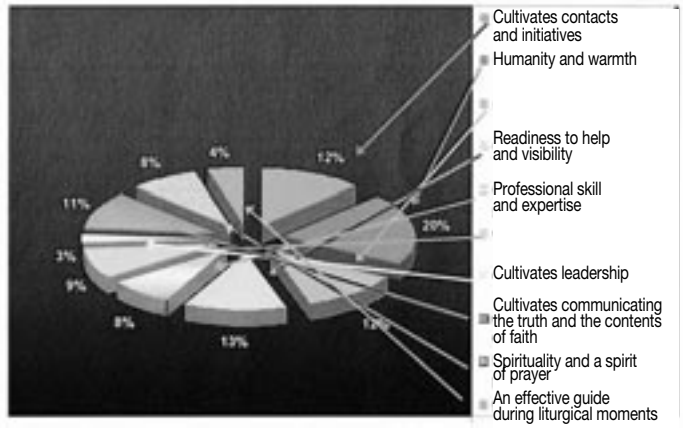
The quality that was most praised was that of being a bearer of humanity and warmth, followed by the qualities of readiness to help and visibility, followed in turn by openness and tolerance.

Of some importance, for many of those who were interviewed, were his capacity to communicate the truth of the faith, his spirituality, his balance and maturity, and his professional skill and expertise.

Held in less account were his capacity to foster liturgical moments and his effectiveness in his role as a leader.

Table 5

What Qualities should a Chaplain Have?



5. In the Interdisciplinary Team when is the Presence of the Chaplain Especially Needed?

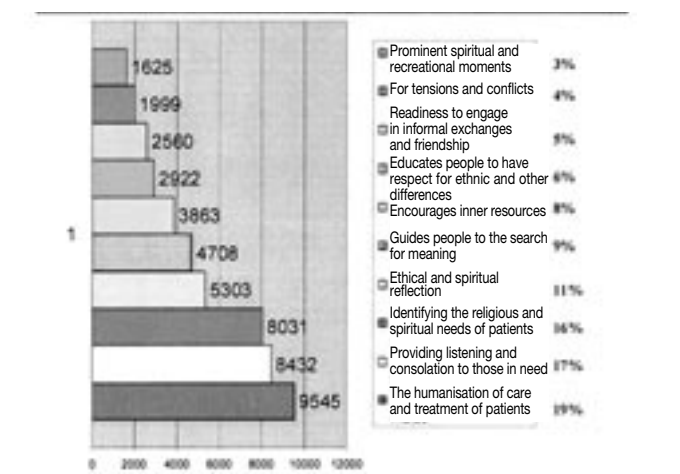
The most prominent heading given by those who were interviewed was that the chaplain should make a contribution to the humanisation of the care and treatment of sick people, followed by his capacity to offer listening and comfort to people, which was followed in turn by his skill and expertise in diagnosing the religious and spiritual needs of patients.

Quite often mentioned was the need for his presence to help people reflect on ethical and spiritual questions and issues (death, forgiveness, euthanasia, God…), his capacity to guide people towards searching for meaning, especially in difficult circumstances, followed by his ability to bring the inner resources of people out into the light of day.

Less cited were the need for the chaplain to foster spiritual or recreational moments, to be a mediator in circumstances involving conflict, and to educate people to have respect for ethnic, cultural or religious differences.

Table 6

When the Presence of the Chaplain is Required



6. At Times the Chaplain is not very much Appreciated by the other Health Care Workers. Why is this?

The most frequently mentioned explanation was that the chaplain was not known by the staff, followed by the perception that he tended to work on his own. This, in turn, was followed by the view that he tended to work with approaches that were overly religious or traditional in character.

Somewhat frequent were the perceptions that he was an elusive or detached person, that he emphasised paying attention to patients and that he therefore neglected members of the staff, and that he seemed to be uncomfortable in his relationships with the other professionals.

Less mentioned were the views that he was not appreciated because he did not take part in interdisciplinary meetings, that he was shallow or that he had a rather rigid character.

The Indications that Emerge from this Inquiry

This research presents a uniform mapping of trends with only slight or minimal variables, in the light of the intersecting tables which take into account the different variables: the geographical areas of the respondents, their sex, age, profession, marital status, religious observance or otherwise, and the health care structures in which they work.

The respondents were highly qualified people and were careful observers of human nature.

The interest demonstrated by the respondents legitimates the value of the chaplain within the interdisciplinary team. Plebiscite-style votes on the quality of the chaplain are not to be found but the need clearly emerged for strong spiritual guidance marked by humanity rather than for someone who is more concerned about appearances than the essentials. If we have to talk about a crisis, it does so much concern the religious expectations of those who were interviewed – which diminish the validity of the view that we are undergoing increasing secularisation – as the interpretive models of the pastoral presence.

The crucial aspects that emerge from the inquiry relate to certain priorities that the chaplain is called upon to follow.

The first challenge involves *making himself known* to the health care workers. The view is that he is not present, that he is governed by haste, that he is elusive or that he pays too much attention to patients and thereby neglects the members of the staff.

Secondly, emphasis is laid on the need for his presence so that he can contribute to the *humanisation of care and treatment for patients*.

To humanise it is necessary to humanise oneself by cultivating those human qualities, such as warmth, a capacity to listen, openness, and a readiness to establish contacts, that make a chaplain closer to patients and the members of the staff.

The third need is for the chaplain to be really a *spiritual guide* within the hospital. Those who were interviewed voiced the need for the pastoral worker to make a contribution to overall care by demonstrating skill and expertise in diagnosing the religious and spiritual needs of patients and by knowing how to direct people to a search for meaning during difficult moments.

A fourth priority was for the chaplain to educate himself as regards *teamwork* so that he could make himself more appreciated by health care workers.

Here – *ad intra* – emerges the challenge, which is also imposed by the limited number of chaplains, to work in harmony at the level of aims with the other religious and members of the laity who form the so-called 'chaplaincy'. The chaplain can also evangelise by creating so-called 'pastoral councils' by which to foster the life of the hospital community at various levels (the spiritual, the human, the cultural and the recreational).

In addition, teamwork requires greater attention to be paid to dialogue and co-operation with medical doctors, nurses, voluntary workers and other categories of professionals who are dedicated to caring for and treating sick people.

In the light of the new health care approach, which reduces the days of stay in a hospital to a minimum, a 'reorganisation' of pastoral activity is required, and hitherto pastoral activity has always laid emphasis on the patient. Perhaps the moment has come for us to shift our emphasis and give more space to pastoral care for the members of the hospital staff so as to bring about, in the final analysis, a better service for patients and their families.

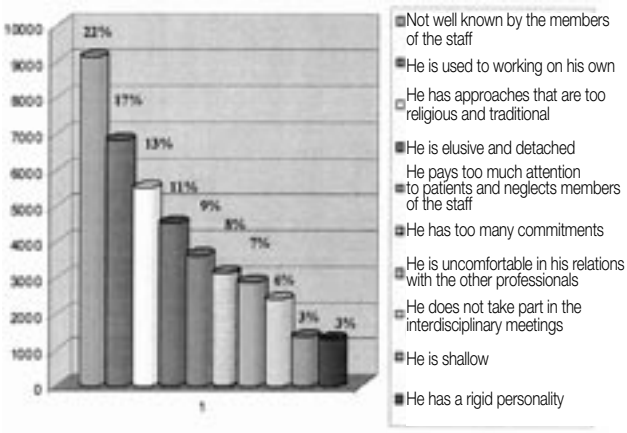
The data that emerge from the inquiry are many in number and deserve reflection, thought and effective answers. The basic observation to be made is that the spiritual/religious dimension is an important factor in the experience of the respondents and patients.

The heart of the challenge is the creation or strengthening of suitable conditions so that the chaplain, the voice and witness of the Church, works to make an effective and healing contribution to institutions, to patients, to their families, and to the interdisciplinary team through a presence that is above all 'spiritual guidance clothed in humanity'.

Rev. ARNALDO PANGRAZZI

Table 7

The Reasons for the Low Appreciation of the Chaplain



Schools and Health: A Pastoral Perspective

There can be no doubt that education and health are the principal instruments that society possesses by which it can achieve its overall and sustainable growth, in line with the extent to which it promotes skill and expertise, well-being and social integration.

These two dimensions of the life of every human being are especially important in infancy and youth because their presence or absence to a great extent condition the fulfilment or the frustration of the whole life of a person. For this reason, it is of primary importance for education and health to be major presences in the contexts of children and young people.

The Church is aware not only that the right to education is required for all children and young people but also that this education should deal with subjects and situations that are vital to their growth and development. As the Congregation for Catholic Education states: 'The education sciences, which previously revolved around the study of children and the training of their teachers, have been led to open up to the different stages of life, to the various contexts and situations which lie beyond the school. New requirements have led to a need for new contents, new skills and new educational figures, beyond the traditional'.[1] And in relation to these new figures or contents we find that 'health' is an increasingly important element within schools.

We can certainly affirm that the subject of health has always been present in schools, but it has been present in a fragmentary and isolated way – something that at times has been the responsibility of certain specific subjects (especially the biological and behavioural sciences) or the responsibility of medical and nursing staff within the educational institution. What is new at the present time is the recent attempt that is being made to achieve integration - the policy of the integration of health into all the contexts of a school. I am referring here to its institutional plans, the staff guiding it and administering it and involved in teaching, the fathers of families, its students, and the nearby communities.

The integration of 'health and schools' has a special importance for the Church and present-day society: there are very many religious communities whose charism revolves around commitment to the sick, to children and to young people, and which look for paths by which to achieve integration. On the other hand, state and private schools are interested in promoting health in their own school contexts. It is no accident that the Pan American Health Organisation has been strengthening the 'healthy schools' project throughout America with the aim of promoting and caring for the health of all the members of the educational community and keeping the contexts of study, work and social life healthy.

1. Towards an Overall Concept of Health in Schools

The concept of health is dynamic because it is a historical-cultural creation. Indeed, it changes according to the epoch, cultural development and life conditions of a population. What can be said of this concept can also be said of attitudes and educational strategies in relation to health.

We will now examine the way in which the concept of health has evolved, the ways in which it is understood, and the attitudes of the members of the educational community which derive from the idea that they have of health.

The first stage: health as the opposite of illness

In this stage health is understood in terms of its opposite – illness. In this way, being healthy means to be free from illness. Health = the absence of illness. This definition leads us to a medical-biological approach: the 'experts' of health are the professionals of medicine alone and people are limited to a passive role where they await for the appearance of illness before placing themselves in the hands of a medical doctor. In this way of thinking, the concept of curative medicine holds sway.

This definition of health involves a teaching body that provides informative health education. In locating health in the absence of illness, the physical dimension predominates and health education is understood as the transmission of knowledge marked by a biological or medical vision.

In the classroom attention is paid to anatomy and the constitution of the body, to the working of the bodily organs, to the first forms of care and treatment that are provided, and to diseases, microbes, vaccines, blood etc. This approach to health looks for health care staff who can give lessons to students. It sees health as the contents and education as the process. In schools it promotes the diffusion of information about the most important characteristics of the most common illnesses so that students are informed about them and will try not to contract them.

The second stage: health as balance in relation to the environment

From the first medical-biological concept of health we move to an environmental paradigm which sees health as the result of the balance and interaction of people with environmental factors such as the air, the temperature, water, the sun and diet, and the way in which people live and become fulfilled.

The creation of better environments was the principal objective of the health care movement of the nineteenth century. This was due to the fact that the level of health of a population

is determined to a great extent by its overall environment. Health is thus understood in this way of thinking as the balance that exists between the individual and his environment, such that when this equilibrium is changed or broken illness is the result.

An important contribution to this stage of development in the concept of health was the notion of adaptation, which is complementary to the concept of balance. The physical and social environment is in a state of constant change because of natural causes and human intervention. Being able to adapt to the new situations that are constantly appearing, or which we ourselves create, means being

healthy. This is because such adaptation allows us to recover balance in the new circumstances that have emerged. Thus every moment in the life of a person is a situation of unstable equilibrium, a state that is dynamic and changing, and in which health and illness coexist: illness appears when a person encounters difficulties in adapting to the on-going needs of the environment.

This stage involves a concept of health education that is termed 'environmentalist'. It argues that the health of an individual does not come from the individual himself but from outside him, from the 'system'. For this reason, it is more important to work to reduce the differences between the social classes than to encourage the most disadvantaged members of society to engage in certain kinds of health-inducing behaviour (namely, not smoking, eating less fatty foods, and so forth).

This approach involves the study in the classroom of the environmental factors that influence people's health: the contamination of the soil, of the air, and of water; noise pollution; the pollution of food etc. This teaching approach can engage in campaigns of varying types of affirmations in order to improve the environment with a view to ensuring that the people who live in that environment have their health improved.

The third stage: health as an ideal of well-being

With the advance of public health and the discoveries about the influence of the environment on people's health, the World Health Organisation proceeded to broaden the concept of health. According to the definition of that organisation: 'health is not only the absence of illness but a complete biological, psychological and social well-being' (WHO, 1946).

Here we encounter innovative aspects that see health in positive terms and which add to the previous biological area of reference two new areas, namely the mental area and the social area. For this reason, a person is healthy not only because he has a certain physical well-being but also because of his mental state and the social conditions in which he lives out his life.

For schools, this conception advanced by the World Health Organisation constituted a major contribution because it allowed a contemplation, analysis and performance of the activities of learning and teaching connected with health in three areas of knowledge: biological knowledge, psychological knowledge, and social knowledge, with which, indeed, it is especially bound up.

For that matter, this state of complete well-being is not something that has already been achieved – it is something that has to be secured. This leads us to a preventive model of health education. To the study of anatomy and the physiology of organs are added the subjects of hygiene and prevention, seen as questions relating to what should and should not be done to achieve the best state of well-being.

This approach refers to illness and personal and social behaviour because it addresses subjects such as accidents, mouth hygiene, drugs, and diet; it acts through vaccination campaigns etc. It believes that telling students about how they should behave when confronted by certain situations is important – situations such as washing one's teeth, not smoking, sport etc.) – so that they can obtain a better state of health.

The fourth stage: health as a lifestyle

Moving one step forward in the construction of the concept of health we encounter a valid contribution made by the Congress of Medical Doctors and Biologists held in Perpiñan. This meeting saw health as 'that way of living that is autonomous, solidarity-inspired and joyous', that is to say health is profoundly linked to the behaviour and lifestyle of people. From this point of view, health is not so much a state of well-being as a process of being well, of living well, which is expressed in three essential characteristics: autonomy, solidarity and joy.

Autonomy. The lack of health involves changes in levels of autonomy. The human organism cannot disengage sufficiently from its environment, it has to stay in bed, or at times the individual is limited in his movements because of fractures, paralysis etc. According to this view, a health-inducing response, during illness as well, is to strengthen the autonomy of people. In contrary fashion, repression and dependence increase states that are not healthy.

Solidarity. This important element is a necessary complement to autonomy. This is because autonomy does not mean isolation or selfish individualism. On the contrary, real autonomy leads a person to co-operate with others. How often,

even though people are not biologically infirm, do individuals and groups of individual manifest a lack of overall health by acting in a way that does not involve solidarity! Paul VI was right when he declared: 'The world is sick. But its sickness

does not consist in a lack of resources but a lack of brotherhood between men and peoples'.[2]

Joy. This is the third characteristic of real health – deep joy, the joy a person feels at being alive. An environment that produces anxiety, depression, fear and bitterness, is a sick environment that makes people ill. In society, the family and schools, joy must be a condition for the promotion of the health and the quality of life of people.

In line with this concept, the prevention of health in its focus must centre around forms of behaviour that increase the frequency and the intensity of risk factors connected with the contraction of illness. Personal habits and individual lifestyles (where people are conditioned by the culture of their relevant social group) are the principal substratum of risk factors. Health is not a fixed or ideal state or a goal with certain characteristics but a path of continual improvement in quality of life; it is a process of personal development so that one's own resources and abilities become complete the more they are suitably used.

This concept involves a formative vision and a vision of personal responsibility in relation to health education. It argues that the causes of health and illness are to be found in one's own person and thus we have a role as protagonists in the outcome of this process of 'being well' because we ourselves are the masters when it comes to whether we do or do not do what we want and choosing our own lifestyles.

This approach understands the difficulties encountered in acting upon the environment so as to change it and it is based upon the pupil so as to educate him to the utmost to ensure that he tries to develop his abilities and resources not only in order to avoid contracting illness but in order to be able to acquire levels of quality of life which are ever higher. To the prevention of illness are added questions of personal relationships, self-esteem, and the development of the capacity to choose in a sensible way etc.

The fifth stage: health as personal and social development

Here we are dealing with a vision of health where health is seen as a means by which to achieve the overall development and growth of the person; where health is seen as a means (not as an end); and where health is perceived as a right by which we are able to fulfil our potential. We do not live for health but we strive to have health so as to live in a fuller way. Health is a daily achievement, a personal and social achievement, and a physical, mental and spiritual achievement by which we can improve our daily quality of life.

The Church promotes this overall concept of health through the Pontifical Council for Health Pastoral Care, which was created by John Paul II.

'Temporal health grows in maturity until it blooms into eternal health. Indeed, every stage of the life of man receives a task from God our Lord that he should perform, a mission to carry out, which is not the same task as that which a child or elderly person has to perform. At every stage there is a special supply of health is needed, which is different from one stage to another. It requires a necessary concrete life, a necessary health, in order to carry out the mission that God asks of each one of us. Pain is not extraneous to each stage and thus pain and suffering are not necessarily banished from the pleasure of health. A person is always in a dynamic tension towards full health understood as total harmony and peace. And thus in old age as in any other stage of life one can be joyful about health even in the presence of illness, as long as one has what is needed to perform the mission that God our Lord has entrusted to each one of us during each of the stages of life that we find ourselves in. And when death arrives this is not a lack of absolute health but the maturity of temporal health that leads to eternal health, to the total harmony which the Apocalypse describes as peace, as rest in the peace of Christ'.

'Perhaps we can sum up of all of what has been said with an essay which describes in a Christian way what health is, and conclude by complementing the definition made by the World Health Organisation by saying that 'health is a tension towards physical, mental, social and spiritual harmony and not only the absence of illness, which makes man able to carry out the mission that God has entrusted to him according to the stage of life in which he finds himself'.[3]

For this reason, 'health does not necessarily exclude pain, and, although this seems contradictory, it does not exclude the whole of the illness… Health as pure absence of ill-

ness is a utopia that does not exist anywhere because man is of necessity mortal. Health is a means by which to carry out a mission and as is evident it changes according to the mission that must be fulfilled. This means that this changes according to the stage of life in which a person finds himself. From this point of view one can clearly see that spiritualised pain blooms into a solidarity-inspired action towards a previously defined goal: health as a real opportunity to fulfil each person's vocation'.[4]

Both the environment and lifestyles affect health but what is most important are the actions that are developed not only to adapt oneself to the conditions of one's environment but also those whose goal is to transform that environment so as to make it more human and healthy. This is a matter of taking part in the development of society. Health, like illness, has a multi-causal origin. Health becomes 'personal, social and transcendent development'.

This concept gives rise to holistic and overall health education which we could also see as individual and social development. A person is not an isolated individual but is part of a community and an environment, and thus one must act with personal behaviour and actions that modify the environment. For that matter, a person lives out the stages of his life where his contribution to society depends on his age and his corresponding state of health. Equally, this physical and psychological development is matched by a moral and spiritual development which is also connected with total health.

'Only with a holistic concept of life is an overall concept of health possible, understanding that it depends upon many factors such as housing, diet, working conditions, recreation, sport, the exercise of freedom, respect for other people, taking care of nature, and striving for harmony with one's environment. A holistic vision is a totalising vision of life, wider than the reductive and positivistic vision of a form of medicine which only has illness as its objective'.[5]

In this sense, teaching, in addition to trying to develop positive attitudes and the acquisition of healthy rules of behaviour, procures the creation of environments where healthy choices are easier to make than those that are not healthy. It takes part in community-based actions and does not only seek to change physical-environmental conditions but also aims to contribute to the generation of climates where changes in beliefs and the growth of values can take place.

Box 1

A Framework Summary of Conceptual Models of Health

Stage 1: Health as the absence of illness and infirmity. This is a synonym for life. It involves such concepts as: medical doctors, medicines, hospitals…
HEALTH EDUCATION CENTRED AROUND INFORMATION

Stage 2: Health as balance with the environment, a dynamic process of adaptation to the environment. Social well-being. This approach involves such concepts as: habitat, the environment, adaptation, balance…
HEALTH EDUCATION CENTRED AROUND THE ENVIRONMENT

Stage 3: Health as a state of well-being, as an ideal of life. This approach involves such concepts as: diet, sexuality, prevention…
HEALTH EDUCATION CENTRED AROUND PREVENTION

Stage 4: Health as a lifestyle. The need for internal and external processes of change. This approach involves such concepts as: behaviour, process, values…
HEALTH EDUCATION CENTRED AROUND FORMATION AND RESPONSIBILITY

Stage 5: Health as a means by which to achieve full personal and special growth and development. This approach involves such concepts as quality of life, human rights, education, lifespan, spirituality…
HOLISTIC HEALTH EDUCATION

2. Health in Education: Integration Strategies

Bearing in mind the importance of health for the educational community, we cannot limit ourselves solely to the construction of the concept. When rooted in this holistic approach, we must move towards its implementation through strategies that allow us to effect its integration into schooling.

The student is a psycho-biological, social, and spiritual being, and his learning ability depends upon his social environment, upon the conditions offered to him by his school and family, and upon his state of physical, mental and spiritual health. For that matter, the heads of the school, the members of the administrative staff, and the teaching body are also bio-psycho-social and spiritual beings who have the same need for harmonious personal growth and development as well as the same problems and expectations in relation to keeping their bodies, minds and spirit in a fit state. Social matters influence their health both positively and negatively, and on their correct functioning depend work performance and life enjoyment.

Lastly, just as health influences school life at its various stages, so schools are called upon to provide their support to the world of health and health care. In recent decades there has been a growth in the awareness of the need to assimilate the advances in teaching methods into the programmes of public health. The right to health involves not only access to health services (health care centres, clinics, hospitals and the staff of the medical sciences) but also education as regards those elements that allow

us to prevent illness and improve well-being, such as diet, physical exercise, the principles of mental health, overcoming forms of incapacity, conflicts etc…

Health education begins with schools and is extended to the whole of the community. The education sciences have a specific role and responsibility in relation to children, young people, families and society as a whole,

The complexity of this subject, the various levels and aims that must be secured, require a strategy regarding the procedure to be followed. A process

is a series of steps, sequences, transformations and interactions that take place during the search for a framework or a specific purpose.

I will now present the processes and the activities that are required to obtain a suitable integration of the world of health and health care into the world of education, observing at the outset that 'the processes are not always linear in character along the lines of a trajectory of a ray of light – it is possible that a process seems more often the flight of a butterfly with its irregular movements, twists and turns, successes and mistakes, advances and errors, moves forwards and moves backwards, and repeated attempts to go on. At other times it can follow a pathway marked by branches, meshes, layers and so forth, but it always follows a principal trajectory. Along this pathway some partial results are obtained whose improvement of the skills and expertise involved have to lead to better results, which in turn, if possible, must lead to great results at the level of education'.[6]

The awareness process

In accepting that the concept of health is a construction that is achieved progressively moving from a limited and simple vision to a complex and holistic one, we have to conclude that in order to obtain the integration of education and health within schools it is necessary to follow a teaching project in relation to awareness which is progressive in character and which takes place in all parts of the educational community.

In the various experiences that have been undergone in various countries of Latin America, we have promoted a series of laboratories in colleges of primary and secondary education (belonging to the Religious Institute 'the Children of the Sacred Hearts'). The following have taken part in these initiatives: members of religious orders, teachers, support staff, and fathers of families. In these laboratories an investigation is carried out into the existing level of awareness about health so as to be able complement that awareness with the more complex ideas that have already been explained and discussed in this paper.

The awareness process begins with the ideas and experiences that the educational community possesses in relation to health or illness. The mental constructions that people form are related to their experiences and the knowledge that they have acquired hitherto. During days dedicated to reflection on this subject, educators and students should be encouraged to express their ideas about what health is and its various elements and levels. An appeal must be made to their creativity. For example: their ideas should be expressed through the methodology of a mental or conceptual map, through diagrams, through social plays, through poems, through pictures and so forth.

These methodologies of reflection carried out in groups help not only in the drawing up of an overall concept of health but also in changing attitudes and forms of behaviour, in placing people actively in their environment and in leading them to consider their relationships with that environment and other people, and in being active promoters of health within the community.

The process involving the integration of health and schools

Once the various elements within the community have begun the awareness process and have enriched their concepts of health, it is necessary to continue with a process marked by the integration of health and quality of life into the curriculum of the school involved and into all the sections of the school environment.

The process of the integration of such elements into the curriculum can take place at three levels: one is organised through activities involving theoretical-scientific interest, with the participation of the whole of the educational community and the guidance of teachers who are specialists in the various branches or disciplines connected with the formation of an overall concept of health, or the contribution of students in research and the carrying out of work that can be of general interest. This level is

engaged in through conversations, conferences and video-forums on specific questions and issues that emerge as problems in the school and the social environment. For example: drug addiction, sexually transmitted diseases, violence and mental health, spirituality as a source of health etc.

Another level of the organisation of the curriculum in relation to health refers to the drawing up and development of teaching projects by areas or in the classroom. This involves organising activity or events with projections as to the time and the specific character of such activity. The 'guidelines for action' that are listed below offer us a rich gamma of possible activities and events that can be engaged in through teaching projects.

As an example of an organisation of the curriculum around health we have the St. John of God Institute of the Hospital Order in Colombia, which proposes as its leading subject axis the motto 'life is health and health is life', which is engaged in through subjects and teaching projects according to each level of the school in the following way:

Subjects

Pre-school, nursery school - transition: the way the body is organised; care for and conservation of the body; habits involving hygiene and image of oneself; diet.

Basic education - levels 1-3: knowledge of the biological processes; inheritance and the evolutionary processes of living beings; the relationship between human beings and their environment; the interchange of energy within ecosystems.

Levels 4-6 - the life processes and the organisation of living beings; inheritance and the evolutionary processes (II); relationships with the environment (II); levels 7-9: the structure of the health service; the levels of the organisation of the national health service; the inter-relationship of living beings.

Vocational medical education (10-11): prevention and health; pastoral care in health; paramedical assistance; administration and health.

Teaching Projects

Living together in society and democracy; the overcoming of conflicts.

The environment.

The prevention of disasters.

Sexual education and the formation of emotional life.

The use of free time.

Social service and health.

Contexts and Protagonists

The world of health and health care is complex in character. As a result, it must be tackled from the point of view of a large number of disciplines, embrace the various contexts in which children and young people, educators and fathers of families, managers and highly placed people connected with the administration and well-being of the school, all find themselves.

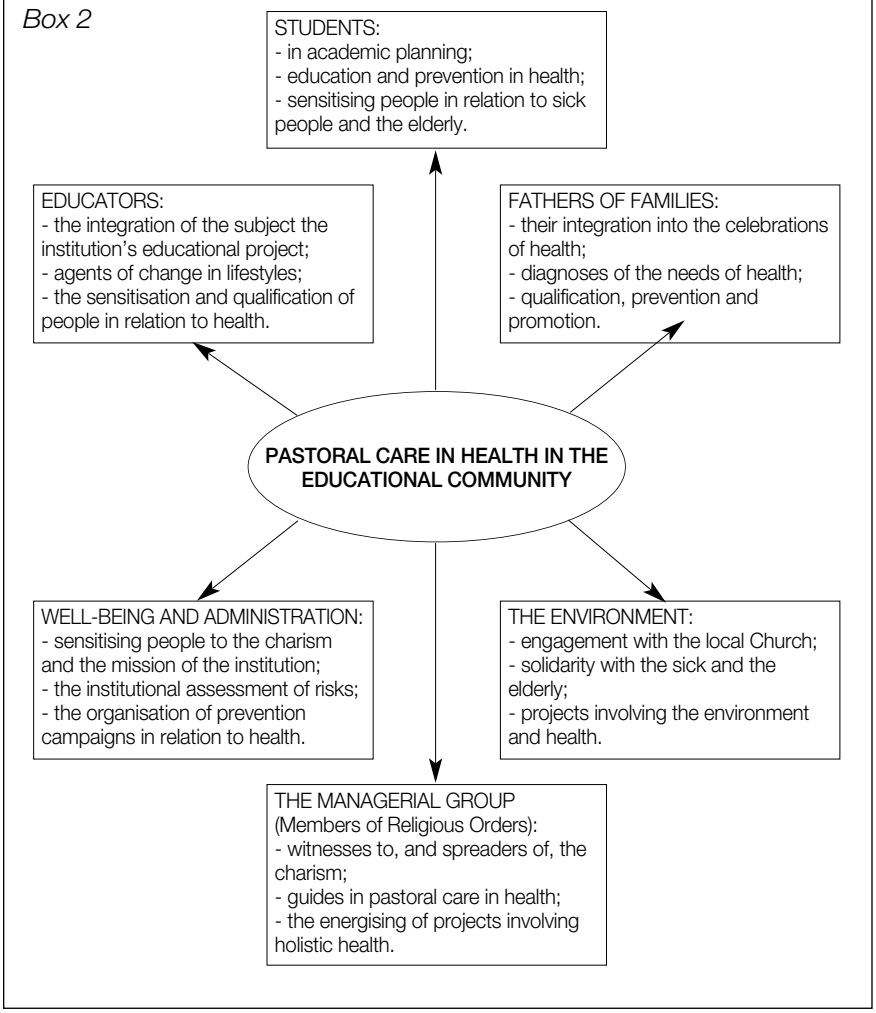
In this way the subjects and problems must be addressed not only by the disciplines of physics, chemistry, biology, psychology, ecology and physical education but also by ethics, economics, politics, history, geography and so forth, and in a way that seems to construct overall contexts of reference.

It is advisable to begin with the formulation of projects that integrate the various contexts and disciplines of the school. At the beginning it is more feasible to start with individual projects such as a teaching project, a curriculum project, and the institution's educational project.

The whole of the educational community is the protagonist of all of this: each level, according to its capacities and responsibilities, is called to be connected to the various forms of knowledge so as to contribute to the construction of overall health in the school, which includes physical health, mental health, social (environmental) health, and spiritual health.

In Box 2 we can see how the whole of the educational community is involved in this task. In this box reference is made, for example, to certain responsibilities and activities that each

Box 2



group can engage in to the benefit of everyone in order to reach the results at the level of the curriculum which lead us to overall health in the school context. These results can be assessed by taking into account:

– Knowledge (concepts, principles, laws, philosophical or sociological approaches).

– Skills and expertise (capacities, aptitudes, knowing how to know, knowing how to act, knowing how to be…).

– Attitudes and values (of an ethical, aesthetic, civic, volitional, affective kind; interests; motivations…).

– Forms of behaviour and performance (actions, procedures…).

Guidelines for Action

For the strategies and procedures that have been adumbrated above to be enacted, it is useful to have available a good list of activities and events that can inspire the protagonists of the educational community to be active through concrete projects. I here offer the results of twelve laboratories which have gathered together the contributions of the members of religious orders, teachers, administrative and well-being staff, and fathers of families, in the process connected with the colleges of the community of the 'Daughters of the Sacred Hearts'.

Guidelines to Sensitise People about Health and the Sick

– to include in the educational project of the institution the subject of pastoral care in health;

– the sensitisation of educators in relation to the holistic concept of health and its influence on education so that it can transcend the students and their families;

– the development of alternative projects: ecological walks, interdisciplinary camping;

– the orientation of the 'Friends of the Sick' group towards service to the sick and the elderly; its co-ordination with the pastoral care in health carried out within the dioceses;

– the promotion of health groups integrated with other levels; days of solidarity demonstrated towards those most in need;

– the narration of experiences of illness at an individual and family level with the expression of the sentiments that are felt and those that are felt towards the sick; the holding of conversations on the illnesses that attack the contemporary world and their possible causes and systems of prevention; the making of dramatic statements on this subject;

– the production of leaflets that help in the strengthening of solidarity and respect towards sick people; the publication of articles which refer to illness and its prevention;

– the celebration within the college of significant dates – the week of the sick, the world day of the sick, the world day of leprosy, the day against smoking etc.;

– the use of qualified human material within the institution in matters of health so that it can serve as a support group; the orientation of students and support groups towards pastoral care in health;

– the practice of values and spirituality as an integral part of the formation of human beings – a healthy mind in an unhealthy body.

Guidelines for the Environment and Healthy Lifestyles

– ensuring the healthy conditions and safety of the members of the community; the promotion of the good use of instruments, chairs and equipment (position, good posture); the promotion of habits involving preventive hygiene;

– educating people to have respect and tolerance ('the tolerance race'); the promotion of forums on juvenile violence; the organisation of life festivals (dances, music, theatre);

– the programmes posted up outside offices, and those concerning social service, should focus on empathy and work to meet the needs of the core groups of the poorest part of the population, in co-ordination with the health institutions of the town council; this should be social work that involves drawing near to street children, to adults and to young people who are engaging in forms of behaviour at risk, to mothers who are heads of their families, and in general to groups who have been victims of violence and social disintegration;

– education in relation to health and diet with the creation of an awareness of the benefit of good dietary habits through the use of the school shop; the provision of an eating hall to the poorest students;

– teaching children about the value of health and life during moments of gatherings, acting together and reflection; conferences on the prevention of illness and the maintenance of health;

– learning to use and administer free time by developing to the utmost the capacities and talents of people and sharing with them so that they produce both personal and community well-being – examples of this are: art, music, painting, physical expression, gastronomy, confections and so forth.

Guidelines for Education, Promotion, Prevention and Commitment

The subjects that integrate pastoral care in health into the educational community are the following:

– physical education and health;

– diet for good activity;

– the relationship between drug taking and performance;

– sexual education;

– democracy;

– prenatal and postnatal gymnastics;

– early stimulation;

– the use of free time.

During general meetings information should be spread about the possible risks bearing on the educational community through descriptions provided by graphs and statistics produced by the results of inquiries.

More weight should be given to programmes on the prevention of illness, disasters and accidents; there should be programmes of prevention on drug addiction and sexual abuse.

There should be a project of awareness-raising in relation to help for people who ask for help – the elderly, the sick, the disabled, special children etc.

There should be support for prevention campaigns with sheets, graphs, short films etc.

Guidelines for the Fathers of Families

– the organisation of teaching on the family around the subjects of physical health, mental health, and spiritual health; the raising of people's awareness about the situation and the realities of those who suffer, utilising prayer and spiritual and material help;

– the holding of conferences for fathers of families on the dimensions of health and their importance in the family and in the education of their children;

– conferences or special groups to guide the fathers of families on a good diet for their children when it comes to snacks the preparation of meals, and in relation to personal and mental hygiene;

– the holding of teaching days on prevention in health (for students and fathers of families).

What has been listed above does not aspire to be a 'recipe' by which to achieve the integration of health into education because this is something that requires attention being paid to the specific situation involved, to planning, to implementation, to continuation, to participation and to time. The guidelines that have been indicated can serve as a basis and a 'shower of ideas' by which to select what seems possible and to generate others according to the actual conditions of each educational context.

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Consultant of the Latin American Secretariat of the Hospital Order of St. John of God

Notes

[1] Congregazione per l'Educazione Catolica, *La escuela católica en los umbrales del tercer milenio,* 2.
[2] PAUL VI, *Populorum Progressio,* 66.
[3] Msgr. J. LOZANO BARRAGÁN, *Teologia Y Medicina* (Colección Selare, Bogotá, 2000), p. 28.
[4] *Ibidem,* p.
[5] MEN (Ministerio de Educación Nacional, Colombia), *Lineamientos Curriculares: Cincias Naturales y Educación Ambiental* (Magisterio, Bogotá, 1998), p. 30.
[6] MEN, *Lineamientos Curriculares,* p. 144.

This paper is based upon his book: *Pastoral della Salud en la Comunidad Educativa* (Collana Selare – Ordine Ospedaliero, 2003).

The Effect of a Thoughtful Reading of the New Testament on the Hyperalgesic Area and on the Perception of Pain in Patients with Lumbar Algic Syndrome

PART ONE

Introduction

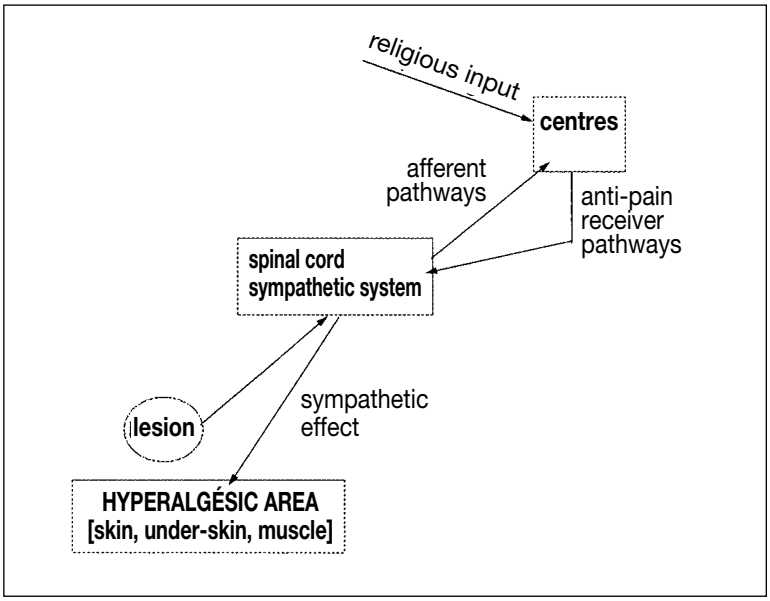
The term hyperalgesia is commonly used in the clinical field (IASP, 1982) to define an increased sensitivity to an external stimulus, which normally is not algogernic. In many pathologies with somatic pain, whose intensity is generally measured using the VAS technique, large areas are to be observed at the skin level where the algic threshold is notably lowered. This area is physiologically delineated by an interruption of telangiectasic lines, by a lowering of temperature, and an increase in the width of the sub-cutaneous tissue (Zucchi, 1981, 1984).

The breadth of such areas can be assessed by using the technique of dermographism. This technique involves rubbing the skin with a full round-tipped needle in a centripetal way. Along the line made by the needle, after a few seconds, there appears a pink and evident line. If a hyperalgesic area is present on the skin, the dermographic line is interrupted at its perimeter. Going from the furthest areas to the centre of the hyperalgesic area, one can thus demonstrate its borders and measure its average diameter.

The validity of the dermographic method has been demonstrated in studies carried out on subjects in whom the syndrome of pain had been artificially induced (Galletti, 1979; Zucchi, 1984).

In the view of a number of authorities (Kellgren, 1938; Lewis, 1942; Zimmermann and Sanders, 1982; Fields, 1988; Tiengo and Zoppi, 1958; Albe-Fessard and Giamberardino, 1997), dermographic reactivity is governed by the nervous system, both because the width of the line is much greater than the diameter of the needle and because stimulations of a low intensity can be matched by extremely lively reactions. It can thus be posited that an external stimulus working on the central nervous system, such as a thoughtful reading of the New Testament (religious input), can influence the phenomenon of dermographism and the physiological reactions that bring about the cutaneous variations present in the hyperalgesic area (Fig. 1).

Fig. 1: A schematic portrayal of the activation of the nerve pathways following the creation of a hyperalgesic area brought about by a peripheric algic pathology (lesion).



From studies that we have already carried out (Zucchi, Honings, 1966; Zucchi, Honings, Voegelin, 2000), the effect has been demonstrated on the VAS in different algic syndromes after the thoughtful reading of a passage from the gospels accompanied by the administration of pharmacological anti-algic therapy with non-steroid anti-inflammatory drugs (NSAIDs).

In this work we have sought to assess whether the effect of a thoughtful reading of the gospels also acts on the extension of the hyperalgesic area, in addition to the intensity of the perception of pain.

In the study a population affected by lumbar pain syndrome with plural pathogenesis was chosen. In this population it was possible to measure in a precise way the extension of the hyperalgesic area in addition to the VAS. In the subjects investigated the size of the hyperalgesic area was specified employing the method of dermographism.

In order to assess if, and to what extent, thoughtful reading of the gospels influenced the result of pharmacological therapy, the subjects who were examined were divided into two equivalent groups: group 'S' (the study group) and group 'C' (the control group).

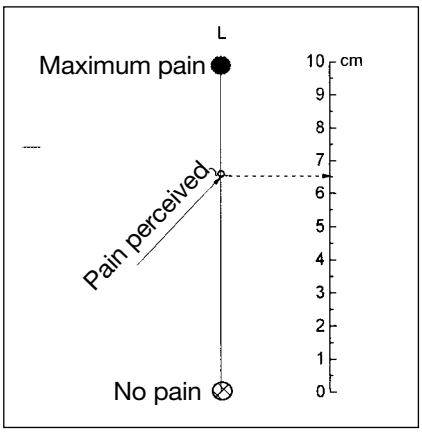
All the subjects had the same therapy with non-steroid anti-inflammatory drugs. Only the patients in the study group were invited to engage in a reading of a passage from the gospels immediately after the administration of the medication.

Material and Method

Sixty patients were subjected to examination (thirty males and thirty females), all of them affected by lumbar pain with plural pathogenesis. The study group was made up of thirty subjects (fifteen males and fifteen females of an average age of 55.5±9.7); the control group was made up of thirty subjects (fifteen males and fifteen females of an average age of 59.3±11.2).

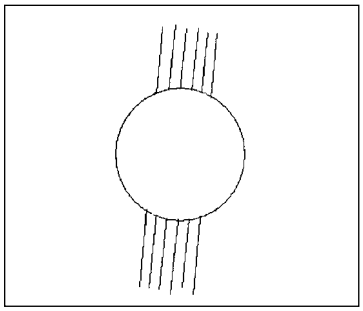
The pain threshold was measured by using the VAS scale. According to this method, the subject associates the intensity of the pain perceived with a part of a L, which following convention is ten centimetres in length. 'L' corresponds to the highest pain possible (Fig. 2).

Fig. 2: VAS method of measuring the pain threshold.



The diameter of the hyperalgesic area was measured using the method of dermographism. This method involves rubbing with a blunt-nosed needle, starting from areas faraway from the pain area and moving towards the area subjected to examination. The lines stop at the borders of the hyperalgesic area (Fig. 3)

Fig. 3: Demonstration of the hyperalgesic area delineated by the ceasing of the dermographic lines.



The pharmacological therapy involved the administration by intravenous injection of 500 mgs of lysine acetylsalicylate in a 250 ml physiological solution for ten consecutive days. The administration always took place at 8 am.

The study group was made to read a passage from the New Testament. A passage from the first letter of St. John was given to the first patient who was invited to engage in a thoughtful reading of it. The passage was as follows: 'God is love; he who dwells in love dwells in God, and God in him. That our life of in the world should be like his, means that his love has had its way with us to the full, so that we can meet the day of judgement with confidence. Love has not room for fear; and indeed, love drives out fear when it is perfect love, since fear only serves for correction. The man who is still afraid has not yet reached the full measure of love. Yes, we must love God; he gave us his love first. If a man boasts of loving God, while he hates his own brother, he is a liar. He has seen his brother, and has no love for him; what love can he have for the God he has never seen? No, this is the divine command that has been given us; the man who loves God must be one who loves his brother as well.

Everyone who believes that Jesus is the Christ is the child of God, and to love the parent is to love his child, If we love God, and keep his commandments, we can be sure of loving God's children. Loving God means keeping his commandments, and these commandments of his are not a burden to us. Whatever takes its origin from God must needs triumph over the world; our faith, that is the triumphant principle that triumphs over the world' (1 Jn 4:16-21; 5:1-4).

The tests were made on the first, fifth and tenth days. In each test the diameter of the hyperalgesic area and the value of the VAS were measured before and two hours after the therapy.

We measured the variation (VD) of the VAS and the maximum diameter of the hyperalgesic area (HD) between the first and second tests in both groups.

The frequency histograms of VD and HD were calculated in order to bring out the variability in each group.

The Results

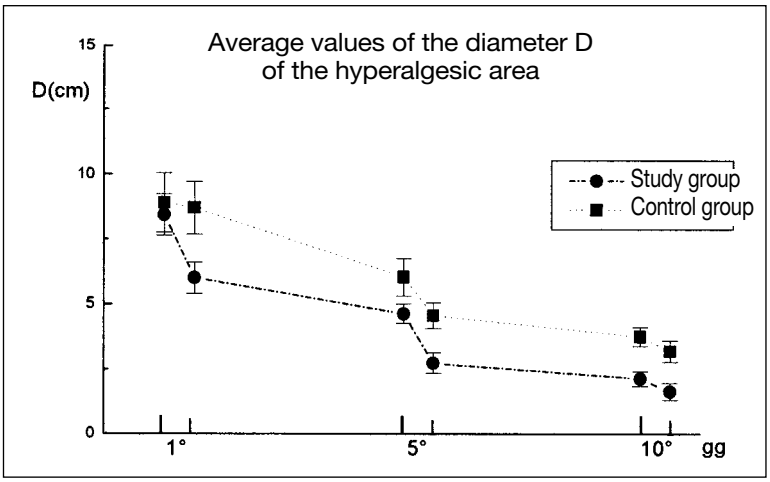
1. Diameter D averages (cm) in the six tests carried out on the study and control groups. Table one contains the values in cm of the diameters of the hyperalgesic area measured in the six tests, 'a' (basal) and 'b' (after two hours of therapy).

Table 1: Average values of the diameters of the hyperalgesic area in the six tests. 'a' = basal; 'b' = after two hours

Day	Test	Average of the Study group cm	Average of the control group cm	t	p
1	a	8.4±1.6	8.9±2.3	/	/
	b	6.0±1.2	8.7±2.0	6.23	<1%%
5	a	4.6±0.8	6.0±1.4	4.67	<1%°
	b	2.7±0.8	4.6±1.0	7.9	<1%%
10	a	2.1±0.6	3.8±0.7	9.93	<1%%
	b	1.6±0.7	3.2±0.8	8.1	<1%%

Figure 4 contains the data of table 1 for the two populations.

Fig. 4: Average values of the diameters D of the hyperalgesic area measured after two hours in three separate sittings at five day intervals in both the study group and the control group.



2. VAS averages in the six tests in the study group and in the control group.

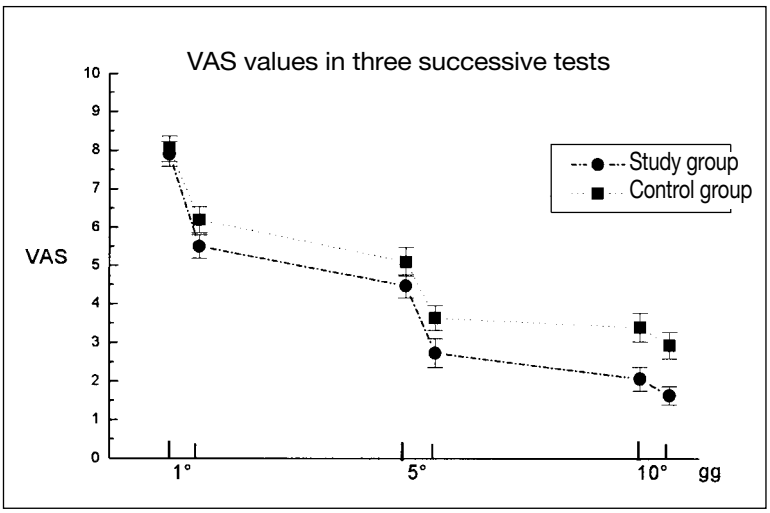
Table 2 contains the average values of the VAS measured in the six tests, 'a' (basal) and 'b' (after two hours of therapy) on the 1st, 5th and 10th day.

Table 2: Values of VAS in the three tests
'a' = basal; 'b' = after two hours

Day	Test	Average of the Study group	Average of the control group	t	p
1	a	7.9±0.8	8.0±0.8	/	/
	b	5.5±0.8	6.2±0.9	3.13	<1%
5	a	4.5±0.8	5.1±0.9	3.14	<1%
	b	2.8±0.8	4.6±1.0	4.02	<1%
10	a	2.0±0.6	3.8±0.7	6.26	<1%%
	b	1.7±0.6	3.3±0.8	6.47	<1%%

Figure 5 contains the data of table 2.

Fig. 5: VAS average values, basal and after two hours measured in three sittings at five hour intervals in the study group and the control group.



3. The Correlation between the VAS and the diameter

With these two groups we carried out a preventive control on the relationship that exists between the perceived pain indicated by the VAS and the clinical sign expressed by the diameter of the hyperalgesic area. Figure 6 contains the correlation between the diameter of the hyperalgesic area and the VAS in basal conditions for both groups and for both the groups who were separated at the end of the therapy. Whereas in the control group (○) there is an, albeit reduced, linear relationship between the diameter and the VAS, with the study group one can observe that the

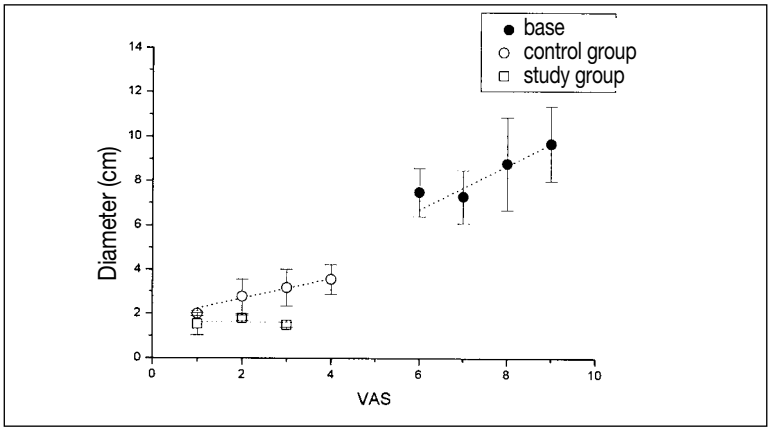
diameter, which is much more reduced than was the case at the beginning of the therapy, is independent of the value of the VAS and practically constant in the whole of the group.

5. Total variation of the VAS

We here indicate by VD the difference between the VAS values measured at the end and at the beginning of therapy

VD (study group) = 6.3±0.7

Figure 6: the correlation between the VAS and the diameter of the hyperalegesic area.
● Basal behaviour of the sixty subjects.
○ Behaviour of the control group at the end of therapy.
□ Behaviour of the study group at the end of therapy.
..... lines of regression.



4. Total variation of the HD diameter:

The HD variation of the diameter of the hyperalgesic area between the first and the last test is significantly different (p<1%) on average in the two groups.

HD study group = 6.8±1.4 cm

HD control group = 5.7±2.2 cm

This is more evident if we consider the variation expressed in percentages.

HD% study group = .80%±.11%

HD% control group = .63%±.14%

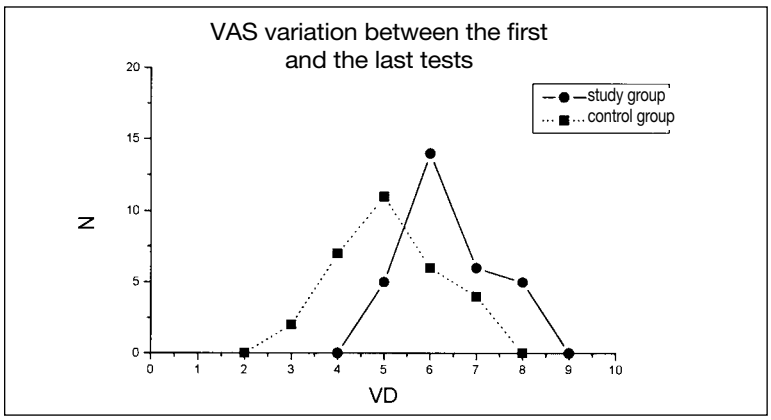
The distribution of these percentage differences have moved in relation to each other, as is demonstrated by figure 7.

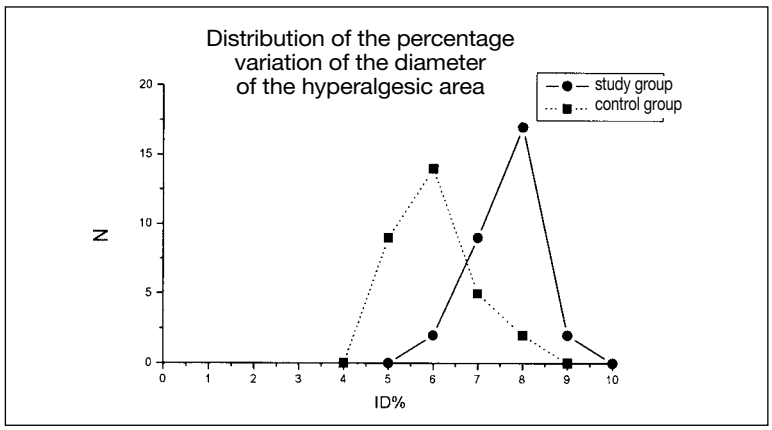
Fig. 7: The number of subjects corresponding to percentage value

VD (control group) = 5.1±0.8

The histograms of the frequency of VD demonstrate the different way in which the VD values of the two groups are distributed (Figure 8)

Fig. 8: Variations in the VAS between the first and last tests (VD)



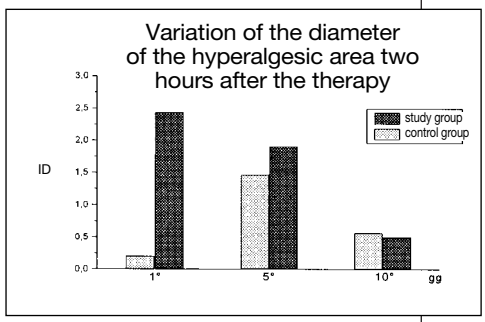


6. Variation in the diameter of the hyperalgesic area with therapy

It is to be observed that during the first day of treatment the effect of the medication on the diameter of the hyperalgesic area is already noticeable after two hours.

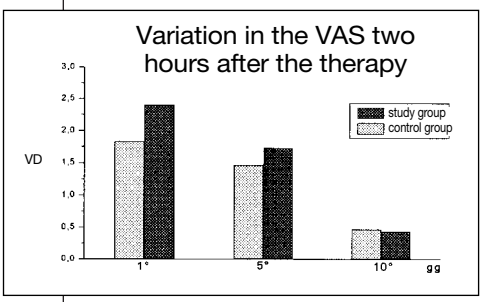
In order to bring out the immediate effect on the diameter of the hyperalgesic area and the VAS, figure 9 shows the differences between the diameters of the hyperalgesic area in the space of two hours both in the study group and the control group.

Fig. 9: Variation (ID) of the diameter of the hyperalgesic area during the two hours after therapy in the study group and in the control group, measured in three sittings at five day intervals (dd).



The variation in the VAS in two hours does not appear to be very different in the study group and in the control group (figure 10).

Fig. 10: Variation (VD) of the VAS in the two hours after therapy in the study group and in the control group, measured in three sittings at five day intervals.



Discussion

The thoughtful reading of a passage from the New Testament produces an improvement in the therapy. This is brought out by the data of the study group when confronted with the data of the control group. Indeed, at the end of the therapy, in addition to having a notably more marked reduction in the VAS (VD), the study group also had a greater reduction of the hyperalgesic area (HD).

This strengthening effect of the thoughtful reading of a passage from the New Testament on the pharmacological treatment was evident from the first therapeutic sitting. Indeed, there was a significant reduction in the hyperalgesic area after only two hours but solely in the study group. In the subjects of the control group only three out of thirty demonstrated a very light reduction of this area after the first administration of the antalgic medication.

In both groups the VAS diminished during the first two hours after therapeutic treatment, even though this was more marked in the study group.

We can give a physiopathological interpretation of the medifications induced within the pain receptor system by a lesion, by pharmacological treatment (F) and by pharmacological treatment (F) linked to a thoughtful reading of the New Testament (religious stimulus) (RI).

In an information technology-style representation, the pain receptor system can be portrayed in a schematic fashion as being made up of three functional blocs: the **lesion,** the set of central and peripheric discriminant filters that establish the threshold level of the pain receptor stimulus **(discriminant),** and lastly the bloc that manages and controls information **(centre).**

Figures 11, 12 and 13 contain the respective models and blocs.

We can represent the pain 'D' that arrives at the centres as the difference between the signal 'A' that comes from the lesion and the value of the threshold 'S' typical of the discriminating bloc.

After arriving at 'D' the centre produces two signals – one return signal 'b' towards the discriminating bloc and a signal 'b1' towards the lesion.

Signal 'b' tends to increase the level of the threshold (adaptation) by a size of 'bS°'. The threshold level then becomes S=S° + bS°, reducing the pain signal 'D'. The signal 'b1' activates the repairer mechanisms. Following the reduced size of the lesion, signal 'A' coming from this becomes less to a level of 'b1A' (Fig. 11).

Figure 12 contains the model that represents in a simplified way the effect of the medication on the pain receptor system.

Fig. 11: model representing the effect of the lesion on the pain receptor system

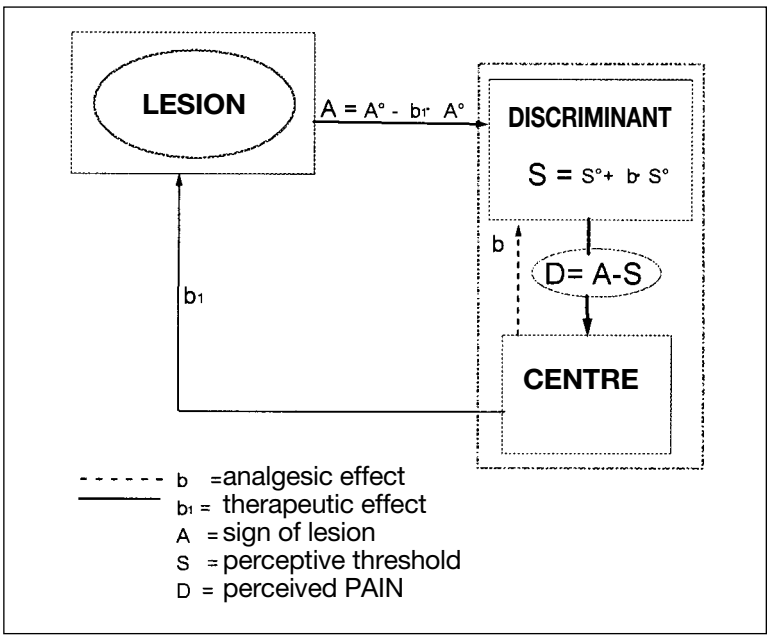
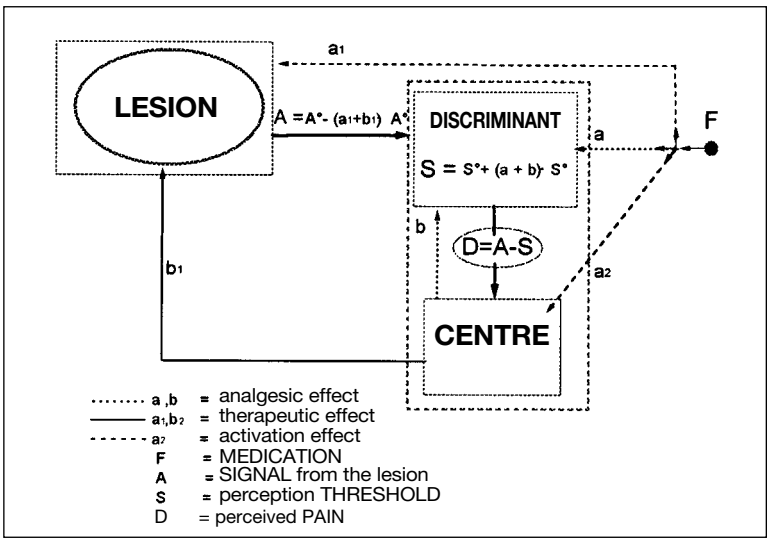


Fig. 12: model representing the influence of the pharmacological treatment on the pain receptor system.

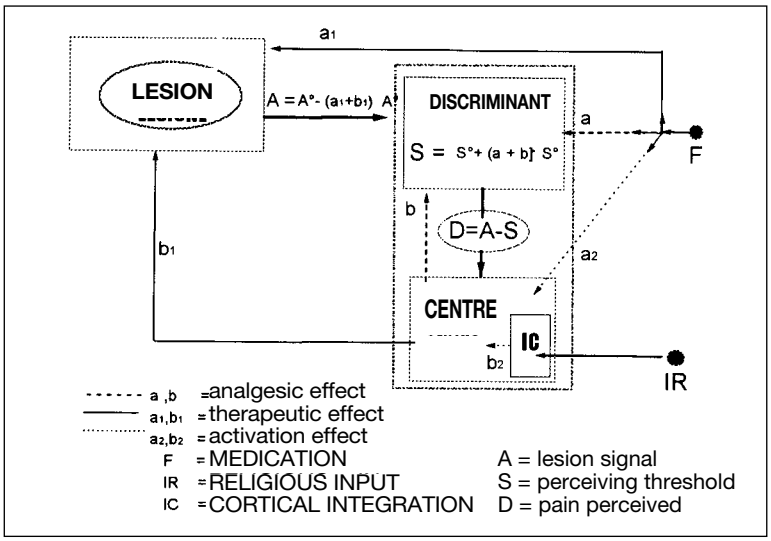


The impact of medication 'F' on pain reception can have three effects: (a) an antalgic effect on the functional bloc that generates the value of the threshold 'S' (discriminant); (a1) a curative effect in relation to the lesion; and (a2) an antalgic effect at a central level. The first effect (a) is translated into a raising of the value of the threshold 'S' by a quantity 'a.S'. As a consequence of the second effect (a1), the signal produced by the centre towards the discriminant is increased.

The direct effect on the lesion (a1) reduces the value of the signal 'A' from this product.

An external input such as a thoughtful reading of the New Testament acts directly at a central level (Fig. 13).

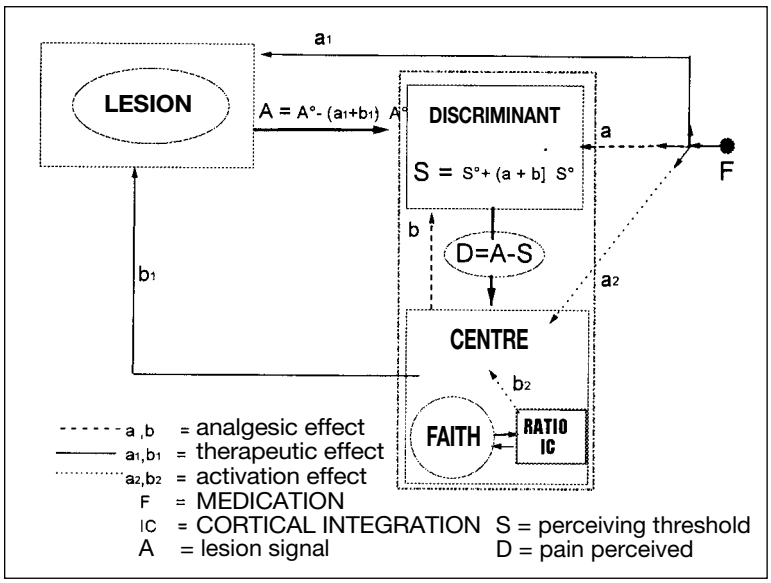
Fig. 13: model representing the effect of the medication (F) and the religious input (RI) on the pain receptor system.



The religious input (RI) connected with medication 'F' acts directly on the centre through the cortical integration blocs (CI), generating an activation (b2) of an analogous kind to the effect 'a2' produced by the medication. In this way, one can explain the increased rapidity of action and the greater pharmacological effect in subjects that have received a religious stimulus.

From previous experiences and studies (Zucchi, Honings, 1996; Zucchi, Honings, Voegelin, 2001), it has been seen that a position of faith can be interpreted as an internal input that produces a further strengthening of the medication. One may represent this approach with figure 14.

Fig. 14: model representing the combined effect of FAITH and the medication (f) on the pain receptor system.



Faith seen as internal input interacts with the central integration systems (CI), producing an activation signal (b2) analogous to that produced by the medication(a2). This further activation increases both the signal 'b', which modifies the discriminant threshold, and signal 'b1' towards the repair mechanisms. It is therefore to be expected that the healing of the lesion takes place more quickly in patients who are believers in which an optimal condition of FAITH-PRAYER is present.

PART TWO

A Theological Anthropological Explanation

The above-mentioned medical-scientific inquiry into *perception* in relation to *the psychic effect* of pain measured by VAS, and variation as regards the *physical effect* of the hyperalgesic area in the lumbar algic syndrome, seeks to explain the possible influence of a thoughtful reading of the New Testament. Two hours after administration of the medication thirty patients of the study group were invited to engage in a reading of a passage from St. John. In this process, Faith was seen as an internal religious input to see if it interacts with the central integration systems (CI), producing a signal of activation (b2) analogous to that produced by the

medication(a2). This latter activation increases both the signal 'b' and modifies the threshold of the discriminant, as well as the *signal b1* towards the repair mechanisms. Thus the healing of the lesion can take place more rapidly in those patients in whom the optimal condition of Faith-Meditation on the passage from St. John is present. We will now try to offer a theological-anthropological explanation of the results of this research by paying special attention to the physical effect on the extension of the hyperalgesic area.

Man in the Image of God

Of all visible creatures, only man is 'able to know and love his Creator',[1] and 'he is the only creature whom God willed for its own sake'[2]. Only man is called to share, by knowledge and love, in God's own life. He was created for this end and this is the fundamental reason for his dignity. This is why every human individual has the dignity of a person – he is not something but somebody. Now, and this is essential to our explanation, 'the human person, created in the image of God, is a being at once corporeal and spiritual. The biblical account expresses this reality in symbolic language when it affirms that 'then the Lord God formed man of dust from the ground, and breathed into his nostrils the breath of life; and man became a living being' (Gen 2:7). Man, whole and entire, is therefore *willed* by God.'[3]

Man: a Unity of Soul and Body

In Holy Scripture the term 'soul' often refers to human *life*[4] or to the whole human *person*. However, and this deserves emphasis, it also refers to everything that is innermost in man,[6] and thus of greatest value.[7] However, 'soul' also means that which especially makes man the image of God because it is 'the *spiritual principle* in man'.[8] Now, precisely because it is a principle *in man*, the soul also makes the body *of man* participate in the dignity of the 'image of God'. This is what the *Catechism of the Catholic Church* teaches so authoritatively: 'The human *body* shares in the dignity of 'the image of God': it is a human body precisely because it is animated by a spiritual soul'.[9] And the Fathers of the Second Vatican Council further added: 'Though made of body and soul, man is one. Through his bodily composition he gathers to himself the elements of the material world; thus they reach their crown through him, and through him raise their voice in free praise of the Creator.[10] From this anthropological value of the body there follows the explanation, from a theological point of view, of why it is not licit for man to despise the corporeal life. Indeed, he is called to see his own body as good and worthy of honour, precisely because it is created by God

and destined for resurrection on the last day.[11]

By now it is more than evident why it is not only licit to engage in a thoughtful reading of the passage from St. John, but also why such an action is even advisable. This is what I now want to explore in detail.

The Soul as 'the Form of the Body'

I have already said that man as an entire whole, that is to say as a unity of soul and body, is willed by God. Now this unity, and this is what interests us, is for St. Thomas Aquinas so deep that the soul must be seen as the form of the body.[12] There are, in fact, two cornerstones to the theological and philosophical anthropology of St. Thomas: the body belongs to the essence, the substance of, man; and the subsistence of the soul even without a body. From these two theses Aquinas deduces: a. the act of being (*actus essendi*) of man is first an act of the being of the soul, and *through the soul* also becomes an act of being of the body; b. linked substantially to the body, the soul is exposed to the impulse of the passions, vehement impulses that it can, however, control.[13] Here it is of importance to emphasise that the act of the being of the soul becomes through the soul also the act of being of the body.

On the basis of this ontological, i.e. intrinsic, substantial duality of every human person (which is not accidental or extrinsic) I believe that I can explain the results of our study.

A Theological Explanation of the Results

From the substantial unity of the soul and body, it follows that the soul expresses itself through the body. Merleau Ponty and Gabriel Marcel do not hesitate to say: '*Le corps c'est moi*! I am my body!' Man's being can be defined as an embodied soul or as an animated body. Because of his corporeal condition, man gathers to himself the elements of the material world, which through him reach their crown and raise their voice in free praise of the Creator.[14] This is why the Fathers of the Second Vatican Council concluded: 'For this reason man is not allowed to despise his bodily life, rather he is obliged to regard his body as good and honourable since God has created it and will raise it up on the last day'.[15] However, man is not wrong when he regards himself as superior to bodily concerns, and as more than a speck of nature or a nameless constituent of the city of man. For by his interior qualities he outstrips the whole sum of mere things. He plunges into the depths of reality whenever he enters into his own heart; God, Who probes the heart,[16] awaits him there; there he discerns his proper destiny beneath the eyes of God. Thus, when he recognizes in himself a spiritual and immortal soul, he is not being mocked by a fantasy born only of physical or social influences, but is rather laying hold of the proper truth of the matter.'[17] In the light of this anthropological-theological vi-

sion it is possible to explain the difference in the results.

The results refer to *two inputs*: one shared by all sixty patients, the *other* shared by only thirty. The first was the *input of a medication* based upon nonsteroid anti-inflammatory drugs (NSAID); the other was a *religious input*, after the administration of the therapy, based upon a thoughtful reading of a passage from the New Testament. The results calculated statistically (see the tables and figures) concerned two *effects*, namely the *physical effect* of the hyperalgesic area at a basal stage and two hours after the therapy, and the *psychic effect* of the VAS threshold. From a comparison of the study and control groups there emerged a notable difference in the diameter *HD* and the variation in the *VAS* in relation to the thirty patients who undertook a thoughtful reading of a passage from the New Testament (religious input). This thoughtful reading produced an improvement in the therapy. Indeed, at the end of the therapy, in addition to having a rather marked reduction of the VAS (VD), the study group also had a major reduction of the hyperalgesic area (HD) The diameter HD reduction is to be explained on the basis of the constitutive unity of the soul and body of the human being. The soul not only ensures that the body becomes a human body but also, and above all else, make it a participant in the dignity of 'the image of God'. The drug does not, therefore, confine itself to the therapeutic influence on the body, as a material element, but also stimulates the soul so that this exercises its influence as the soul of the human body, or rather its spiritualising constitutive influence. This is why we can observe certain reductions, both at a physical level and at a psychic level in all the sixty patients.

As regards the thirty patients of the *religious input*, we must look for the explanation in the specific innermost part of man, or better in the superiority of man over corporeal things. The spiritual tradition of the Church here speaks of the *heart*, in the biblical sense of the 'profundity of being'[18], where the person decides or does not decide in favour of God.[19] Indeed, the reading of the passage of St. John makes the patient-man turn to his heart, where God is awaiting him; God who reads a men's heart, the place where men makes decisions under the watchful eye of God. It is then that man expresses his substantial unity of soma, psyche and pneuma at the level of his essential integrity and existential wholeness.[20] 'For the word of God is living and active , sharper than any two-edged sword, piercing to the division of soul and spirit, of joints and marrow, and discerning the thoughts and intentions of the heart'.[21]

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Acknowledgements

The authors of this article would like to thank Prof. Gian Franco Gensini, Dean of the Faculty of Medicine and Surgery at the Universiy of Florence, who expressed his great estee to them after reading this work.

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Footnotes to Part Two

[1] Ecum. Council Vat.II, *Gaudium et spes*, 12, 3.

[2] *Ibidem*, 24, 3.

[3] *Catechism of the Catholic Church* (CCC), 362.

[4] Cf. Mt 16, 25-26; Jn 15, 13.

[5] Cf. Acts, 2, 41.

[6] Cf. Mt 26, 38; Jn 12, 27.

[7] Cf. Mt 10, 28; 2 Mac 6, 30.

[8] *CCC*, 363.

[9] *CCC*, 364.

[10] Ecum. Council Vat.II, *Gaudium et spes*, 14, 1.

[11] Cf. *ibidem.*

[12] The Council of Vienna of 1312 supported this conception of the substantial unity of the soul and the body of man (cf. Denz.- Schönm., 902; *CCC*, 365.

[13] BATTISTA MONDIN, *Dizionario enciclopedico del pensiero di San Tommaso d'Aquino* (Ed. Studio Domenicano 1991), p. 50

[14] Cf. Dan. 3, 57-90.

[15] Ecum. Council Vat. II, *Gaudium et spes*, 14.

[16] Cf. 1 Kings 16, 7; Jer. 17, 10.

[17] Ecum. Council Vat. II, *Gaudium et spes*, 14.

[18] Cf. Jer 31, 33.

[19] Cf. *CCC*, 368; cf. Dt 6,5; 29, 3; Is 29, 13; Ez 36, 26; Mt 6, 21; Lk 8, 15, Rm 5, 5.

[20] Cf. ZUCCHI, P.L. and HONINGS, B., 'Faith as a transcendent element facilitating therapeutic results in suffering patients', *Dolentium Hominum*, 3 (1996) 16-28,

[21] Hebrews, 4, 12.

The History of Monastic Medicine in the Christian West

By the term 'monastic medicine' one usually refers to that complex of health care activities carried out by religious personnel, generally within monasteries, to the benefit of their religious brothers or pilgrims in need of assistance and treatment. Monastic medicine developed above all during the medieval period and then slowly declined during subsequent epochs.

For various reasons, Christian monasticism from its first appearance had a close relationship with medicine. First of all, care for the infirm was directly recommended by the Gospel as a work of mercy towards the human body. In addition, even if illness was seen as a means of purification and salvation, the body as a gift of God had to be respected through hygienic practices and looked after through therapeutic practices. The Church, especially at the outset, sought to extirpate from the population every residue of paganism and also combated superstitions about health and illness. The monks, lastly, in the peace and quiet of their monasteries had the possibility of examining and studying the ancient texts, on medical and scientific subjects as well, that their brothers had saved from destruction and oblivion by restoring them or copying them.

Monastic medicine, like, in general, the medicine of the Christian West, had certain important characteristics. For health care personnel there was a correspondence between serving *(servitum)* and offering hospitality (*hospitalitas*), and between the poor *(paupers)* and the sick *(infirmi).* The poor and the sick were seen as lords *(domini)* who were to be served and revered as the chosen of the Lord; their bodies had to be cared for and defended as though they were the chosen limbs of the body of Christ. And the body, in which illness expressed itself, was not seen as being separate from the soul, indeed, the somatic illness was seen as almost always being the expression of a spiritual malady (error or sin). Treatment, therefore, was not to be concerned only with the body of sick people but also and above all else dealt with the needs of their souls. The treatment of illness, which was seen as a direct consequence of original sin and sent by God to punish Christians or put them to the test, had, therefore, to involve not so much and not solely medical practices (the administration of potions or the practice of bleeding) but also forms of devotion and religious rites or the work of someone who had received special healing virtues from God. Illness, therefore, was part of an overall divine plan directed towards the purification of Christians. Death itself was generally seen as a stage in this journey towards the salvation of both the soul and the body; indeed, at the end of time the body would rise again, and would be released from every imperfection. *'Sanitas corporis'* and '*salus animae'* were the two objectives and they were substantially interchangeable; indeed, they were pursued at the same time or separately in monastic medicine. They were also, however, pursued by the secular medicine of the time and also by the various therapeutic rituals generated by popular religious beliefs. During the medieval period, in substance, the Christian felt that he was part of a network of forms of correspondence between himself and the universe, where the whole of the creation was, without forms of exception, a participant in the inscrutable plans of God.

For the reasons just mentioned, one can well advance the view that from the beginning of Western monasticism, amongst the various needs that the monks had to provide for, assistance and care for their sick brothers occupied a position of importance, and such care and assistance was soon extended to the pilgrims or travellers who came to their monasteries. Hospices for the sick and pilgrims had, for that matter, already arisen in the third and fourth centuries AD within the context of Eastern monasticism, for example there were the hospices founded by St. Basil in Cesarea of Cappadocia and by St. John Chrysotome in Constantinople. When, beginning in the fifth and sixth centuries AD, the phenomenon of monasticism moved from its early original locations (that is to say the South-Eastern Mediterranean coasts from Egypt to Turkey) to the northern part of the Mediterranean basin (at first in Italy and Gaul and then in Central Europe as well), in the organisation of the monastic communities attention was soon directed to forms of health care activity for needs that arose in the monasteries.

A certain interest in hygiene and medicine was demonstrated, for that matter, by the founders of monastic communities and religious orders in the composition of their writings or the drawing up of the various 'rules'. Thus, for example, St. John Cassian, who together with St. Martin of Tours began monasticism in Gaul, was concerned in his work, *Collationes,* with hygiene, correct diet and sleep. It was above all St. Benedict of Norcia, the founder in 529 of the monastery of Montecassino, who, in his *Regola Monachorum,* gave precise instructions about the practice of health care in the monasteries of his religious order. *'Infirmorum cura ante omnia et super omnia adhibenda est'* reads the beginning of chapter XXXVL. The Abbot in person had to ensure that such health care activ-

ity guaranteed the provision of suitable and efficient services *('ergo cura maxima sit Abbati ne aliquam negligentiam infirmi patiantur').*

St. Benedict's approach to monastic medicine was soon extended to the other monasteries that had either been founded by him and his early followers or which were to follow the Benedictine rule over the next centuries, both in Italy (Subiaco, Casamari, Fossanova, Farfa, Trisulti, Bobbio, Nonantola, Novalesa, etc.) and abroad (Fulda, Reims, Saint Gallen, Tours, Fleury, Reichenau, Werden, etc.). This approach also continued in the religious orders which came into existence after the first millennium as a result of the initiatives of those who continued and developed in an innovative way the Benedictine rule (for example the Cluniacian, Camaldonian, Vallombrosian and Cistercian orders).

The health care system in the monasteries envisaged, according to the indications of St. Benedict, certain constant characteristics, which may now be outlined.

First and foremost there was the *monacus infirmarius* or *monacus medicus,* a religious brother who had the task and also the skill to care for and treat those sick people who were entrusted to him. This monk was required to have special traits, such as *'timens Deum'* (that is to say he had to be rich in faith and love for his neighbour), *'diligens'* (that is to say he had to be careful and attentive in his learning) and lastly *'sollicitus'* (that is to say he had to be dynamic and untiring in his profession).

Then there was the infirmary, that is to say a place for sick monks, as was prescribed in the Benedictine rule *('quibus fratibus infirmis sit cella super se deputata').* The infirmary was soon separated from the main part of the monastery and given its own bathrooms because of the importance that was then given to water treatment. With the progressive growth and development of monastic medicine, the infirmary soon had other areas attached to it (for example, for special forms of treatment or for the residence of the physician and his assistants) and this sector soon constituted an autonomous functional unit within the abbey.

There was, in addition, the *hortus simplicium,* that is to say a small plot of land *(hortulus)* within the walls of the monastery used to grow the herbs and medicinal plants that were needed in the preparation of medicines. This facility was in line with the general autarkic approach to the life and economy of the monastery. Side by side with the cultivation of health-giving herbs, the monks subsequently also developed botanical and phytotherapy studies and compiled real and authentic tracts, such as the so-called *Hortuli,* in which the properties of the various medicinal plants were described.

Then there was the *armarium pigmentariorum* which was at first a cupboard and later an authentic separate room or set of rooms where the products of the *ortulus* were stored and kept. Subsequently, this unit gave rise to the apothecary or pharmacy of the monastery which was used for the preparation and storing of medicines in special jars or vases. This part of the complex was usually dedicated to phytotherapy.

Lastly, in the monastery there were two other structures which, although they did not have strictly health care origins, could also have close links with the practice of monastic medicine – the *Hospitium* and the *Scriptorium.* The first (at times divided into the *hospitium hospitum* for important people, and the *hospitium pauperum* for the less important) was used for the pilgrims who had come to the abbey and often needed medical care and treatment, in addition to food and rest. The second was used to copy, restore and conserve (in the annexe to the library) ancient volumes, on medical-scientific subjects as well, which had come into the possession of the abbey and were thus more easily consultable.

The health care methods used in monastic medicine involved phytotherapy, water therapy, diet therapy and also small-scale surgery. The medical and nursing staff was made up, in addition to the *monacus infirmarius* (who was responsible for nursing), of such other figures as the *monacus erbarius*, who was responsible for

the herb garden; the *monacus pigmetarius*, who was responsible for the pharmacy; and the *famuli*, people who had minor health care tasks (they included such figures as the *minutur* or *phlebothomator,* the *sutor*, the *rasorius*, the *coquus*, etc.). It seems probable that the

Scholae coenobiales medicae were an integral part of the health care system. These were those parts of the various monasteries that handed down the medical and surgical knowledge that had been accumulated over the years by the *medicus infirmarius* and his predecessors so as to ensure a solid cultural and scientific grounding for those monks that were responsible for the health of their religious brothers.

Amongst the exponents of greatest importance in the history of monastic medicine we should list the following: Raban Maurus (776-856) of the monastery of Fulda; Lanfranc (born around 1010) of the French monastery of Bec; Constantine the African (1015-1085) of the monastery of Montecassino; and lastly Hildegard (1098-1179) of the monastery of Rupertsberg in Bingen.

One example of the system of monastic health care is provided by the lay-out of the monastery of S. Gallo, which belongs to the high medieval period (the ninth century). In this lay-out, next to the apse of the abbey church, there was a group of buildings entirely dedicated to health care activity: a hospital-infirmary, a garden for medicinal plants, the home of the physician, a room for the practice of bleeding, a kitchen and bathroom for the infirmary and for the room for bleeding, and a chapel (shared by the infirmary and the novices). Near to this area were the *scriptorium* (with the annexe to the library) and the residence of the abbot. Somewhat more distant from the area devoted to health care in a strict sense, but on the same side of the abbey's church, was the hospice with its connected services (a brewery and a bakery).

Monastic medicine continued to flourish in Europe during the first centuries of the second millennium, after the additional foundation in the twelfth and thirteenth centuries of the so-called 'mendicant orders' whose monks based themselves on the gospel teachings and in large measure lived off alms. Indeed, in the monasteries of these religious orders (the Dominicans, founded by St. Dominic of Guzinan, and the Franciscans, founded by St. Francis of Assisi), assistance to the sick was also guaranteed, as is borne out by the rule of this latter order to be found in chapter X for the monks (the Franciscans properly called) and to be found in chapter VIII for the nuns (the Clarissans).

During an epoch which had not yet experienced the development of hospital institutions, monastic medicine also had in medieval society the important function of providing assistance and treatment to the population that lived in the environs of the monasteries, which were undoubtedly places to which all social classes turned to when in need. Thus impressive buildings came into being which had a health care purpose, such as the large-scale infirmary of the Cistercian abbey of Omrscamp (in Noyon), which had space for a hundred patients, or the buildings erected in a number of monasteries designed specifically for lepers and plague victims.

Usually, patients who belonged to the lower social classes went directly to the monastery to benefit from the skills of the *medicus infirmaries* and the other health care workers that were there. The nobles and other high ranking people, on the other hand, wanted health care to be provided in their homes and thus often obliged the *monacus infirmarius* to leave the monastery. Many of these physicians achieved great fame – the monk Notkerus of the abbey of S. Gallo, consulted by a very large number of patients, for example, or Baldovin of Chartres, who was called to treat two kings of England (Edward the Confessor and William the Conqueror).

Many monks thought poorly of such tasks and increasingly believed that such responsibilities called them away from their primary vocation. The Church as well began to realise that such health care activities outside the walls of the monasteries, even if engaged in because of the prestige and economic-political advantage that thereby accrued to the abbey, were too often distant from the principles of monastic life on which the rules of many religious orders were based. Then the first synods and councils were held which tried to regulate the medical and surgical activity of monks and also limited their field of action, and this to the point of prohibiting the practice of the health care profession (Reims, 1119; Clermont, 1130, Lateran II, 1139; and Montpellier, 1162).

Finally, the decrees of Onorius III (1216-1227) and Clement VI (1265-1268) were issued which repeated the limitations and prohibitions that had been expressed in the past and expressly forbade ecclesiastical members of the Church to engage in the study and the practice of medicine.

During the late-medieval period, therefore, monastic medicine began to decline and was gradually replaced at the level of treatment and care by the first secular hospitals and at the level of the transmission and teaching of medical-scientific knowledge by the first universities. On the part of the Church, however, there was an attempt to avoid losing all the heritage of knowledge and

skills that had been accumulated by monks down the centuries. By the decree of Boniface VIII (1294-1303) the abbot had the option and responsibility of allowing a religious brother who displayed a specific predisposition for health care activity to engage in the study and the practice of medicine. From that age onwards, however, monastic medicine, although it continued to exist, remained restricted to, and in the hands of, a few monasteries, and no longer involved broad and dynamic activity, not least in relation to outside society.

During subsequent centuries, monks have confined themselves at times to looking after (within the monastery walls) the valuable works on medicine and health care instruments used in the past, or frequently, and above all in recent times, to selling certain medicines of a herbal kind (syrups, infusions, tinctures, balsams etc.) and a number of products that were not strictly to do with health care (soaps and other cosmetics, diet products, distillates etc.), produced by their pharmaceutical laboratory, in the pharmacy of their monastery.

Even today the pharmacies of the most important monasteries are often, despite the structural modifications and at times the spoliations that have succeeded one another down the centuries, a valuable and fascinating testimony to the splendid past of monastic medicine and to the fundamental contribution that this made to the growth and development of Western medicine.

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Overall Assistance and Continuity in Treatment for Cancer Patients: the Experience of the Tiber Island

Introduction

Today cancer is certainly one of the most complex diseases that exists, and it involves not only the physical and functional sector of the person but also his or her psychological, spiritual and social dimensions.[1] The treatment of cancer is complex in character and requires a number of specialists, but accepting it is also complicated at any age, for any social level, both when we consider patients and their families. It is in addition a malady that afflicts the industrialised countries, the rich countries of the world, with greater intensity, almost as though it was the revenge of the poor countries for the infectious diseases they frequently sufferer from. This is an opposition, however, that disappears in the face of an illness that is still often disabling and incurable, and which makes all people, both rich and poor, lose those certainties that they had up to that moment enjoyed.

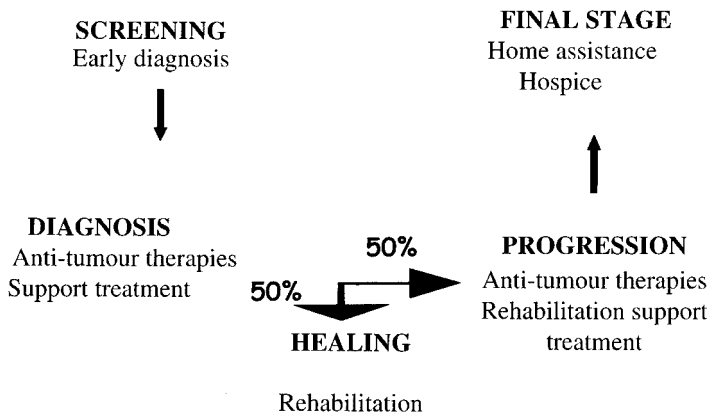
Even in the case of a complete cure, cancer leaves its marks behind it, and often to such an extent that a person's life is frequently changed radically, his or her values are changed, 'small things become extremely valuable', and a person's relationships with his or her family relatives and friends are also altered. Cancer strips us naked before life and death.

For all these reasons, a cancer patient should be seen today as being amongst those patients who are most in need of overall treatment: care that does not stop at the mere provision of health care but which takes on all the needs of the sick person. This is what St. John of God also proposes to us. But how can hospitality be achieved in practical terms today for the person afflicted by cancer?

The stages of the tumour and the needs of the patient

In order to know and recognise the needs of the patient it is necessary to go over the stages of his oncological illness. In fundamental terms, we may distinguish five stages, and more particularly the following (see fig.1):

Figure 1: the stages and evolution of the tumour



1. Screening and early diagnosis

The objective of screening and early diagnosis is to avoid tumours through the adoption of a healthy lifestyle (diet, physical exercise, possible treatment etc.). This policy is required of families, schools, family doctors and local health care support structures. At the same time, the intention is to recognise pre-tumour alterations that can then degenerate into a tumour, or to detect the tumour at an early stage, through periodic tests and controls. This constitutes a rather recent chapter in the history of oncology and which is progressively expanding because, on the one hand, of the discovery of certain genetic alterations that increase the risk of cancer (colon cancer, breast cancer, and ovary cancer), and, on the other, because of the evidence we have on the usefulness of engaging in screening tests of the population, some of which have been well established for some time (breast screening for breast cancer, the pap-test for the uterine cervix) and others that have only recently been demonstrated to be useful (the search for blood concealed in the faeces in the case of colon cancer, the PSA for prostrate cancer).

Situations involving a family genetic risk require psychological support and the clinical and therapeutic decisions involved are not always simple.

2. Diagnosis and therapy

This is certainly the most important stage and it begins with the diagnosis of the tumour and involves the sick person being admitted to hospital for specific forms of treatment. During this stage, in the presence of a diagnosis of cancer, the patient reconsiders his or her life, in part deliberately and in part without being aware of the fact that he or she is doing so. He or she changes his or her life because of the cancer and the forms of treatment that are connected with it (for example a temporary or permanent absence for his or her job; a change in his or her role within his or her family; a change in his or her life plans in the short and medium term; the suspension of his or her studies, and so forth). Human relationships, especially in the family, the value of things, change with the emergence of cancer.

About a half of cancer victims

can today be cured of their affliction. The best therapeutic results in terms of healing and quality of life are obtained through the employment of a combined use of more than one therapy (surgery, chemotherapy and/or radiotherapy in particular), integrated with each other in various ways. It is therefore indispensable for surgeons, radiotherapists and medical oncologists to assess the patient together and to establish a single programme of treatment and act in a co-ordinated way to make their own individual contributions to the treatment, thereby ensuring the best possible results.

3. Rehabilitation and the return to normal activity

After completing the programme of anti-cancer treatment, the patient returns to his or her life and the rhythms that existed before his or her illness. This return to 'normality' can be definitive in the case of healing. In some cases, however, a complete curing of the tumour can undermine the person involved to such an extent that he or she cannot return to a life of relationships and/or normal work.

In other instances, however, the cure is only apparent, and the cancer, over a period that can vary from months to years, emerges once again in the future.

4. Progression

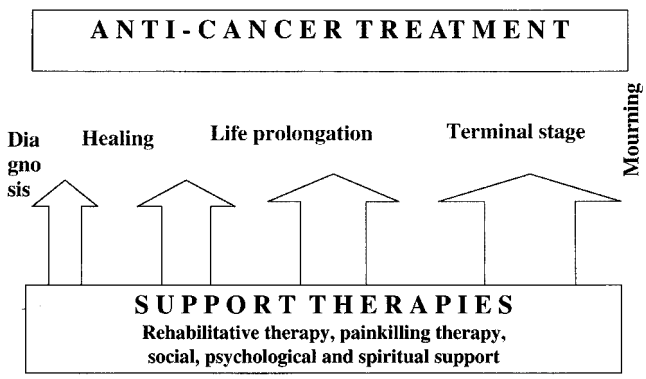
This takes place according to varying timescales because one of the effects of anti-cancer treatment is to make the tumour condition chronic. During this stage the patient returns periodically to hospital and is subjected to new anti-cancer treatment, or if this is seen as being opportune, to support therapies (in particular pain-killing treatment, nutritional therapy, and anti-fatigue methods), which have the aim of conserving a quality of life that is acceptable and to ensure that the patient has, as far as this is possible, functional autonomy.

5. The final stage of the illness

In the case of a further advance in the illness, the patient is entrusted to home assistance or to suitable structures (hospices) in order to control the pain he or she suffers from, the other symptoms, and to accompany him or her to his or her death. This journey is always very critical for the sick person, who often feels abandoned by the team that previously treated him or her. There is a need, therefore, to assure continuity of assistance and to ensure all the socio-health care help that will allow him or her to live at home, helped and comforted by his or her family relatives. But it is even more important to assure an assistance in line with ethical and moral principles that will avoid 'abandonment' in human and care terms, that is motivated by respect for personal freedom, and that prevents the patient from being left alone at a truly time.

From what has been said hitherto in this paper, it can be clearly seen that healing and treating cancer do not always correspond to healing the sick person. The illness and the therapy, in fact, undermine the organism of the sick person from more than one point of view (one need only think of weight loss, pain, asthenia and insomnia), elements which at times compromise the person's state of health more than the cancer itself, in addition to interfering with his or her functional autonomy. There is also a need for rehabilitation in relation to the patient's family and social role, which can be partly or totally compromised by the tumour and by the length of time required by the treatment. Social, psychological and spiritual support thus become a determining part of the process of assistance to ensure not only a better outcome for the anti-cancer treatment but also the maintenance, as far as this is possible, of the physical, functional, psychological and spiritual integrity of the patient and his or her family. For this reason, the best possible assistance for cancer patients is ensured through a team in which different professional figures take part in establishing a single programme of therapeutic assistance and intervene according to the priority of the needs manifested (fig. 2).

Figure 2: Model for the Treatment of the Patient



The experience of the Tiber Island

In 2000 an Operational Oncology Unit was established at the Hospital of the Tiber Island in Rome, an institution which for five hundred years has been a centre of assistance administered by the religious order of the 'Fatebenefratelli'. This unit finds its mission and vision in the model of hospitality proposed by St. John of God(3) (table 1).

Table 1: the Vision and Mission of the Operational Oncology Unit and the Department of Oncology of the Fatabenefratelli Hospital on the Tiber Island, Rome.

Vision:	To assure that the cancer patient has the best possible therapeutic outcome – in line with international and national guidelines – in terms of healing, where possible, as well as the best quality of life for himself or herself and his or her family.
Mission:	The sharing amongst different specialists of integrated diagnostic-therapeutic pathways whose objective is to provide solutions to all the needs of the patient - both expressed and not expressed - his or her well-being, and that of his or her family. – Continuity in care and treatment during the advanced stage of the illness – Support for the family relatives during mourning for the deceased person.

The placing of the needs of the sick person at the centre of the concerns of those who live and work in a hospital, as the model for care and treatment of the Fatabenefratelli proposes,(2) requires a radical change in ways of working but also a revision of the structure of the hospital, which plays an important role in facilitating or making more complicated not only the interchange between workers who belong to different units but also the pathway of the sick person within that structure.

The length of time involved in cancer illness, and its evolution, also explain how the relationship that is established between the patient and the team looking after him or her is not limited to a mere action or actions which have a short duration but which last for the whole of his or her life, albeit with an intensity of controls or presence that vary according to the evolution of the illness itself.(3) It is thus indispensable to establish from the outset a relationship of mutual trust which will become consolidated over time and whose human value for both parties goes beyond therapeutic results and professional success.

At the same time, a radiotherapy service was opened which was provided with equipment that was very advanced at a technological level so as to allow conformational forms of radiotherapy and integrated chemo-radiotherapy treatment and the limitation of undesired effects. Given traditional high-level surgery (in particular for tumours of the gastrointestinal tract, for breast cancer and for sarcoma cancer), as well as specialist surgery (in the field of otolaryngology, urology, and gynaecology in particular), cancer patients already turned to this hospital but they did not find a suitable response at the level of continuity of treatment. It was also necessary to conform the different diagnostic-therapeutic pathways of patients in order to ensure overall treatment for everyone in addition to continuity of assistance and therapy during the advanced stage of the illness.

The overall assistance we propose (figure 2) has the aim of achieving the hospitality envisaged by St. John of God, and at the same time of acting in conformity with criteria of quality and efficacy to help oncological patients.(4)

In particular, the cardinal points round which we have organised our activity are as follows:

1. A transparent relationship with the patient

Aware that in order to be able to help the patient and highlight his or her needs it is necessary to listen to him or her, we have given ample room to *listening*, which begins at the moment of the patient being received into the hospital or his or her first visit to a surgery. Listening improves the knowledge that the health care workers have about the state of health, the functional autonomy, and the quality of life of the sick person, as well as the knowledge that the patient has about his or her illness, prognosis, and possible forms of treatment. To put the patient at ease on his or her first encounter with the structure is in fact the first therapeutic act. All of this is also indispensable in planning a transparent programme of care and treatment based upon mutual trust and the involvement of the patient in the therapeutic choices.

We have also created a *library* where daily newspapers, information on tumours and the effects of treatment, as well as journals, books and videocassettes for patients who have been admitted to the hospital or to the day-hospital, can be read and used.

In the waiting room of the day-hospital, for two hours two times a week, a number of workers have conversations with the patients and their fami-

ly relatives on very different subjects chosen by the patients themselves.

Tabella 2: Calendario degli incontri per malati e famigliari.

Giorno	Argomento	A cura di
3.4	Guida al mangiare sano	Serv. Dietetico
4.4	Riabilitazione motoria	Serv. Fisioterapia
8.4	Terapia e Preghiera	Serv. Pastorale
9.4	Colpa	Serv. Psicologia
10.4	Percorsi amministrativi	U.O. Oncologia
11.4	Politiche sociali	Serv. Sociale
14.4	Il linfodrenaggio	Serv. Fisioterapia
17.4	Assistenza Domiciliare	Serv. Sociale
22.4	Preghiera e Terapie	Serv. Pastorale
23.4	Nutrizione e salute	Serv. Dietetico
25.4	Effetti indesiderati della Radioterapia	U.O. Radiot.
28.4	Terapia della mucosite	U.O. Oncologia

The patients also have a board available to them where it is possible to communicate news or make complaints or suggestions of all kinds. Those working in the hospital respond periodically to what has been written up on this board.

Because we have noticed that patients have an extreme need to know as much as possible about their cancer and their treatment, we are creating an Internet point through which it is possible to connect with the various sites that provide information on publications on cancer and possible therapies for it.

2. An integrated team

A series of professional figures make up the Operational Oncology Unit: a social assistant, a psychologist, a nutritionist, a physiotherapist and a priest. They work in close cooperation with the medical doctors and nurses, and together assess the patient and establish a single assistance project for him or her. The constant presence within the team of these professional figures ensures, in addition to the anti-cancer treatment, care as regards the different needs of the sick person, that is to say it contributes to the acceptance of the forms of treatment themselves and thus to the final result.

3. Surgeries with a number of specialists

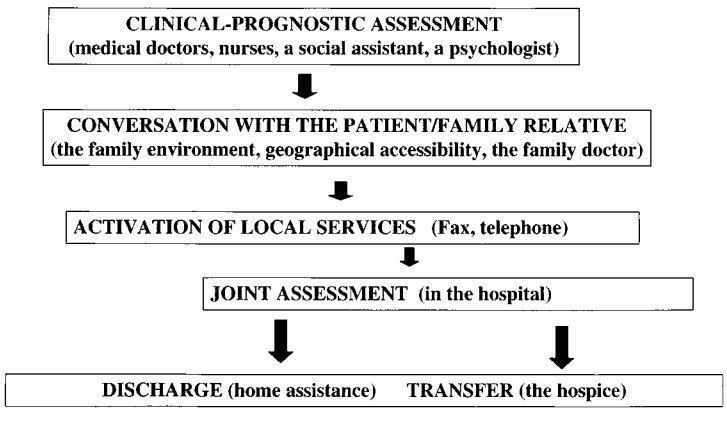
This integration of the various kinds of anti-cancer treatment has allowed over recent years an improvement in results not only in terms of healing but also as regards quality of life by frequently avoiding mutilating or destructive actions that prevented the patient –although he or she was 'cured' of cancer - from returning to a normal life.

In order to facilitate such integration as a way of doing routine work, integrated surgeries were created in which for each kind of cancer a surgeon, a radiotherapist and an oncologist are present who assess the sick person on his or her first visit to the hospital and plan his or her therapeutic pathway. In addition to reassuring the patient about the choices regarding the treatment he or she will receive, this requires these specialists to be constantly up-dated about their own way of working and to engage in a periodic verification of their own approaches.

4. Continuity in care and treatment during the terminal stage

Our aim is to be able to accompany the patient from the diagnosis of his or her cancer to his or her cure or death. At the moment, given that we are not able to assist him or her in concrete terms during the advanced stage of his or her illness, we have organised a 'handing over phase' (see figure 3) that takes

Figure 3: Continuity in Care and Treatment



the form of a sharing of the assistance project with those structures in the local area that are entrusted with assistance during the advanced stage of the patient's illness. To do this, after an assessment carried out by the team, a discussion is engaged in with the patient and his or her family relatives about whether to choose home assistance or a hospice, and this within the context of the family situation and the availability of local services. A joint assessment, carried out by the hospital team and the home or hospice assistance team, then takes place, and this is designed to ensure continuity in assistance and therapy at home or in the hospice.

The greatest difficulty we are faced by does not lie in ensuring assistance to the sick person but rather in sharing, from an ethical and moral point of view, certain fundamental principles that can significantly modify the behaviour of the health care workers during the last few months of the patient. Sharing an approach that ensures the well being of the sick person, avoiding exaggerated therapy but also an excessive policy of inaction, is not always easy and requires above all else a serene and transparent dialogue between workers from different backgrounds and beliefs.

For this reason, being able to accompany the sick person to his or her death and to support the family relatives in overcoming their mourning, would be the right ending to a complete process of assistance and therapy.

5. Training and the continual updating of personnel

The continual improvements in therapy in the oncological field require a constant updating of personnel so as to be able to apply new therapeutic procedures to patients in rapid time. The nursing staff must, in addition, be adequately instructed on the procedures and the protocols to be adopted in the preparation and administration of chemotherapy and anti-blastocyte treatment, as well as the assistance to be provided for possible side effects of the treatment. Furthermore, the personnel should be supported from the psychological point of view in order to avoid the burnout syndrome, as well as being motivated with regard to the important human and professional role that they perform. These aspects are also a primary goal of our work. For this reason, every year, specialisation courses are organised for our nursing staff, as well as exchanges of professional experiences with the staff of other operational oncological units. In addition, with the support of a psychologist the personnel meet periodically to discuss clinical cases that have most involved the team at an emotional level.

6. Participation in international and national oncological co-operative groups

Participation in international and national co-operative study protocols, established through good clinical practice, ensures that the sick person will enjoy very good choices as regards treatment, and also allows workers to engage in constant dialogue with other groups as well as constant updating. In addition, it facilitates the availability of new molecules that are periodically inserted into cancer treatment, thereby ensuring that patients can employ new drugs and medicines in rapid time.

The department of oncology: a way of operating that overcomes architectural and cultural barriers

The functional incorporation of more than one operational unit and service that look after the patient can allow the realisation of a model for the overall care and treatment of a sick person. This department, which is an organisational system designed to co-ordinate and manage the shared process of different operational units and services, in which there is a convergence of scientific, technical and assistance experiences, has the purpose of maximising and co-ordinating a diagnostic-therapeutic pathway. In this sense, a department of oncology which incorporates a number of operational units and services that share the same treatment and assistance for the same oncological patient can be an opportunity by which to overcome cultural and structural barriers and to allow, through the work of interdisciplinary groups, the creation of a real pathway of integrated assistance, which is, indeed, the foundation of overall assistance.

The priorities as regards the provision of assistance to an oncological patient have been identified. The formation of work groups, each one made up of eight to ten people who belong to different operational units and services, with a co-ordinator, has also been promoted. These groups meet every month to achieve short-term (one year), medium-term (two years) and long-term (three years) objectives. Table 3 sets out the working groups and the objectives that have been proposed for the next three years for the department of oncology.

Table 3: The Department of Oncology: Work Groups and Objectives

1. Diagnostic-therapeutic pathways in the case of cancer

Objectives:
a. The sharing of a diagnostic-therapeutic pathway (screening, diagnosis, therapy, follow-up) for patients with cancer of the gastrointestinal tract, breast cancer, urological cancer, cancer of the otolaryngological area, lung cancer, sarcoma cancer etc.
b. The establishment and application of nursing procedures and assistance protocols for cancer patients.
c. Verification of its applicability in the operational units belonging to the department.
d. Its application (after possible correctives) to all the cancer patients in the hospital.

2. A computerised oncological file

Objectives:
a. The creation of a computerised oncological file that follows the whole pathway of the cancer patient and is the operational instrument for each worker responsible for the patient during the different stages of the development of the tumour.
b. A verification of its applicability in the operational units belonging to the department.
c. Its application (after possible correctives) to all the cancer patients in the hospital.

3. Overall assistance

Objectives:
a. To ensure care for the patient by an integrated multidisciplinary team (spiritual service, psychological service, socio-assistance, a nutritionist, a physiotherapist) for all cancer patients according to their needs.
b. The application of assistance to all the patients admitted to the operational units belonging to the department.
c. The application of assistance to all the oncological patients admitted to the hospital.

4. Continuity in hospital and local care

Objectives:
a. To ensure continuity in assistance for the patient during the final stage of his or her illness and to accompany him or her to his or her death.
b. To ensure that this takes place in conformity with shared moral and ethical principles.
c. To help family relatives in managing their mourning for their deceased relative.

5. The training and updating of personnel

Objectives:
a. To establish the processes and procedures of oncological nursing assistance.
b. The application and testing of this.
c. To ensure constant training and updating for all the professional figures involved in providing assistance to the oncological patient, and to ensure that this has positive consequences for that assistance.

The activities of the department of oncology began about seven months ago. It is still too early to draw conclusions but the mutual dialogue and professional exchange are already bearing fruit.

Concluding remarks

The cancer patient manifests a multiplicity of needs at the level of clinical assistance, which, if suitably met, act to achieve the best therapeutic outcome possible.

Today it is possible to cure about 50% of tumours, but not always is one dealing with a 'healing' for the patient, who sees his or her life compromised from different points of view when he or she knows that he or she has cancer.

Being a hospital means ensuring a human value in professional service but it also means sharing a project of assistance with more than one specialist in order to offer complete assistance to the cancer patent. This also assures respect for the individuality of the sick person by attributing to him a protagonist's role within the therapeutic process and recognising and appreciating at the same time his identity at an existential level.(2)

To achieve this it is also necessary to review the structural aspects of the hospital involved in order to facilitate the pathways taken by patients and the exchanges at the level of communication between the various workers.

The development of the clinical activity of the department will increasingly facilitate the achievement of overall assistance in the future.

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GIOVANNI PAOLO II

Difesa della vita e promozione della salute

DISCORSI E MESSAGGI NEL VENTICINQUENNIO DEL PONTIFICATO

a cura di D. Di Virgilio e A. Maltarello

Editrice Orizzonte Medico
Roma 2003

N.B. 'John Paul II. The Defence of Life and the Promotion of Health.
Addresses and Messages during the Twenty-five Years of His Pontificate'.
This book can be ordered from Casa Editrice Orizzonte Medico, via della Traspontina, 15 - Rome 00193

Preface

In the twenty-fifth year of the pontificate of John Paul II the publication of a volume that brings together all this Pope's speeches to medical doctors and sick people is highly significant and is worthy of great attention: not only because the volume reaffirms with clarity the centrality of the question of life in the teachings of this Pontiff – as for that matter one could already foresee at the beginning of his pontificate with the long catechesis on human love, and as has been successively demonstrated by numerous initiatives, amongst which we recall, by way of example, the establishment of a pontifical dicastery for pastoral care in health, the creation of the World Day of the Sick, and the regular and moving visits to hospitals during all his apostolic journeys – but also because it testifies to the important role that the Holy Father attributes to health care workers, and in particular to medical doctors, called as they are to engage in the defence and promotion of human life.

Because of the singular vastness of the material brought together in this volume, it is certainly not possible for me to present it effectively, albeit in a summarising way, nor even less to offer some brief notes by way of comment. However, it could undoubtedly be more useful to point out to the reader some key approaches that will help him to understand the dominant theme that links together texts that are extremely heterogeneous as regards the subjects that are dealt with, the form employed, the circumstances in which they were produced, and the audience to which they were addressed.

1. John Paul II, in proposing again the anthropology of the Second Vatican Council, frequently observes that man on earth 'is the only creature on earth that God has willed for its own sake' (*Gaudium et spes*, 24) and that God's love for man makes man a privileged being. It follows from this that those who work in the health care field must always, in their approach and behaviour, bear in mind that they have before them a being who is the living object of God's really special love.

2. Medical doctors, whose 'identity' is that of those people who by vocation and by profession are 'guardians and servants of human life' (*Evangelium vitae*, 89), must never forget, when they draw near to the sick and the suffering, that in every person is visibly mirrored the face itself of Christ, in whose image that person was created. In this sense the Second Vatican Council, in a splendid passage that has since become classic, wrote: 'The truth is that only in the mystery of the incarnate Word does the mystery of man take on light. For Adam, the first man, was a figure of Him Who was to come, namely Christ the Lord. Christ, the final Adam, by the revelation of the mystery of the Father and His love, fully reveals man to man himself and makes his supreme calling clear' (*Gaudium et spes*, 22). Christ, therefore, must be the hermeneutic principle for the medical doctor, the central approach and interpretation that allows him, first, to penetrate the enigma of the human being, and, second, to treat him.

3. It is thus of particularly urgent importance for the medical doctor to cultivate a *contemplative outlook*, an outlook that is to say that does not seek to take possession of reality through technical-professional tools and instruments but which helps the medical doctor not to surrender in a discouraged way in the face of a person who is in illness, in suffering, in a marginalised condition, and on the threshold of death. This is, indeed, a contemplative outlook, but it is also certainly capable of releasing commitment and concrete action. Indeed, all these difficult situations call on him and lead him to engage in a search for a meaning, and specifically in these circumstances he becomes able to rediscover in the face of every person an appeal to interaction, to dialogue, and to solidarity. 'It is time for us all to adopt this outlook, and with deep religious awe to rediscover the ability to *revere and honour every person*' (*Evangelium vitae*, 83). Only this contemplative outlook, the source of wisdom and sapience, has within it the light and the force to suggest, in the most complex and new situations as well, the really and fully human solution to the questions regarding the life of every person.

4. To the three approaches hitherto outlined, I would now like to add another element for reflection: the medical doctor can engage in this contemplative outlook in relation to a sick person – and this pre-supposes a 'receptive' attitude – only if he directs this contemplative outlook first of all towards himself and his own profession in an approach that we could define as 'self-receptivity'. In fact, one cannot see the face of Christ in a sick person (*Christus patiens*), if one does not see the face of Christ in oneself as a medical doctor (*Christus medicus*). The presence of Christ asks to be recognised and experienced both by the medical doctor as the presence of *Christus medicus*, of Christ who places himself at the service of the sick person, and by the patient as the presence of *Christus patiens*, of Christ who in a certain sense continues his passion in the history of mankind, in the sick person, in the suffering limbs of his 'body', the Church (cf. Colossians, 1:24).

I will conclude by expressing the wish and hope that this volume will receive the diffusion that it really deserves. These are pages which, while bearing witness to the magisterium and the 'passion' of John Paul II in defending the most precious good of human life, also demonstrate at a practical level his extraordinary contribution to outlining and calling for a real and authentic 'pedagogic art' able to lead to the recognition not only of the incommensurable personal dignity of every human being but also and especially of his transcendent and sacred value, to the point of reaching the admired discovery of the face of Christ. It is precisely this face, which is mirrored in man – whether he is a man who is suffering or a man who heals and treats – that is the foundation of, the reason for, and the guarantee of, his absolute inviolability.

His Eminence Cardinal DIONIGI TETTAMANZI,
Archbishop of Milan,
National Assistant of the AMCI.