DOLENTIUM HOMINUM

N. 60 – Year XX – No. 3, 2005

JOURNAL OF THE PONTIFICAL COUNCIL
FOR HEALTH PASTORAL CARE

Editorial and Business Offices: PONTIFICAL COUNCIL FOR HEALTH PASTORAL CARE
VATICAN CITY; Tel. 06-6988-3138, 06-6988-4720, 06-6988-4799, Fax: 06-6988-3139
www.healthpastoral.org - e-mail: **opersanit@hlthwork.va**

Published three times a year. Subscription rate: € 32 postage included

Printed by Editrice VELAR, Gorle (BG)

Cover: Glass window Rev. Costantino Ruggeri

Poste Italiane s.p.a. Spedizione in Abbonamento Postale - D.L. 353/2003 (conv. In L. 27/02/2004 n° 46) art. 1, comma 2, DCB Roma

Summary

The illustrations in this edition are taken from the book:
"Archivio Segreto Vaticano"
a cura di Terzo Natalini, Sergio Pagano, Aldo Martini.
Firenze, Nardini Editore, 1991

Message of His Holiness Benedict XVI for the XIV World Day of the Sick

ADELAIDE, AUSTRALIA, 11 FEBRUARY 2006

Dear Brothers and Sisters,

The World Day of the sick will be held on 11 February 2006, the liturgical memorial of the Blessed Virgin of Lourdes. Last year this Day was held in the Marian sanctuary of Mvolyé in Yaoundé, and on that occasion the faithful and their pastors, in the name of the whole of the continent of Africa, reaffirmed their pastoral commitment to the sick. The next World Day of the Sick will be in Adelaide, in Australia, and the events will culminate in the celebration of the Eucharist in the cathedral dedicated to St. Francesco Saverio, the untiring missionary of the populations of the East. On that occasion, the Church intends to bow with especial solicitude to the suffering, calling the attention of public opinion to the problems connected with mental disturbance, which by now afflicts a fifth of mankind and constitutes a real and authentic social-health care emergency. Remembering the attention that my venerated predecessor John Paul II gave to this annual event, I, too, dear brothers and sisters, would like to make myself spiritually present at the World Day of the Sick, so as to pause to reflect, in harmony with those taking part, on the situation of the mentally ill in the world and to call for the commitment of the Church communities to bear witness to the tender mercy of God towards them.

In many countries, legislation in this field does not yet exist and in other countries a precise policy on mental health is absent. It should also be observed that the prolongation of armed conflicts in various areas of the world, the succession of terrible natural catastrophes, and the spread of terrorism, in addition to causing a shocking number of deaths, have also created mental traumas in not a few survivors, whose re-

covery at times is difficult. And in countries with high economic development, the experts recognise that at the origin of new forms of mental disturbance we may also find the negative impact of the crisis of moral values. This increases the sense of loneliness, undermining and even breaking down traditional forms of social cohesion, beginning with the institution of the family, and marginalising the sick, and especially the mentally ill, who are often seen as a burden for their families and the community. I would like here to thank those who work in various ways and at various levels to ensure that the spirit of solidarity does not decline and that people persevere in looking after these brothers and sisters of ours, basing themselves on human and Gospel-based ideals and principles.

I thus encourage the efforts of those who work to ensure that all mentally ill people are given access to necessary forms of care and treatment. Unfortunately, in many parts of the world the services for these sick people are lacking, insufficient or in a state of decay. The social context does not always accept the mentally ill, with their limitations, and for this reason, as well, difficulties are encountered in securing the human and financial resources that are needed. One perceives the need to integrate in a better way the tandem *appropriate therapy* and *a new sensitivity towards disturbance* so as to enable workers in this sector, in a more effective way, to help these sick people and their families, who on their own would not be able to take care of their relatives in difficulty in an adequate way. The next World Day of the Sick is a suitable occasion to express solidarity to families who have mentally sick people dependent upon them.

I would here like to address myself to you, dear brothers and sisters burdened by illness, so as to invite you to offer your condition of suffering, together with Christ, to the Father, certain that every ordeal received with resignation is meritorious and draws the benevolence of God upon the whole of mankind. I express my appreciation to those who help and care for you in residential centres, day hospitals and wards providing diagnosis and treatment, and I exhort them to strive to ensure that medical, social and pastoral assistance for those in need which respects the dignity specific to

every human being is never absent. The Church, in particular through the work of chaplains, will not fail to offer you her own help, being well aware that she is called to express the love and care of Christ for those who suffer and for those who look after them. I commend pastoral workers and voluntary associations and organisations to support – in practical forms and through practical initiatives – those families who have mentally ill people dependent upon them, in relation to whom I hope that the culture of welcoming and sharing will grow and spread, as a result, also, of suitable laws and health-care programmes that envisage sufficient resources for their practical application. The training and updating of the personnel who work in such a very delicate sector of society is as urgent as ever before. Every Christian, according to his specific task and specific responsibility, is called to make his contribution so that the dignity of these brothers and sisters of ours is recognised, respected and promoted.

Duc in altum! This invitation of Christ to Peter and the Apostles I address to the Church communities spread throughout the world and in a special way to those who are at the service of the sick, so that, with the help of Mary *Salus infirmorum,* they may bear witness to the goodness and the paternal solicitude of God. May the Holy Virgin comfort those who are afflicted by illness and support those who, like the Good Samaritan, soothe their corporeal and spiritual wounds! I assure each one of you that you will be remembered in my prayers, and I willingly impart my Blessing on you all.

From the Vatican, 8 December 2005

BENEDICT XVI

Address of His Holiness Benedict XVI to Staff and Patients at "Bambino Gesù" Children's Hospital

GIANICOLO HILL, ROME - FRIDAY, 30 SEPTEMBER 2005

Hospital Administrators
and Distinguished Authorities,
Dear Children,

At the end of my visit, I am glad to speak to you and to thank you for your warm welcome. I am grateful to the President of the "Bambino Gesù" Paediatric Hospital for his words on behalf of you all, words of faith and true Christian charity. I greet the Presidents of the Region and of the Province, the Mayor of Rome and the other Authorities gathered here.

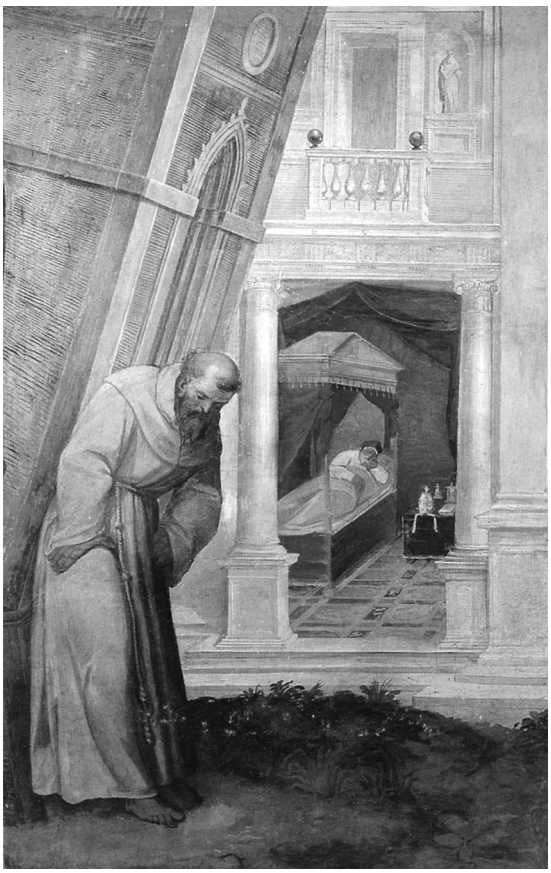
My gratitude then goes to the Administrators, Directors and Coordinators of the Hospital Wards, and to the doctors, nurses and all the personnel. I address you in particular with affection, dear children, as well as your relatives who are beside you to care for you. My heartfelt thanks go to your representative who has paid me a kind tribute on behalf of the entire family of the "Bambino Gesù". I am close to each one of you and want to make you feel God's comfort and blessing. I would like to express these same wishes to those in the branches of this hospital at Palidor and Santa Marinella, who are equally close to me.

I chose the "Bambino Gesù" for my first visit to a hospital for two reasons: first of all, because this Institution belongs to the Holy See and is caringly watched over by the Cardinal Secretary of State, who is present here. Passing through several wards, meeting so many suffering little ones, I thought naturally of Jesus who loved children tenderly and wanted them to be allowed to go to him. Yes, like Jesus, the Church too expresses a special fondness for children, particularly when they are suffering.

And this is the second reason why I have come to see you: to witness personally to Jesus' love for children, a love that wells up spontaneously from the heart and that the Christian spirit nurtures and strengthens. The Lord said: "As often as you did it for one of my least brothers, you did it for me" (cf. Mt 25: 40, 45). In every suffering person, especially if he or she is little and defenceless, it is Jesus who welcomes us and is expecting our love.

Consequently, dear friends, the work you do is important. I am thinking of the advanced surgery that has made the "Bambino Gesù" famous. But I am also thinking above all of the ordinary everyday work: of the welcome, hospitalization and painstaking care provided to the small patients - and there are so many of them! - who have recourse to your health-care structures. This requires great availability and a constant effort to increase the available resources; it demands attention, a spirit of sacrifice, patience and disinterested love to ensure that parents find here a place where they can breathe hope and serenity, even in moments of the most acute anxiety.

Permit me to say another word precisely about the welcome and care that is given to those who are sick. Here you are concerned to guarantee excellent treatment, not only from the medical but also from the human point of view. You seek to give a family to the patients and those who are with them, and this requires a contribution from all: the directors, doctors, nurses and staff in the vari-



ous wards, the personnel, and the many praiseworthy organizations of volunteers who daily offer their precious service.

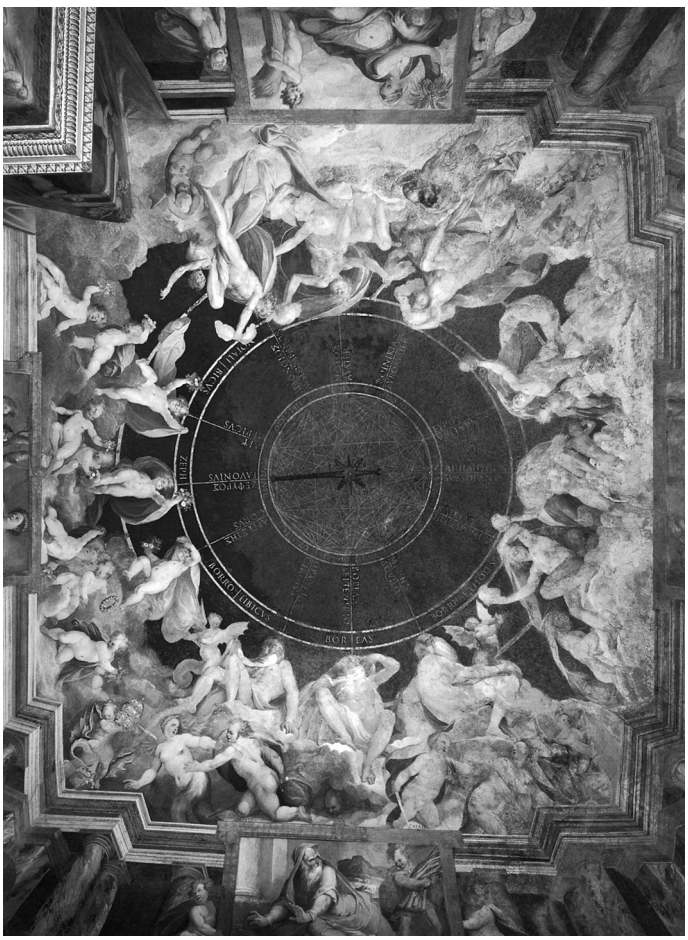
This approach, which is effective for every clinic, must be a special feature of those inspired by Gospel principles. For children, then, no resources should be spared. May every project and programme, therefore, always be centred on the good of the sick, the good of the sick child.

Dear friends, thank you for your collaboration in this work of great human value that is also an especially effective apostolate. I pray for you, knowing that this mission of yours is far from easy. However, I am convinced that everything will be easier if, in devoting your energy to all your little guests, you are able to recognize in their faces the face of Christ.

When I went to pray in the chapel I met the priests, women religious and all those who accompany your work with their dedication, assuring in particular an appropriate spiritual animation. May the Church herself be the heart of the Hospital: draw from Jesus, truly present in the Eucharist, from the sweet Doctor of body and soul, the spiritual strength to comfort and care for all who are hospitalized here.

Lastly, as Bishop of Rome, may I be permitted to make a supremely pastoral reflection. The "Bambino Gesù" Hospital, in addition to being an institution of the Holy See that directly provides practical help for sick children, is an outpost of the Christian Community's evangelizing activity in our City. Here a practical and effective Gospel witness can be offered in contact with suffering humanity; here, the power of Christ, who with his spirit heals and transforms human existence, is proclaimed through deeds.

Let us pray that together with their treatment, the love of Jesus may be communicated to the little ones. *May Mary Most Holy, Salus infirmorum* - Health of the sick, whom we feel yet closer as Mother of the Child Jesus and of all children, protect you, dear sick children, and your families, the administrators, the doctors and the entire Hospital Community. I impart my Apostolic Blessing with affection to you all.



Letter of the Holy Father to Cardinal Lozano Barragán

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

I unite myself to all the beloved Mexican community both in Rome and your homeland, Venerable Brother, and I willingly associate myself, at this happy moment, with the shared and keenly-felt expressions of gratitude that will be expressed to you over the next days, when the golden jubilee of your priesthood is celebrated.

Indeed, before our predecessor, John Paul II, of immortal memory, entrusted you with the position of President of the Pontifical Council for Health Pastoral Care, you had already completed most of your priestly ministry in various and numerous works and services to the benefit of the Church in your homeland, where you shone forth with your pastoral qualities and your awareness of duty.

It does not seem necessary to us to evoke in detail the useful advice that you provided in your role within the Theological Society of Mexico and the Pastoral Theological Institute CELAM, but above all else in your position as Bishop at the archdiocese of Mexico City and then for twelve years in the prudent guidance of the flock of Zacatecas where, with a completely special love, you promoted the renewal of the clergy, the strengthening of the structures of the diocese, and dialogue with culture.

In addition, with regard to the merits of your productive apostolate, we should add the numerous and great services that you render as an active member of the various Offices of the Roman Curia. And as we have already mentioned, your activity has been characterised during these nine years by the benefit you have brought to pastoral care in health.

Thus, Venerable Brother, we have good reasons, through this letter, for personally addressing to you our keenly-felt congratulations on the occasion of the fiftieth anniversary of your priesthood, which, by the grace of God, falls on 30 October 2005.

We are united to you, therefore, with a special benevolence, but also in this colloquium, giving thanks to God, the Author of every good, and expressing to you deserved congratulations on such a fertile and varied ministry. Lastly, expressing our best hopes and wishes of good health, for many years still to come, in the chosen vineyard of the Church at the service of God, in a heartfelt way we impart to you Our Apostolic Blessing, a secure pledge of celestial graces and an evident sign of our benevolence.

From the Vatican, October 26, 2005,
the first year of Our Pontificate

BENEDICT XVI

Speech in Honour of Cardinal Javier Lozano Barragán on the Occasion of the Golden Jubilee of his Priesthood

30 OCTOBER 2005

Most Reverend Eminence,

On behalf of the Pontifical Council for Health Pastoral Care and all those present, I address to you, Your Eminence, words of tribute on the occasion of the fiftieth anniversary of your ordination as a priest.

1. The circumstance which brings us together this afternoon in this very beautiful Church of Holy Mary in Trastevere is known by everyone, namely the celebration of the fiftieth mass, as is said here in Italy, of Cardinal Javier Barragán, President of the Pontifical Council for Health Pastoral Care.

2. Your eminence, the number '50' is biblical as, indeed, we all know. In your case it is a matter of celebrating half a century of generous and faithful service to God and to the Church.

3. Your jubilee is a *Kairos* in the sense that it is celebrated at the end of the Year of the Eucharist and in the month of the Synod of Bishops on the Eucharist. I would like here to emphasise the deep bond that unites the priesthood with the Eucharist, which we are about to celebrate.

4. During these fifty years of rich and fruitful priestly ministry, as the Holy Father observed in his letter, you have certainly be able to experience the goodness and benevolence of God towards you, but also His love and His mercy in calling you to, and in bestowing upon you, the great gift of priesthood. To this great grace you replied by saying 'yes' to the project of God, to the example of Our Most holy Lady, entrusting yourself to the full to God, who brings about the growth of that spiritual sowing which, in pastoral charity, configures you to Christ, the Eternal Priest and Good Shepherd. In front of such a sublime mystery, that of the vocation to, and the gift of, priesthood, we can only sing with the Psalmist:

Misericordiam domini in aeterno cantabo

5. In a little while you will raise, as you did fifty years ago, the chalice of the Blood of Christ, the chalice of Salvation, the source and summit of your priestly life. The priesthood is a sacred ministry of the Church for the '*Salus animarum*'. The Eucharist is the best answer there is to the fundamental question: how can we give thanks to the Lord for all the spiritual benefits that have been received during the course of these fifty years? I will raise the chalice of salvation, invoking his name.

May this Holy Eucharist increasingly strengthen your friendship with the Eucharist Jesus and animate in the faithful, in us, the desire to know, love and serve God in everything and in everyone.

Once again, on behalf of everyone, very many best wishes of peace, joy and well-being in the Lord.

And may it be so.

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

Homily for the Golden Jubilee of his Priesthood

BASILICA OF ST. MARY IN TRASTEVERE, ROME,
30 OCTOBER 2005

Fifty years of priesthood are a very special gift from the Lord. The very vocation to the ministry of the priesthood is already something that gives rise to amazement.

Life in itself is a great gift that the Lord has given to us. To celebrate a anniversary such as this is an even greater reason for giving sincere thanks to God. He has placed this gift in our hands and to each one of us He has entrusted a task which, in the final analysis, is that of further developing this gift which has been received. God distributes these gifts as He thinks fit. Of these gifts, in my opinion, the greatest is that of making us become children of God and, amongst the children of God, of granting to us the gift of the ministry of the priesthood.

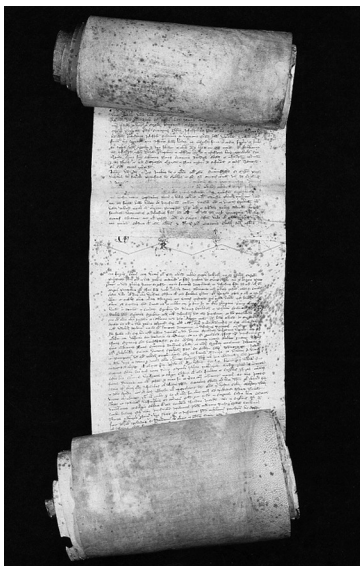
Thus in reaching the fiftieth anniversary of the acceptance of this gift which has shaped the whole of my life, my response can be none other than that of thanking the Lord for everything that these fifty years have meant for me. The Lord gave me life, he gave to me the fundamental gift of divine filiation through baptism and the other sacraments, and fifty years ago he wanted to offer me the special gift that provokes in me even greater amazement – that of my ordination as a priest.

Every gift also involves an obligation that must be developed according to the way in which the Lord has wanted to express himself in each one of us. He helps us so that the development of this gift continues by belonging to him as well. Today, I want to thank the Lord for everything that he has wanted to do through me over these last fifty years. I am aware that all good comes from the Lord, and that all failings, on the other hand, come from me. For this reason, together with my full thanks to the Lord, I sincerely want to ask from him forgiveness and mercy for all the times that I have failed because I was not of the level that I should have been. At my ordination as a priest my motto was the glory of God; at my ordination as a bishop it was the witness of the Resurrection of the Lord, which was also my motto at the time when I was made a Cardinal. When, last year, I commemorated my silver jubilee as a bishop I celebrated the Eucharist as thanks for this. Today, in commemorating my golden jubilee as a priest I would like to offer the Eucharist as a prayer to obtain mercy and forgiveness from God.

But today is also a day to give thanks to all of you and to all those people who have marked my life as a priest during these last fifty years. Thus in my mind I can see the diocese where I began, Zamora; my seminary; and my bishop who called me to become a priest, His Excellency José Gabriel Anaya y Diez de Bonilla. I can also see in my mind the bishop who ordained me: Cardinal Carlo Confalonieri, and also the Pontifical college 'Pio Latino Americano' where I was ordained, and my Superiors of those days; my lecturers at the Pontifical Gregorian University; my fellow teachers at the seminary of Zamora; the much loved Cardinals and Bishops of the Episcopal College for Latin America with whom I worked for over twenty-five years; the various theological centres that welcomed me as a lecturer both in Europe and America; the Archdiocese of Mexico, where I was Auxiliary Bishop for five and a half years; the diocese of Zacatecas, where the Lord allowed me to be his bishop for twelve years; the much lamented Pope John Paul II who called me to work with him in the Roman Curia; His Holiness Benedict XVI who deigned to confirm me in the same position and who has made himself especially present today through his very much appreciated letter of good wishes, which we listened to a little while ago.

I also feel the special presence of the Cardinals' College which, through the Cardinal Secretary of State, His Eminence Angelo Sodano, sent me the cordial letter of best wishes which we have also read; of the Pontifical Council for Health Pastoral Care with its Secretary, H.E. Msgr. José Luis Redrado, and its Under-Secretary, Rev. Felice Ruffini; of my personal secretary, Msgr. Antonio Soto and all the other Officials of the Pontifical Council, together with its Members and Consultors, whom I would like to thank for having welcomed me and for the work that we have been able to do over these last nine years; and of the whole of the Roman Curia.

My family also deserves to be remembered in a special way. My mother, in particular, who played such an important part in my vocation as a priest and who accompanied me from close at hand during the first twenty years of my life as a priest until her death. And also my brothers and sisters, my nephews and nieces, and all



the people to whom I owe so much.

A special expression of gratitude must be extended to the sisters who have accompanied me during the whole of my life as a bishop – Sister Estela and Sister Eloisa.

When I arrived in Rome nine years ago I was welcomed with special friendship by many Roman families who honour me with their special attention. They made me feel at home. I would here like to thank the Romagnoli-Castellano family, the Magiarditi family, the Giunchiglia family, the Padoan family, the Colucci family, and Prof. Giovanni Minisola, as well as many other families to whom I owe a great debt. I thank them all.

The Lord has granted to me fifty years of priesthood without any worthiness on my part. To act *in persona Christi*, at the same time making his salvific work present, is the most gratifying gift that I could receive; it is the greatest fulfilment that I could find to give meaning to my life. I give infinite thanks to the Father who granted His Spirit to me so that I could shape myself to Christ the Head, the Shepherd, the Servant and the Spouse of his Church. Allow me once again to extend my most keenly felt thanks, which he will receive in heaven, to the Holy Father John Paul II, who called me to help him in his task of directing, promoting and co-ordinating pastoral care in health in his name. And I want once again to thank the Holy Father Benedict XVI, not only for having reappointed me President of the Pontifical Council for Health Pastoral Care but also for all the benevolence that I received from him before he was elected Supreme Pontiff.

I cannot end this homily without expressing words of sincere and very cordial thanks to Don Matteo, the parish priest of this parish of Rome, which, indeed, bears the first number of all the parishes in the city, for his kind and helpful approach to his nearest parishioner, given that my home is at the corner of this very beautiful basilica. Don Matteo, from the moment I expressed my wish to celebrate my jubilee here, accepted the proposal with very much cordiality and great readiness to help so as to make everything even more beautiful and also as efficient as possible. As well as the parish priest I would also like to thank the Comunità di Sant'Egidio. Their concern and effectiveness have been indispensable for this significant event. Thank you, thank you for everything.

Life is in the hands of the Lord. As regards that space that the Lord will want in the future to still grant me to work in his Church, I ask you to help me to implore from the Lord Jesus, the High and Eternal Priest, the grace to carry out my mission in the best possible way.

Our Lady was at the beginning of my priesthood, especially under the avocation of Guadalupe. In her sanctuary, in Mexico, I received my ordination as a bishop, I gave thanks for the freely-given gift of the Cardinalship, and I celebrated the silver jubilee of my being a bishop. Today, in this Basilica of St. Mary in Trastevere, which is one of the oldest and most beautiful basilicas to be dedicated the Most Holy Virgin, I have the privilege of celebrating my golden jubilee as a priest. In the central icon of the apse we can contemplate Christ as he tenderly holds his mother and says to her: come my chosen one and I will place you on my throne. Our Lady answers: his hand on my head and with the right hand he holds me. May Our Lady welcome me into her maternal arms and may Christ also hold me close in his infinite mercy! May this be the meaning of this Eucharist and a pledge of the final embrace of forgiveness and welcome that I benignly hope to receive!

H.Em. Card. JAVIER
LOZANO BARRAGÁN
President of the Pontifical Council for Pastoral Health Care, The Holy See

Topics

Pain, Music, Prayer

Human Security and Health

Sick People in Prison, the Importance of Pastoral Intuition

Note of the Pontifical Council for Health Pastoral Care on the So-called Right to Reproductive Health

The Catholic Health Ministry in Canada

The Health-care Professionals: We Need them and they Need us

Homosexuality and the Campaign against Homophobia in Mexico

Protocol of Agreement between the Regional Government of Lombardy and the Ecclesiastical Regional Government of Lombardy

Pain, Music, Prayer

ASSESSMENT OF THE EFFECTS OF MUSIC AND PRAYER ON THE EFFECTIVENESS OF PHARMACOLOGICAL THERAPY IN SUBJECTS SUFFERING FROM CERVICAL MYALGIC HEADACHE (CRANIAL-FACIAL PAIN).

PART ONE

General Part

In order to have a better understanding of the study that is analysed in this paper, we would like to begin by presenting the most accredited definitions of pain, of music (music therapy) and of prayer that appear in the literature in the field.

The definition of pain

In relation to pain we present here 1) the definition of pain offered by the Committee for Taxonomy of the International Association for the Study of Pain: 'pain is an unpleasant sensorial and emotional experience associated with a real and potential damage of the tissue or described in terms that refer to such damage' (I.A.S.P., 1979), and the definition of pain of the Algological School of Florence: 'pain is a psychophysical entity with universal meanings in the perception of which individual, cultural and religious factors are at work and in the contextualisation of which participate not only the branches of medicine and biology but also those of the human sciences (philosophy and psychology) (P.L. Zucchi, 1983).

The definition of music therapy

Rolando Benenzon defines music therapy in the following way: 'music therapy is a psycho-therapeutic technique which uses sound, music, movement and corporeal, sound and musical instruments to determine a historical process of bonding between the therapist and his or her patient or groups of patients with the aim of improving quality of life and rehabilitating and retrieving patients for society'

The definition of prayer

From the various definitions of prayer we have chosen those that appear in the *Dizionario Enciclopedico di Spiritualità* ('Encyclopaedic Dictionary of Spirituality' (vol. 3, Città Nuova, 1990) and in the *Catechism of the Catholic Church* (CCC). *Il Dizionario Enciclopedico di Spiritualità* defines prayer in the following way: 'prayer is a primary phenomenon of the religious life, it is its heart, its central gesture, and this to the point that prayer distinguishes the religious man from the non-religious man. It is, like religion, a universal fact that is to be found in the popular piety of all peoples and all cultures. It presupposes faith in a personal and present God. God is in the consciousness of the praying person not as a philosophical idea but as a reality, a person who is present. The relationship with God is experienced as a distance and also as contact. The believer does not have any doubts about the possibility of communicating with God, even though he or she does not see God. He or she also knows that he or she is obliged, in the strictest sense of the term, to engage in prayer. For this reason, prayer is to be found in all the theistic religions as a fundamental act of religious life even when faith in a personal God (or in personal gods) appears only vaguely or is muddied by false portrayals. This is a sign that non-degenerate man cannot live without prayer'. And the *Catechism of the Catholic Church* (*CCC*), for its part, defines prayer in the following terms: 'Prayer presupposes an effort, a fight against ourselves and the wiles of the Tempter. The battle of prayer is inseparable from the necessary 'spiritual battle' to act habitually according to the Spirit of Christ: we pray as we live, because we live as we pray' (*CCC*, n. 2752).

'In the battle of prayer we must confront erroneous conceptions of prayer, various currents of thought and our own experience of failure. We must respond with humility, trust and perseverance to these temptations which cast doubt on the usefulness or even the possibility of prayer' (*CCC*, n. 2753).

'The principal difficulties in the practice of prayer are distraction and dryness. The remedy lies in faith, conversion, and vigilance of heart' (*CCC*, n. 2754).

'Two frequent temptations threaten prayer: lack of faith, and acedia – a form of depression stemming from lax ascetic practice that leads to discouragement' (*CCC*, n. 2755).

'Filial trust is put to the test when we feel that our prayer is not always heard. The Gospel invites us to ask ourselves about the conformity of our prayer to the desire of the Spirit' (*CCC*, n. 2756).

''Pray constantly' (1 Th 5:17). It is always possible to pray. It is even a vital necessity. Prayer and Christian life are inseparable' (*CCC*, n. 2757).

'The prayer of the hour of Jesus, rightly called the 'priestly prayer' (cf. Jn 17), sums up the whole economy of creation and salvation. It fulfils the great petitions of Our Father' (*CCC*, n. 2758).

Historical Aspects

All historians agree that the first example of the positive effect of music therapy on the human organism is to be found in the Bible in the passage that we reproduce here (1 Samuel 16:23): 'And whenever the evil spirit from God was upon Saul, David took the lyre and played it with his hand; so Saul was refreshed, and was well, and the evil spirit departed

from him'. Other documents that emphasise the influence on the body of music therapy are the ancient Egyptian papyruses on medicine that were discovered by Petrie in Karoun in 1899 and which are dated to 1500 BC. In these papyruses emphasis is placed on the therapeutic influence of music on the fertility and the wellbeing of pregnant women. This approach is also to be found in recent studies (R. Coluzzi, *Musicoterapica e Gravidanza*, Il Microtauro Editore, Rome, 2004). In ancient Egyptian culture it was believed that the god Thot had created the world, not through thought or action but with his voice.

From the literature in the field it emerges that studies on the effect of music on various pathologies have been carried out primarily on an empirical basis. In primitive societies it was quite common to believe that every living or dead being could be identified with its own sound, to which, indeed, it had to respond. It was for this reason that during magical rites to secure the health of their patients that exorcist physicians tried to discover the sound to which the sick person could respond.

The ancient Greeks used music as a real and authentic therapy for the prevention and the treatment of many physical and mental illnesses. Right up until the pre-Homeric age of the myth of Orpheus and Euridices, reference was made to the beneficial therapeutic effects of music. It is narrated, in fact, that Orpheus, the son of Apollo, who was the god of music, and Calliope, who was the muse of song, created pleasant conditions from his art, and to such an extent that birds came close to him and created a halo around him; that fish came out of the water to listen to is singing; and that trees bent down to draw closer to him. In the texts of mythology it is narrated that Orpheus, who was in love with Euridices who had died because she had been bitten by a snake, went to the underworld to meet his beloved and to take her back to the land of the living. At the Styx, the river that separated the world of the living from the world of the dead, he met the ferryman Charon. Orpheus began to sing to Charon and enchanted by the melody the latter ferried him to the other side and even followed him for a part of the way. Cerberus, the beast with three heads, on hearing the singing of Orpheus became meek and mild and lay at his feet. The whole of Hades stopped to listen to the singing of Orpheus and from all parts of Hades souls of the dead came running to him, inebriated with his singing. Unfortunately, Orpheus was cut into pieces by a group of drunken priestesses of Dionysius, and Zeus, much saddened, placed the head of this sublime singer in the constellation of the lyre.

With Plato (427-347 BC) was introduced the concept that the world is constituted according to musical principles, that music has power over the irrational part of the self, and that philosophy is the highest expression of music. For Plato, music was a form of mental hygiene, and thus he wrote: 'the whole of our lives need eurytmia (*The Republic*). For Aristotle (384-322 BC), a musicology expert, the arts of rhythm helped to improve morale and to obtain calm, serenity and the disappearance of anxiety. Pliny the Elder (23-79) relates that Cato remembered a musical motif for the treatment of pain caused by muscular cramps, and Varron (116-27 BC) listed other motifs for the treatment of gout. Enricus Cornelius Agrippa (63-12 BC) correlates the four vocal parts to cosmic elements: the bass with the earth, the tenor with water, the contralto with air and the soprano with fire. He then compared the Doric mode with water and phlegm, the Phrygian mode with fire and yellow bile, the Lydian mode with air and blood and the Mysolidian mode with earth and bile.

However, in every culture and every epoch music has an evocative power, almost a magical power, for each individual. One need only think in our tradition of the sedative power of the rhymes or chants said out aloud to children.

Man has identified sound as a cosmic force that has been present ever since the beginnings of the world and which has taken on a verbal form. This concept is emphasised in the first chapter of the Gospel according to St. John: 'In the beginning was the Word and the Word was with God and the Word was God'. During the course of history sound has not only had an individual meaning – it has also had a social significance. Some researchers believe that at the beginning of Christianity the bells of churches were used to distance the spirits of hell from these places of worship through sound.

Aurelianus (214-275 AD) recalled the use of music for the general treatment of madness and for the local treatment of sciatica. St. Augustine (354-430 AD), in the sixth volume of his *De musica*, emphasised experience of music as being fundamental in the existence of an individual. During the medieval period, from the fifteenth century onwards, monks were the custodians both of musical science and of music. In the Monastery of St. Gallus in Switzerland highly beneficial powers were attributed to the musical compositions of the monk Notker Balbulus. During the sixteenth century the medical schools of Salerno and Montpellier stressed the importance of music as 'universal sympathy', defined as such by Arnaldo di Villanova of the Medical School of Montpellier.

Paracelso (1493-1541), who was certainly the best known of the physicians of the Renaissance, defined illness as the result of a profound imbalance

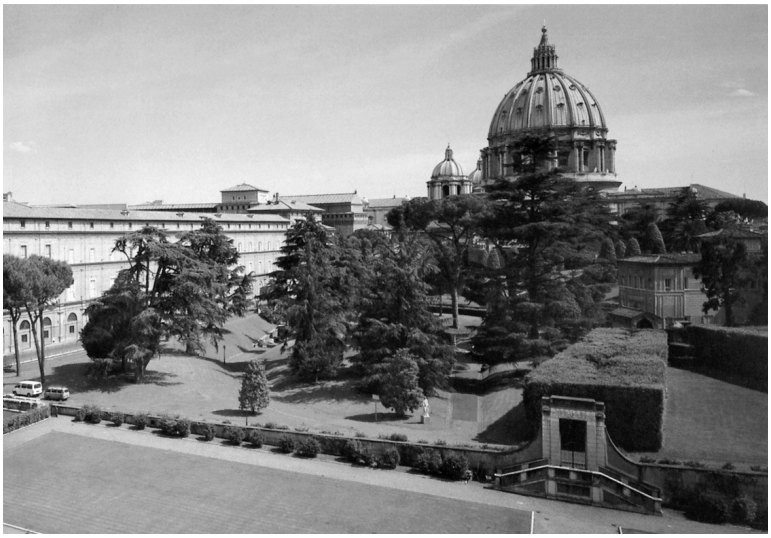
whose origins are at one and the same time physical, mental, emotional, of the passions and musical. In his book *Anatomy of Melancholy* (1632),

Robert Burton (1577-1640) stressed the therapeutic benefits of music as regards pathological states of the mind, and in particular as regards melancholy.

During the eighteenth century Mesmer, a friend of Mozart, Haydn and Gluck, and a supporter of the famous thesis that the planets have an influence on physiological and pathological phenomena, was a proponent of the essential role of music in the life of individuals. In the thought of Schopenhauer (1788-1860), as throughout the whole Romantic period, music was held to be the 'science of harmony' and was the most direct point of access with the Absolute. Schopenhauer argued that whereas art in general is the objectification of the will to life, music is the immediate or direct revelation of the will to live. On this point he observes: 'music is as direct an objectification and image of the whole Will as the world is; or indeed as ideas are, whose multiplied phenomenon is the world of individual objects. Music is not, therefore, like the other arts the image of ideas but the image of the will itself, of which ideas as well are objectivity. Thus the effect of music is so much more powerful and pervasive than the effect of the other arts because these last give us only the reflection whereas music provides is with the essence'.

For Kant (1724-1804) music was a *semantic a-priori* and thus *a-semantic*, that is to say it provokes emotions that refer to a meaning in a way that is different from verbal language in which reference is made first to meaning and then to emotion. Hegel (1770-1831) exalted music and stated that it is the expression of the Absolute in the form of feeling: from Pythagoras's notion of music as harmony to the Romantic theory of music, the approach has never changed. In the view of Stravinskij and Wackenroder (1773-1798) music expresses only itself. It is the language of the interior man that has lost its relationship with the world. In harmony with the Romantics, they believed that music is the expression of the Interior Absolute.

During the nineteenth century it was the work of Helmholtz (1821-1894; the physiological theory of music) and of Stumpf (*Tonpsychologie*, 1890) that emphasised the influence of music on the psyche. In 1888 Knoblauch introduced the term 'amusia' to refer to an alteration in musical perception. Nietzsche (1844-1900) concentrated his thought on music in his early work *The Birth of Tragedy* (1872) in which he called for a net distinction between Apollonian art and Dionysian art. Apollonian art is identified with plastic and figurative art whose object is the world of appearance. Dionysian art is identified with music, which is essence, differently from the other arts which change the physiognomy of appearance. Nietzsche understood music as the primordial language which expresses the essential truth of life. Musical language, for this thinker, differently from verbal language, does not have any direct reference to reality because it is the language of emotion, which has a close relationship with the affective life of each individual.



Sigmund Freud (1856-1939) always demonstrated a substantial distance from the therapeutic effects of music in the psychological and psychoanalytical field. Lenin (1870-1924), like Freud, adopted a negative position in relation to music, and to such an extent that the Russian dictator used to declare: 'I cannot listen to music often, it works on my nerves, I feel like saying foolish things and to caress men who, living in a sweaty hell, manage to create so much beauty. But today caresses are not possible. They would tear off your arm. Today you have to hit people on their heads, hit them without pity, even though at the level of ideals we are against every form of violence' (R. Vizioli, *La Musica e il Cervello*, Piccin Editore, Padua, 1987). In the case of Hitler (1889-1945) and of Stalin (1879-1953), the first of whom was affected by a messianic delirium and the second by a persecution delirium, it appears that music managed to make them calmer when they suffered moments of agitation.

During the twentieth century Victor Bott declared that 'anthroposophic medicine draws upon therapeutic painting, modelling, music, the art of speaking and eurytmia' (*Médicine Antroposophique*, Vol II, Paris, 1976, p. 177). At the beginning of the same century, musicians were sent to a number of hospitals in the United States of America, Argentina and Europe (England, Belgium, Italy, Sweden, Denmark and France) to alleviate the physical and moral pain of patients.

Nicola Abbagnano (1901-1990) argued that since the Hegelian interpretation of mu-

sic little has changed in the Romantic definition, which is still strongly present. In his *Dizionario di Filosofia* (U.T.E.T., Turin, 2001), Abbagnano, indeed, states that: 'this definition has found and still finds frequent embodiments in the figure of the musician, priest and prophet, who knows how to listen to the voice of the Absolute and to translate that voice into the sound language of feelings. Even today only with difficulty do people not gaze fondly on this Romantic representation of music: this allows those who cultivate it to be swept up in a mystical horizon within which the musical chords are words of a hidden divinity'.

Don Campbell and Rolando Benenzon (R. Benenzon, *Manuale di Musicoterapica*, Borla Ed., Roma,1998) are some of the most important contemporary experts in the field of the relationship between music and wellbeing. Don Campbell, in particular, has studied the positive effects of music, and especially the music of Mozart, on creativity, learning, health and healing, and has referred to this condition as the 'Mozart effect'. By 'Mozart effect', in fact, he means the positive influence of music on the emotional, physical and mental state of individuals. Don Campbell, in his book *L'effetto Mozart* (Baldini e Castaldi Ed., Milan, 2002), provides numerous examples of the positive effects of classical music:

– In some monasteries in Brittany monks make their animals listen to music because they discovered that cows treated with Mozart produce more milk.

– In the state of Washington the officials of the Department for Immigration play Mozart and Baroque music during English lessons for the people who have just arrived from Cambodia, Laos and other Asian countries because they argue that this accelerates the learning process.

– At the Saint Agnes Hospital in Baltimore patients in the intensive care departments listen to classical music. Dr. Raymond Bahr, head consultant for the heart department, states that half an hour of music produces the same effect as 10 mg of valium.

– In Edmonton in Canada the music of string quartets is played in the streets to calm the frenetic rhythm of the pedestrian traffic.

– In Japan the Ohara distillery states that the density of the fermentation used in the production of sakè (rice wine) increases almost tenfold (thereby improving the quality of the product) if the fermentation is subjected to the influence of music by Mozart.

– In the early 1950s Tomatis and V.E. Negus observed that in many cases chicks that hatched from eggs brooded by parents of a different species did not sing or imitate the sounds of the birds that have brooded them. This led Tomatis to study the role of sound in the womb. In contrast with dominant medical opinion of the time, Tomatis declared that the foetus is able to feel and discovered that the ear begins to develop in the tenth week of pregnancy and is completely functional at the intrauterine age of four months and a half. This can be explained with reference to the fact that low frequency sounds (such as those produced by the human voice) have a deep power of penetration in relation to the biological tissues. Studies by other researcher agreed on the ability to distinguish melodies by a newly born child from the first months of life and that at the age of four months babies are already able to distinguish between consonant and dissonant musical intervals: action potentials induced by sounds in succession and lasting less than a hundred minutes determine the perception of dissonance or consonance (Trainor, 1933; Tramo, 1993; Cariani, 1996).

Studies on the relationship between music and body temperature have brought out that relaxing music tends to lower the heat levels of the organism whereas stimulating music tends to keep the heat levels higher (Mc Farland, 1985). The heart beat and breathing rates, in a way similar to temperature, tend to diminish with listening to relaxing music and to decrease with listening to stimulating music (Iwanaga,1997; Staum, 2000). Iwanaga (1955) also argues that music with tempos between seventy and a hundred and ten beats a minute are preferred compared to swifter or slower rhythms. The preference of each individual is directed towards musical performances of a speed that most conforms to that of his or her heart beat.

Hughes (1998) emphasised that to foster learning in children the 'Mozart effect' had been used in schools by making them listen to a piano sonata (K 448) by Mozart. In the neurological field it has been shown that listening to this sonata by subjects affected by epileptic crises is translated into a reduction in the breadth of the electroencephalographic waves (Hughes, 1998).

Studies carried out on the threshold of pain have shown that this is raised during listening to pleasant music, which is said to stimulate the liberation of endorphins (Hetz,1992; Jones,1992).

In a heart unit it has been demonstrated that music produces the desired effect of relaxation in patients who have had a coronary by-pass. (Barnason,1995).

During the twenty-first century the subject of music as a therapeutic instrument was addressed in very rigorous studies at the International Congress of Venice on 'The Neurosciences and Music' (25-27 October 2002), a congress that had been organised by the Pier Franco and Luisa Mariani Foundation.

In a recent book by Vittorio Volterra (*Melancolia e musica. Creatività e sofferenza mentale*, Ed. Franco Angeli, Milan, 2003), the view of numerous psychiatrists and physiologists that music is a privileged treatment for melancholy and depression was given prominence.

In music therapy one can identify two different currents of thought: the Benenzon-Lecourt approach and the Alvin-Nordoff-Robbins-Cremaschi approach. Rolando Benenzon (Argentina) and Edith Lecourt (France) include music

therapy in psychoanalytical theories. This therapeutic approach is followed above all in the Latin countries. Reference is made to the *administration* of pre-recorded musical pieces, and in the relationship between the medical doctor and the patient there emerges above all else the role of the music therapist.

Juliette Alvin in Great Britain, Paul Nordoff and Clive Robbins in the United States of America, and Giulia Cremaschi Trovasi in Italy use music to stimulate the inner world of the interlocutor who is led to discover its potentialities. The patient is the active part of the process and is at the centre of the therapy. Music therapy is solely a stimulus for the growth process of the patient.

The Neurophysiology of Listening

The part of the nervous system that is specialised in sounds is the auditory system, with the ears which are placed on either side of the head. The auditory system is divided into two parts: the central and the peripheral.

The peripheral auditory system

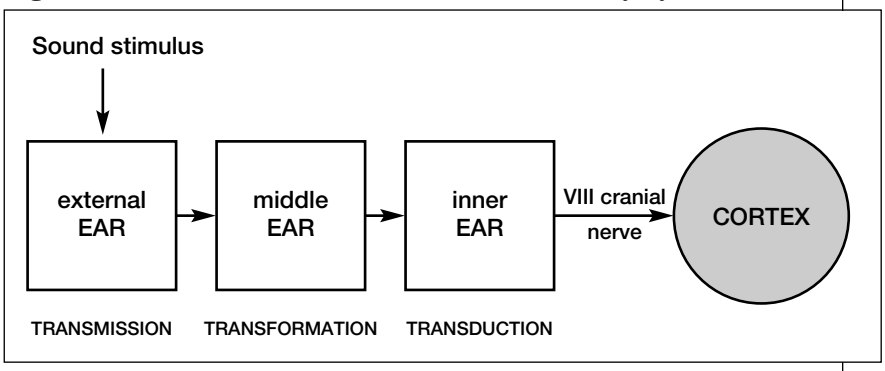
The peripheral auditory system involves the structures that are located outside the encephalon, namely the external ear, the middle ear (*ossicula*), which deals with transformation, and the inner ear (*cochlea*), which deals with the translation of the stimulus of sound.

The central hearing system involves the specific cortical areas, to which the afferent and efferent paths, with their interconnections, refer.

Sound waves are pressure waves which, when received by the ears, are transmitted through the external ear to the middle ear, where they are transformed into mechanical vibrations by a series of ossicula and then sent to the cochlea in the inner ear.

In the cochlea the mechanical vibrations are transformed into fluid vibrations by the liquid that is present to the full inside it. The nerve endings, located in the cochlea, transduct the hydraulic vibrations into electrochemical inputs which are then sent to the encephalon (Fig. 1).

Fig. 1 - Functions of the Outer and Central Auditory System



The central Auditory system

The nerve activity generated in the cochlea is transmitted to the central nervous system through the cochlear bundle of the VIII nerve. From an ontological point of view, the peripheral auditory system is very similar in all animal species, whereas the central auditory system is rather different in species of rodents and cats to its corresponding system in primates.

The central auditory system contains a large number of subcortical centres in which the discrimination can take place. Auditory stimulation reaches the cerebral cortex only after a sequential activation of at least four sub-cortical centres: *the cochlear nucleus*, *the upper olivary complex*, *the nuclei of the lateral lemniscus*, and *the medial geniculate*.

Both hemispheres play a role in listening to sounds through interconnections between the right and left side of the brain, as has been clinically demonstrated in studies carried out on patients with cerebral lesions. The right auditory cortex is fundamental in the perception of tonality, melody, harmony, timbre, and rhythm. This last is identified and processed in the outer zones of the cortical auditory areas (Tramo, 1993; Sidtis, 1988; Liegeois-Chauvel, 1998).

Neurophysiological studies have demonstrated that different areas of the encephalon are affected according to whether the movements have a metric rhythm (tup-tup-tuptup) or do not have a metric rhythm (tup-tutup-tup-tu-tup), as happens, for example, with the tapping of a finger on a table (Sakai, 1998). If this tapping, which has a metric rhythm, is done with the right finger, the left frontal cortex, the right parietal cortex and the right cerebellum are activated. If the beat does not have a metric rhythm there is also the use of the right frontal cortex and the whole cerebellum (Tramo, 1993). The auditory cortex is very differentiated, as is the case with the visual cortex, in which sectorial lesions cause very specific symptoms (Ungerleider, 1982; Kaas, 1999; Calvert, 1977; Romanski, 1999; Mendelson, 1993).

Words and music are identified as being different sides of the same coin. Knoblauch (1888) introduced the term 'amusia' to refer to an alteration in musical perception, and made a distinction between sensitive amusia and motor amusia. 'Sensitive amusia' involves an inability to listen to, read or understand music, whereas 'motor amusia' refers to difficulties in singling or writing music or in playing an instrument. The relationship between aphasia and amusia has been studied by prestigious researchers (Auerbach, 1906; Henschen, 1920; Kleist, 1928, 1962; Head, 1926).

Cerebral lesions have shown that the loss of the verbal function (aphasia) is not necessarily accompanied by the loss of musical faculties (amusia), and indeed cases of amusia without aphasia have been described. This clinical dissociation indicates that there is a functional

autonomy between the two pathologies, even though it is to be observed that verbal and musical capacities usually advance together (Schuppert, 2000).

Observations on Music and Music Therapy

From what has been observed so far in this paper, important reflections can be made on music and music therapy. Music is: 1) a form of intervention that seeks to foster forms of interior expressiveness through a special form of communication; 2) an element of important complementary support in the relationship between the medical doctor and the patient; leads to a decrease in every subject of tensions due to affective-relational impulses; is for the patient an undoubted source of cognitive stimulation; constitutes a cultural occasion of individual and social relevance; makes up a parameter that can be shared and understood by everyone in the medical doctor-patient-environment because it transmits a universal language; and is an important point of union because both when active – in which the subject is the emitter of the sound – or passive or involves listening (where the subject allows himself or herself to be transported by it), it fosters non-verbal communication, the development of creativity and the capacity for socialisation by improving muscle sense, mood tone, the empathetic capacities of the individual and of the individual in his or her relationship to a group.

Special Part

Introduction

No study exists, as Benenzon has observed, that demonstrates in a scientific way (the recruiting of subjects according to the random criterion; the examination of blind subjects; and the assessment of data through statistical calculation) that external stimuli such as music can strengthen pharmacological therapy, improving both its mental and its physical effects. The most plausible reason for this seems to be the difficulties encountered in placing music therapy in medical and physiatric protocols in a way that respects within hospital structures the working system of the paramedical staff and the organisation of the services – these are the limiting factors within a therapeutic protocol for the insertion of the musical aspect as well, which for many people does not even appear to be useful for patients. Studies previously carried out in the theological field by distinguished scholars (Ratzinger, J., Bertone, T., 2000; Saraiva Martins, J., 2004) and by the authors of this paper have demonstrated that prayer can affect the mental component (the VAS) (Zucchi, P.L., Honings, B., 1996; Honings, B., 2004) and the physical component (the diameter of the hyperalgesic area) of pain (Zucchi, P., Honings, B., Voegelin, M.R., 2001; 2003).

In this study the authors wanted to examine not only the beneficial effects of prayer, which, indeed, had already been analysed, but also the possible effect of music on the strengthening of therapeutic effects. The inquiry was carried out by considering the effectiveness of music on the intensity of pain in subjects with cervical myalgic headache both as regards mental improvement (a decrease in the VAS) and physical improvement (a decrease in the diameter of the hyperalgesic area). In this study, in addition, the spiritual position of the subject was also taken into consideration in order to explore the influence of faith on a possible strengthening of pharmacological treatment by music and prayer.

Material and method

A group of sixty patients with cervical myalgic headache were separated into three groups by a randomised procedure. All the patients were subjected for ten consecutive days to treatment with FANS; the subjects of the first group (the TER group) did not receive any treatment. In the subjects of the second group (the MUS group), the pharmacological therapy was accompanied by listening to musical pieces, and in those of the second group (the PRE group) by the thoughtful reading of a passage from the Gospels.

In three sittings, on the first, the fifth and the tenth days, the intensity of perceived pain was measured with the VAS method (Tab. II) and the level of physical suffering was assessed wit reference to the diameter of the hyperalgesic area (ID) (Tab. II), determined by the dermographism method (Zucchi, Honings, Voegelin, 2003).

Tab. I - Average VAS Levels

	Believers			Agnostics		
Days	TER (9)	MUS (8)	PRE (7)	TER (11)	MUS (12)	PRE (13)
0	8.4 ± .5	8.1 ± .8	8.4 ± .5	9.2 ± .6	8.6 ± .9	8.5 ± .6
0+2h	7.3 ± .6	5.9 ± .7	5.3 ± .6	8.9 ± .7	6.3 ± .8	5.8 ± .6
5	6.9 ± .5	5.1 ± .7	5.3 ± .5	7.8 ± .6	5.7 ± .8	5.5 ± .7
5+2h	5.6 ± .5	4.0 ± .8	3.7 ± .5	6.6 ± .6	4.5 ± .7	4.0 ± .6
10	5.4 ± .6	4.2 ± .6	3.3 ± .5	6.5 ± .7	4.2 ± .6	3.9 ± .5
10+2h	4.6 ± .5	3.8 ± .6	1.3 ± .4	5.7 ± .7	3.8 ± .6	2.7 ± .4

TER = only pharmacological treatment
MUS = pharmacological theraphy and music
PRE = pharmacological theraphy and prayer

Tab. II - Average ID Levels

	Believers			Agnostics		
Days	TER (9)	MUS (8)	PRE (7)	TER (11)	MUS (12)	PRE (13)
0	13.4 ± 1.6	12.0± 1.0	13.4 ±1.9	13.0 ± 1.1	12.7± 1.2	13.1± 1.7
0+2h	12.5 ± 1.7	9.9 ± 1.1	9.1 ± 1.8	12.8 ± 1.3	10.1± 1.1	9.4 ± 1.5
5	11.3 ± 1.6	7.8 ± .9	9.5 ± 1.2	11.9 ± 1.2	8.7 ± 1.0	8.4 ±.1.3
5+2h	9.7 ± 1.5	5.5 ± .7	5.4 ± .9	9.5 ± 1.4	6.7 ± 1.0	5.7 ± 1.1
10	8.7 ± 1.6	4.8 ± .6	4.8 ± .7	8.7 ± 1.2	5.3 ± .9	5.2 ± 1.1
10+2h	7.2 ±. 1.7	3.1 ± .3	2.4 ± .7	7.6 ± 1.3	3.9 ± .9	2.8 ± 1.0

TER = only pharmacological treatment
MUS = pharmacological theraphy and music
PRE = pharmacological theraphy and prayer

Fig. 2 - VAS levels on the first, fifth and tenth day of treatment a)FANS; b) FANS+music; c) FANS+prayer

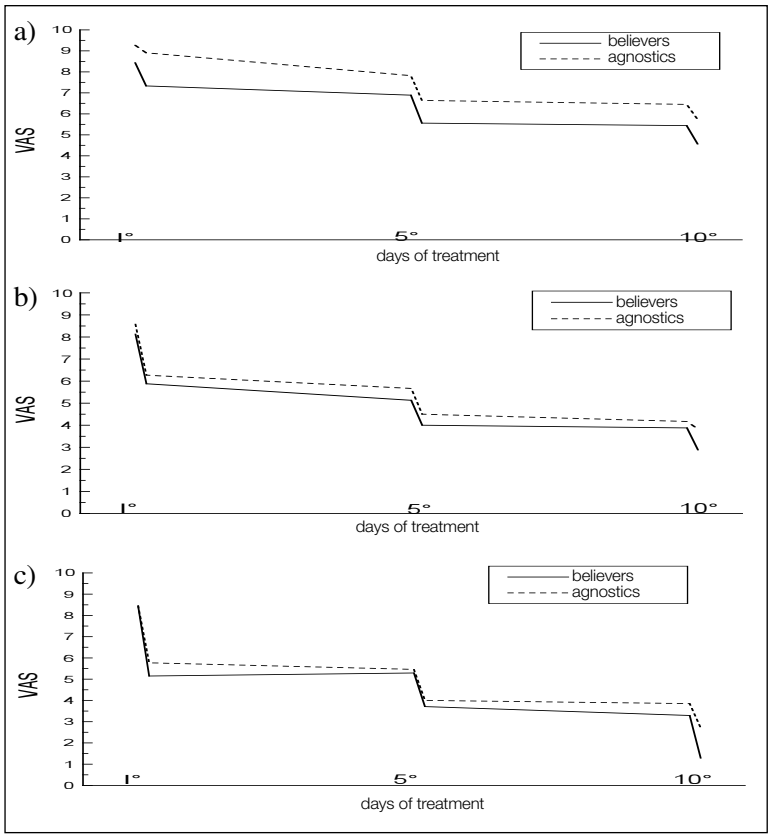
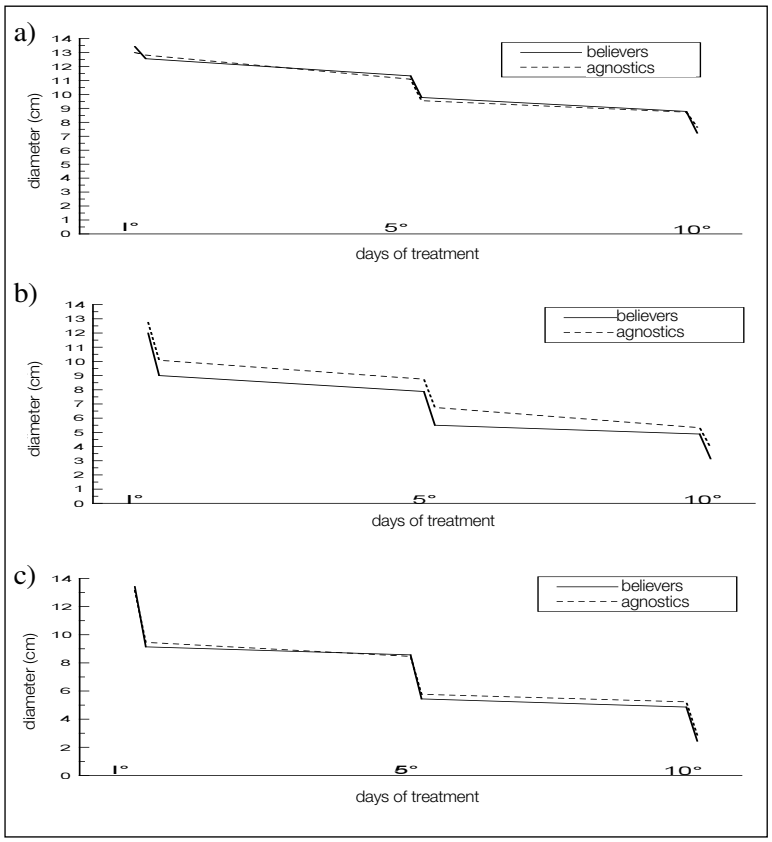


Fig. 3 - Development of the diameter of the hyperalgesic area on the first, fifth and tenth day of a) FANS therapy; b) FANS therapy with music; c) FANS therapy with prayer.



At the first sitting these measurements were carried out before the administration of the therapy and two hours after this administration. At the end of the therapeutic cycle the subjects were asked their spiritual position in relation to religious faith (the blind examination of subjects). Following this inquiry each of the three groups was divided into two subgroups – believers and agnostics. In the TER group there were nine believers and eleven agnostics, in the MUS group there were eight believers an twelve agnostics, and in the PRE group there were seven believers and thirteen agnostics.

One may observe from this table the following facts: a net difference in the result of the therapy in the thee groups between believers and agnostics; a net difference between believers and agnostics in each group; a strong decrease in the parameter in the MUS and PRE groups during the first two hours (the rapidity of the action of the pharmaceutical was greater) for believers and agnostics alike; and a decrease in dispersion in the MUS and PRE groups at the end of the treatment for believers and agnostics (the homogenisation of the group).

The results are represented graphically in Fig. 2.

One may observe from this table, in parallel with the VAS data, the following facts: a net difference in the result of the therapy in the three groups for believers and agnostics; a net difference between believers and agnostics in each group; a strong decrease on the parameter in the MUS and PRE groups during the first two hours (a more rapid action of the pharmaceutical) for believers and agnostics; and a decrease in dispersion in the MUS and PRE groups at the end of the treatment for believers and agnostics (homogenisation of the group)

The results are represented graphically in Fig. 3.

In order to assess the effect of different forms of treatment an average was constructed of the variations in the two parameters between the beginning and the end of therapy (Tab III-Tab IV).

Tab. III - Average levels in the difference in the VAS between the beginning and the end of treatment

	TER	Nt	MUS	Nm	PRE	Np
Believers	3.88±.73	9	5.25±1.20	8	7.14±.64	7
Agnostics	3.54±.78	11	4.75±0.92	12	5.69±.72	13
U	-.858		-1.039		-3.056	
P	NS		NS		<5%	

TER = only pharmacological treatment; Nt = number of subjects
MUS = pharmacological theraphy and music; Nm = number of subjects
PRE = pharmacological theraphy and prayer; Np = number of subjects

Tab. IV - Average levels in the difference of the diameter of the hyperalgesic area

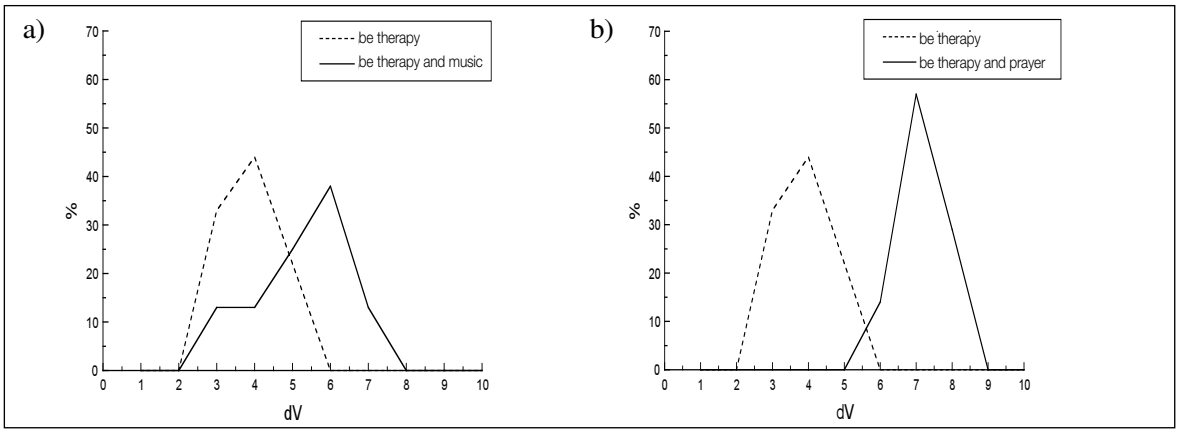
	TER	Nt	MUS	Nm	PRE	Np
Believers	6.22±.1.31	9	8.87±1.05	8	11.00±0.76	7
Agnostics	5.36±1.06	11	8.83±0.89	12	10.30±0.72	13
U	-1.41		-.16		-1.66	
P	<10%		NS		<5%	

TER = only pharmacological treatment; Nt = number of subjects
MUS = pharmacological theraphy and music; Nm = number of subjects
PRE = pharmacological theraphy and prayer; Np = number of subjects

It should be observed that the average decrease in the diameter of the hyperalgesic area is higher than the decrease of the VAS, even in the case of FANS therapy alone.

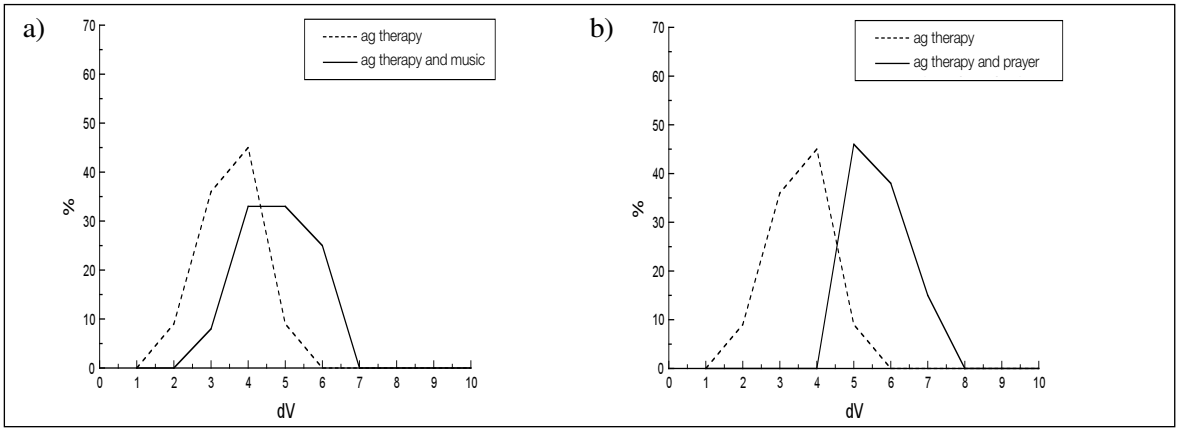
Figs. 4 and 5 present the distributions of the variation of the two parameters in the group of believers and the group of agnostics.

Fig. 4 - Believers. Impact of music and prayer on the decrease in the VAS



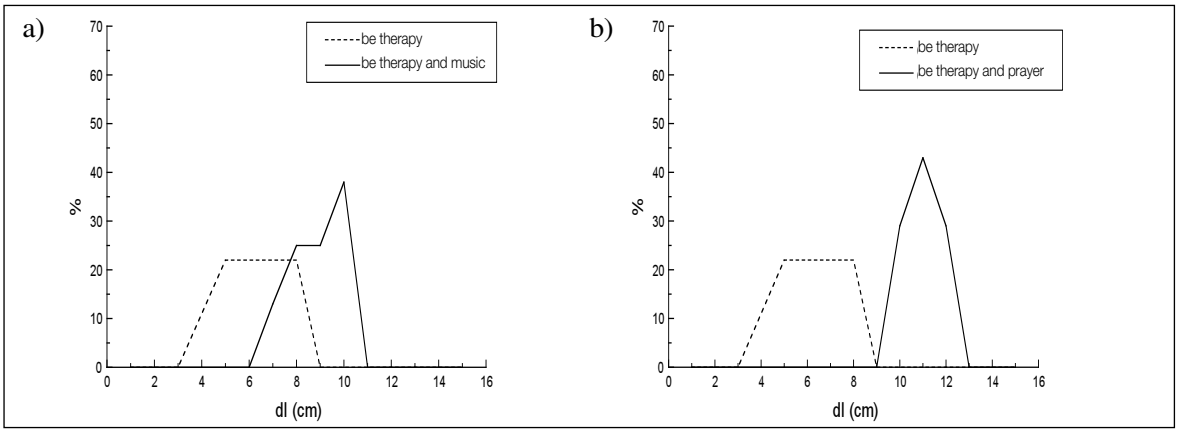
% = percentage of subjects
dV = decrease in the VAS
a) comparison between therapy alone and therapy with music
b) comparison between therapy alone and therapy with prayer

Fig. 5 - Agnostics. Impact of music and prayer on the decrease in the VAS



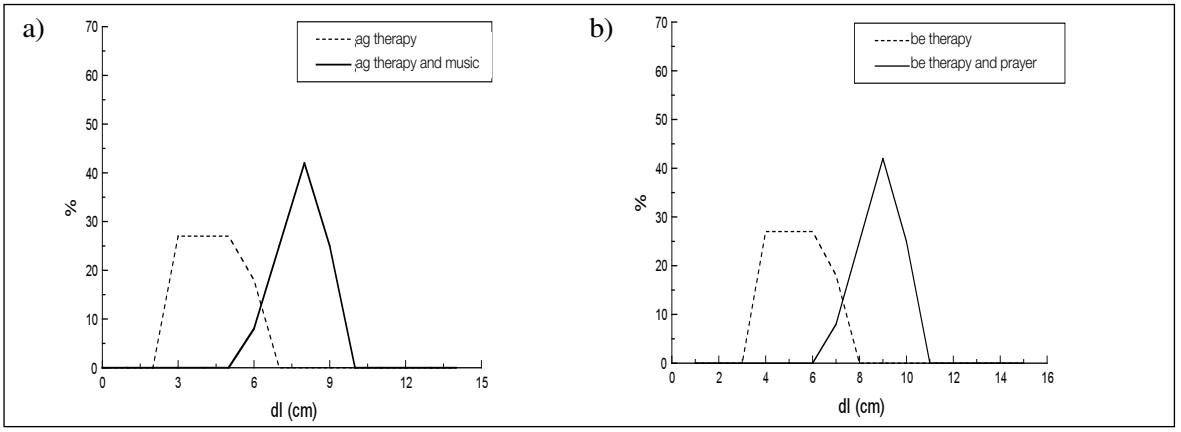
% = percentage of subjects
dV = decrease in the VAS
a) comparison between therapy alone and therapy with music
b) comparison between therapy alone and therapy with prayer

Fig. 6 - Believers. Impact of music and prayer on the decrease in the diameter of the hyperalgesic area



% = percentage of subjects dl = decrease in the diameter (cm)

Fig. 7 - Agnostics. Impact of music and prayer on the decrease in the diameter of the hyperalgesic area



% = percentage of subjects
dl = decrease in the diameter (cm)
a) comparison between therapy alone and therapy with music
b) comparison between therapy alone and therapy with prayer

In tables V and VI the significance of the difference between the different treatments is presented in relation to believers and agnostics, with reference to the VAS and the diameter of the hyperalgesic area.

Tab. V - Significance of the difference in the decrease in the VAS in different pairs of treatment in subjects who are believers and subjects who are agnostics.

	Believers			Agnostics		
	U	N1-N2	P	U	N1-N2	p
TER-MUS	2.226	9-8	<1.‰	2.696	11-12	<1‰
TER-PRE	3.4	9-7	<1‰	4.06	11-13	<1‰
MUS-PRE	2.8	8-7	<5‰	2.32	12-13	<5‰

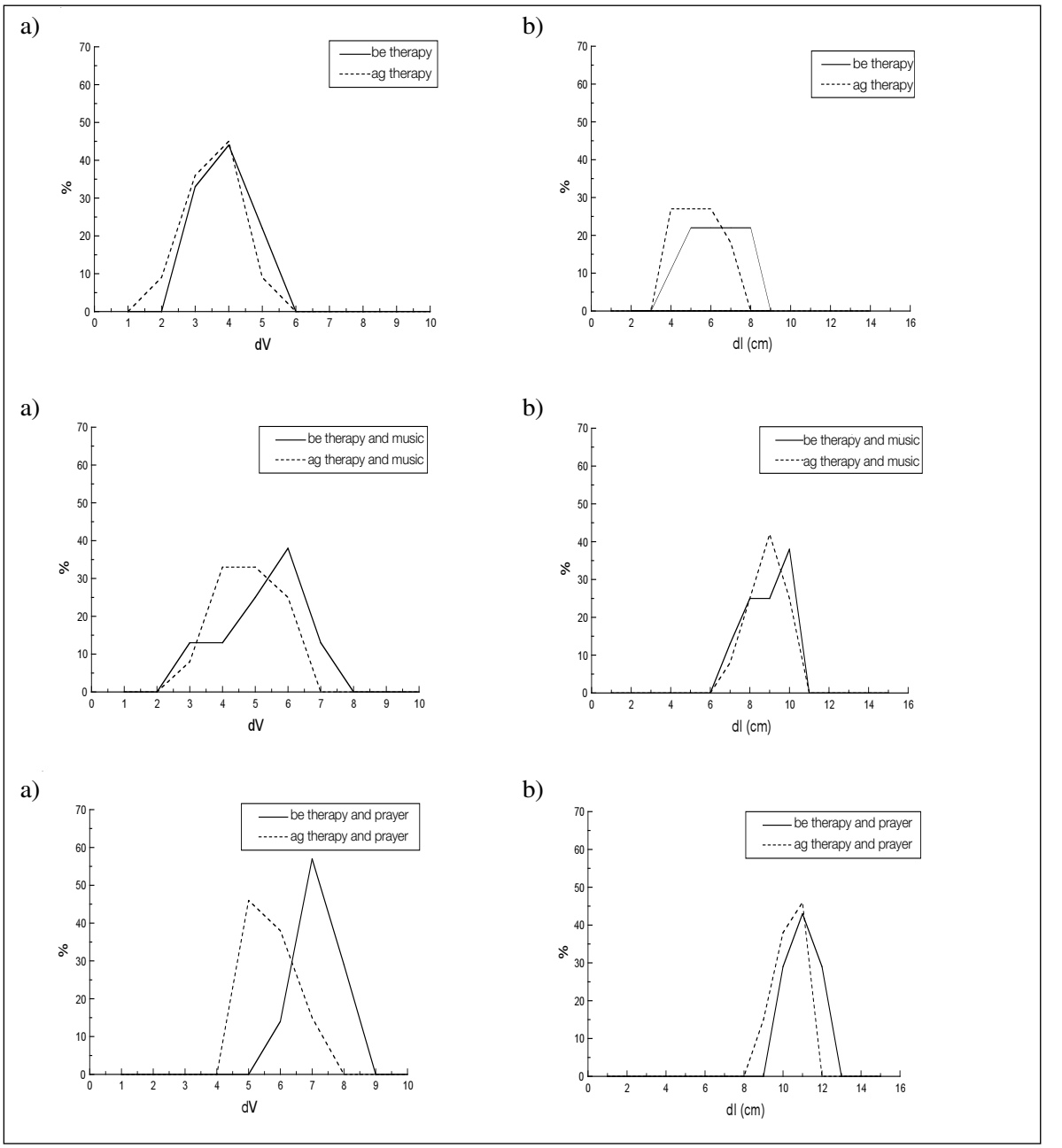
N1, N2: membership groups; TER: only pharmacological treatment;
MUS: pharmacological treatment and music; PRE: pharmacological treatment and prayer;
U: Mann-Withney U level; p: significance

Tab. VI - Significance of the difference in the decrease in the VAS in different pairs of treatment in subjects who are believers and subjects who are agnostics.

	Believers			Agnostics		
	U	N1-N2	P	U	N1-N2	p
TER-MUS	3.02	9-8	<5.‰	4.05	11-12	<1‰
TER-PRE	3.36	9-7	<1‰	4.21	11-13	<1‰
MUS-PRE	3.28	8-7	<5‰	3.35	12-13	<5‰

N1, N2: membership groups; TER: only pharmacological treatment;
MUS: pharmacological treatment and music; PRE: pharmacological treatment and prayer;
U: Mann-Withney U level; p: significance

Fig. 8 - Distributions of the dV variations of the VAS (left) and the dI hyperalgesic area (right) for believers (___) and agnostics (…..) in the three treatments: a) pharmacological therapy; b) pharmacological therapy and music; c) pharmacological therapy and prayer



To bring out the difference between believers and agnostics both as regards the variation in VAS and in the variation of the hyperalegesic area, Fig. 8 presents the distributions of such variations in the two categories for the different treatments.

Tables VII and VIII present the significance of the differences between believers and agnostics as regards variation in the VAS and the hyperalgesic area in the three treatments.

Tab. VII - The significance of the differences between believers and agnostics as regards variation in the VAS in pharmacological therapy alone (TER), in pharmacological therapy with music (MUS) and in pharmacological therapy with prayer.

	N1-N2	U	P
TER	9 – 11	.858	NS
MUS	8- 12	1.039	NS
PRE	7- 13	3.06	<5‰

N1-N2 group membership;
U Mann-Withney U level;
P = significance

Tab. VIII - The significance of the differences between believers and agnostics as regards variation in the VAS in pharmacological therapy alone (TER), in pharmacological therapy with music (MUS) and in pharmacological therapy with prayer.

	N1-N2	U	P
TER	9 – 11	1.48	<10%
MUS	8- 12	.161	NS
PRE	7- 13	1.66	<5%

N1-N2 group membership;
U Mann-Withney U level;
P = significance

Conclusions and Discussion

In the study that was carried out, the strengthening of the therapeutic effect induced by external stimuli such as classical music and the thoughtful reading of a passage from the Gospel was statistically significant. The strengthening effect of the musical stimulus on pharmacological therapy can be connected with the way in which such a stimulus is received on the part of the central nervous system.

We know, in fact, that the brain is divided into two hemispheres and that each hemisphere receives the information coming from the counter-lateral half of the body in priority fashion. The notion that each hemisphere has a specialisation is more recent: the left hemisphere controls logic, the rational, and symbols; the right hemisphere exams the intuitive, emotional and artistic aspects, the recognition of forms and music. Learning, and especially Western learning, sees the left brain as the dominant hemisphere because it is the hemisphere of speech and intellectualisation. However, the right hemisphere must also be held to have the same value because it deals with forms, sounds and emotions. And it is in this hemisphere that artistic and musical perception takes place and thus the consequent activation of the emotional processes. It may thus be advanced that a gratifying emotional stimulus can activate the process of reaction and repair in relation to suffering and even in relation to the physical damage caused by a pathology.

If we compare the scale of the strengthening induced by music with that induced by prayer in both groups of subjects (Figs. 9-10), we can observe a greater effect produced in the case of thoughtful reading than in that of music.

We can observe that the process by which the two different stimulations interfere positively with the action of the pharmaceutical cannot be considered to be the same. Whereas the perception of music and the consequent emotional activation takes place in the right hemisphere, reading involves the left hemisphere and produces an amplified emotional activation in the right hemisphere through a process involving the integration of the two hemispheres (Fig. 11). As a result of a gratifying stimulation there is an activation of the peripheral nervous system and of the circuit with relative consequences for the diameter of the hyperalgesic area (a decrease). In Italy the proverb 'rice produces good blood' is well known. Unfortunately, whereas there are many studies that have examined the freeing of chemical substances such as the endorphins following painful stimuli, there is little

Fig. 9 - The different effect of music and prayer on the variation in the VAS in believers and agnostics

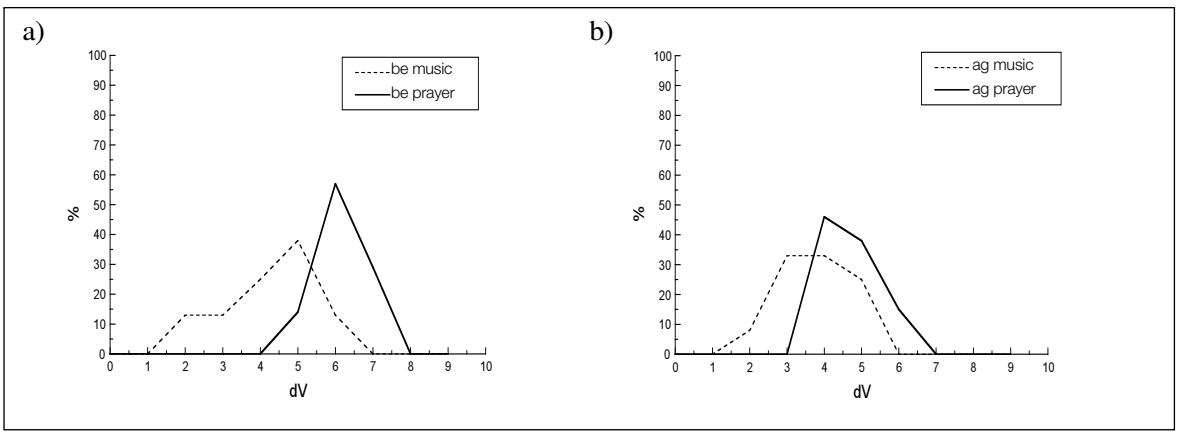
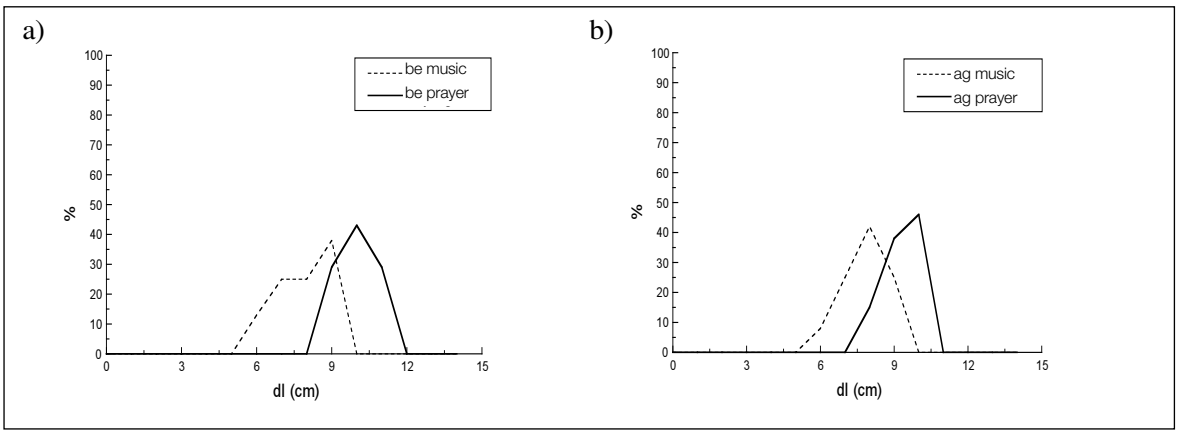


Fig. 10 - The different effect of music and prayer on the diameter of the hyperaglesic area in believers and agnostics



and imprecise information on the nature of the substances that are activated by pleasant stimuli, even though it is reasonable to suggest that in such circumstances there is an activation of the anti-pain pathways.

A further observation concerns the level of the improvement in pain induced by the two kinds of stimulus in believers as compared to agnostics. Indeed, from the data presented in Figs. 9 and 10 one can see that the difference between music and prayer is greater in believers than in agnostics. From this result one may advance the idea that there is an effect involving the raising of the pain-receiving threshold (a decrease in pain) induced by faith at a mental level (a diminution of the VAS) and at a physical level (a decrease in the hyperalegesic area), with a relative strengthening of the pharmacological treatment (a decrease in the taking of pharmaceuticals).

PART TWO

Theological Interpretation

According to the two definitions, pain denotes a psychophysical or unpleasant sensorial and emotional experience associated with a real or potential damage to the tissue. The Florentine school perceives, in addition, certain very important specifying factors. In the perception of pain different individual, cultural and religious factors are at work whose understanding requires not only the participation of the branches of medicine and biology but also those of the human sciences.

Within the context of this variety of factors and elements, the therapeutic influence of medicine and thoughtful prayer with a careful reading of a passage from the Gospel have been studied, together with the administration of non-steroid anti-inflammatory pharmacies (FANS), with special attention being paid to the level of the spirituality of the subject.

The various tables bring out a notable strengthening of the therapeutic effects as regards the intensity of pain experienced in subjects affected by muscular headache both at the level of mental improvement (a decrease in the VAS) and at that of physical improvement (a decrease in the diameter of the hyperalgesic area).

With respect to music therapy, it should be stated that this is a technique that uses sound alone, that is to say music, movement and corporeal, sound and musical instruments, to bring about a historical process of bonding between the therapist and his or her patient or groups of patients. The aim of all of this therapeutic process between the therapist and his or her patient is to improve quality of life and to rehabilitate and to retrieve patients for society.

With respect to prayer, this is a dialogic relationship between God and a human person who meditates on a text from the Gospel and in which God and man speak to each other and listen to each other. Prayer, because it is primarily a religious phenomenon, thus marks out the man who is a believer from the man who is an agnostic. Prayer, like religion, is a factor that is universally present in all forms of popular piety and in the most varied of cultures. As religious dialogue, prayer presupposes belief in a personal God who is present to speak, to listen, to communicate, and to be communicated with.

After offering these clarifications as a premise, one comes to the philosophical-theological explanation of the therapeutic effects of pharmaceuticals, music and prayer, beginning with the concept of pain as passion[1] to actuate the reparation (therapy) of the disorder caused by original sin (Fig.12).

Fig. 11 - Model representing the effect of the auditory input (music) and the visual input (thoughtful religious reading) on the central and peripheral function

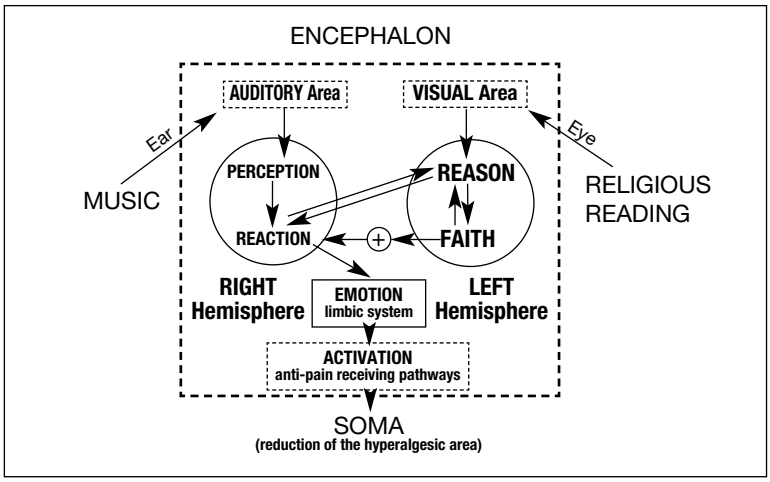
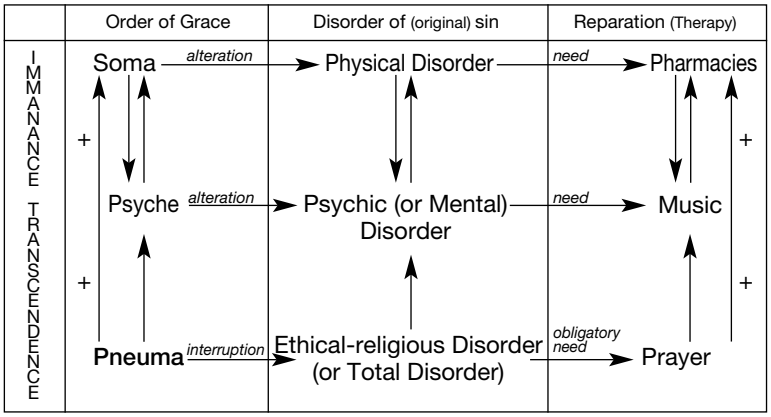


Fig. 12 - Reparation (therapy) of disorder. Reparation of physical disorder (pharmaceuticals), of psychic disorder (music), and of ethical-religious disorder (prayer)



Pain as Passion

The term 'passions' belongs to the Christian inheritance and

means emotions or movements in sensitivity that lead a person to act or not act in view of what is felt or imagined to be good or bad. These emotions are natural components of the human psyche and act as a conduit and ensure the connection between the life of the senses and the life of the spirit.[2] The principal passions are love and hate, desire and fear, joy, sadness and anger.[3] St. John of the Cross knew four natural passions, namely joy, hope, fear and pain.[4] Those movements in which the will does not take part either beforehand or afterwards he termed natural and involuntary. This is because in this life it is impossible to eliminate them.[5] Indeed, in themselves the passions are neither good nor bad – they are neutral. However, to the extent to which they depend or otherwise on reason and will there is in them moral good or moral bad. Thus the emotions and the sentiments can taken be on in the virtues or perverted in vices. This humanising capacity and thus the morality of pain as passion or sensorial and emotional movement acts as an interpretative principle. There is confirmation of this in the case of Saul that is related in the first book of Samuel: 'Let our Lord now command your servants, who are before you, to seek out a man who is skilful in playing the lyre; and when the evil spirit from God is upon you, he will play it, and you will be well'. Saul said to his servants: 'Provide for me a man who can play well, and bring him to me'. One of his courtiers answered: 'Behold, I have seen a son of Jesse, the Bethlehemite, who is skilful in playing'. Thus Saul sent messengers to Jesse to say: 'Let David remain in my service for he has found favour in my sight. And whenever the evil spirit from God was upon Saul, David took the lyre and played it with his hand; so Saul was refreshed, and was well, and the evil spirit departed from him' (1 Samuel, 16:16-23). The *Catechism of the Catholic Church* makes clear on this point that in the Christian life the Holy Spirit carries out his work by mobilising all of the being, including that being's pains, fears and sadness, as is evident in the agony and the passion of the Lord. In Christ, human feelings, and thus pain as well, can receive their perfection in charity and blessedness. This is why this Catholic doctrine on morality acts for me as a source by which to explain the therapeutic effects in question. Pain as an unpleasant psychophysical experience, perceived at a sensorial and emotional level, and associated with a real and potential damage to the tissue, is an organic reaction of a spontaneous or natural character. As regards the theological explanation, it is of the utmost importance that the emotion of pain as passion is a natural component of the human psyche, that it acts as a conduit and assures the connection between the life of the senses and life of the emotions of the body on the one hand, and the intellective and affective life of the soul, on the other.

The Data of Science

The effect of the strengthening of the musical stimulus of pharmacological therapy induced by an external stimulus involving the hearing of music and/or an internal stimulus of the religious dialogue of prayer connects us from a scientific point of view with the central nervous system. The brain, in fact is divided into two hemispheres: a left hemisphere and a right hemisphere. The left hemisphere controls logic, the rational and symbols, and the right hemisphere examines the intuitive, emotional and artistic aspects. It is interesting to observe that the left hemisphere is dominant because it is the hemisphere of speech and intellectualisation. I would also to point out, as an important fact, that the right brain is able to process forms, sounds and emotions. On the basis of these data of science, musical perception can activate the emotional process of pain and induce the right hemisphere of the brain to have a gratifying reaction to suffering and to the physical damage caused by a pathology.

The philosophical-theological explanation

The scientific description of the brain, with its two hemispheres, leads the theologian to dwell, first, on the constituent features of man, that is to say his unity of soul and body. In recognising that he has a spiritual and immortal soul, man is not in error when he sees himself as being superior to corporeal things and considers himself as being more that a particle of nature belonging to an anonymous moment in the human city.[6] Hence the importance of a philosophical analysis of the intellect and the will, that is to say the spiritual powers of the soul…

The unity of the soul and body

The importance of the spiritual faculties derive from the fact that every man is a unity of soul and body in which the body is human specifically because it is animated by a spiritual soul.[7] Because of the fact that the soul is the form of the body, the intellect and the will, precisely because they are faculties of the spiritual soul, can exercise a determining influence on the body and its passions or sensorial emotions. An attempt is made to explain this when considering the efficacy of music on the intensity of pain in subjects afflicted by cervical myalgic headache both as regards mental improvement (decrease in the VAS) and with respect to physical improvement (decrease in the hyperalgesic area). One begins here with the observation that pain as such is not a specific object of the intellect and as a consequence it is not a specific object of the will either. However, the ontological unity between soma, psyche and pneuma, as constituent elements of each person, implies not only the possibility but also the real effectiveness of a connection between the sensations and emotions of the body and the specifically spiritual operations of the soul. One should specify with St. Thomas Aquinas that this does not compromise the

specific spirituality of the soul because a possible and effective dependency on the body by the soul is not 'subjective' but 'objective'. Indeed, when the spiritual operations require the body this is not requested as an efficient causal instrument but only as a means of a formal causal order. This explains why *intelligere* (*intus-legere* = reading within by the intellect) is not actuated through a corporeal organ but only needs a corporeal object. St. Thomas Aquinas explains this point in the following way: 'One must say that understanding (intellective knowledge) is an operation specific to the soul when

one considers the principle from which the operation is born. Indeed, it is not born from the soul through a corporeal organ like sight is through the eye. Its tie with the body concerns the object: indeed ghosts, which are the objects of the intellect, cannot exist without the reality of corporeal organs'.[8] In man there is only one soul, the rational soul, which also carries out the operations of the lower souls, the vegetative and sensitive souls. Indeed, 'although simple as to essence, the soul is potentially many in number because it is the principle of various operations, and given that the form perfects matter in order not only as to being but also as to acting, it is necessary for the soul, although it is a unique form, perfect the parts of the body in various ways, as is useful to every individual operation'.[9] This is why the external stimulus of music, the specific object of the ear, a corporeal organ, to be gratifying and to strengthen pharmacological therapy must be the object of the spiritual faculty of the intellect. To interfere in a positive way with the action of the pharmaceutical, the sound stimulus must still become an object of intelligence or a formal cause. Indeed, the ontological uniqueness of the person of the patient does not allow a dualistic division between the emotional sensations of the body and the spiritual operations of the soul. Not only the soul but also the body belong to the essence, the substance of man. Man is a person, that is to say, a subsistent in the order of the spirit thanks to the act of the unique and unrepeatable being of the soul. His act of being is primarily a act of the being of the soul and through the soul he becomes an act of the being of the soul.[10] For this reason, the effect of gratifying and the strengthening of the pharmaceutical's effect of the musical stimulus at a corporeal or somatic level is caused by its reception by the soul or by the influence of the spiritual faculties of the organism. From this explanation of a more philosophical character I will now move on to a more specifically theological explanation.

Music and the reparation of intra-personal harmony

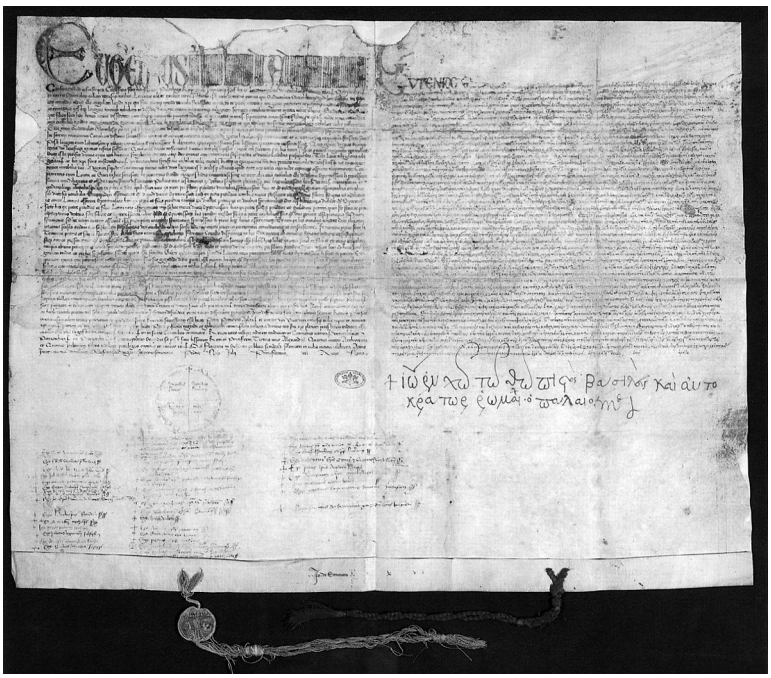
Interpreting in an authentic way, that is say with the authority conceded to her by God, the Church teaches that the first man was not only created good but was also created in a state of friendship with his Creator and in harmony with himself, with his neighbour, and with the Creation. Our progenitors Adam and Eve were created in a state of 'original holiness and justice', that is to say in a state of 'participation in the life of God', and as result in a state of the *strengthening* of all the dimensions of life. The whole of man was strengthened by the irradiation of his friendship with God, that is to say intimacy with God, so that he would neither have to die nor to suffer. In other words man was created in a state of inner harmony, of harmony between man and woman, and lastly of harmony between the first couple and the whole of the Creation. Man was integral and ordered in all his being because he was free from the triple concupiscence that made him a slave of the pleasures of the senses, of greed for earthly goods, and of self-affirmation that was in contrast with the imperatives of reason.[11] St Thomas Aquinas rightly observes on this point: 'passions, such as fear and pain, whose object is the evil of the same subject in which they are present, are incompatible with the perfection of the primitive state'.[12] I would like to make clear, because this is a very important point, that this harmony of original justice that God in his design had previously envisaged for man was lost because of the sin of our progenitors. The harmony in which Adam and Eve were placed thanks to original justice was destroyed; command of the spiritual faculties of the soul was broken; the union of a man and a woman was subjected to tensions; and their relationships would be marked by concupiscence and by the tendency to servitude. Harmony with the Creation was fractured: the visible Creation became alien and hostile to man. Because of man, the Creation was subjected to the reality of being perishable; man would return to dust, that dust from whence he had come.[13] All of this demonstrates that the subordination of the body to the soul and of the inferior faculties to reason was not due to nature; otherwise it would also have remained after sin because the natural endowments also remained in devils after sin. It is clear, therefore that also the first subordination, that

is to say the subordination of reason to God, does not depend exclusively on nature but on the supernatural gift of grace'.[14]

From what has been argued hitherto, the theological explanation of the strengthening of the stimulus of music on pharmacological action could be the following. Pain as passion, that is to say as an emotional sensation of the body, in no longer being subordinated to reason produces a state of disharmony between the soul and body. The use of music therapy denotes, according to the various tables, that the musical stimulus strengthens the pharmacological treatment at both a mental and a physical level. Music thus engages in, carries out, a greater reparation of harmony in the person suffering pain. Between his or her soul and his body, between the soma and the psyche, less disharmony takes place. Why does this take place? Perceived as an object of the spiritual faculties, of the intellect and of the will, classical music acts in a gratifying and strengthening way on pharmacological therapy in relation to pain. This rationalisation of the stimulus of music makes pain not only more bearable but also reduces its threshold. The nature of man and the grace of God use classical music to re-establish in a greater way the lost harmony between the body and the soul. Music therapy thus enters the creative design of God with the man of science and technology, who is called to 'dominate' the earth as a 'steward'. In the image of the Creator, 'who loves all things that exist' (Wis 11:24), man participates in divine Providence through the other creatures. Hence his responsibility towards the world that God has entrusted to him.[15] This explanation seems to find a plausible explanation in the strengthening part of prayer.

Prayer and inter-religious reparation

Man, who was created in a state of holiness, that is to say of friendship with God, was destined to be fully 'divinised' by God in glory. Seduced by Satan, man wanted to become 'like God' but 'without God and opposing himself to God and not according to God'.[16] Holy Scripture shows the dramatic consequences of this first disobedience. Adam and Eve immediately lose the grace of original holiness. They are afraid of that God of whom they have created a false image, that image, that is to say, of a God jealous of His own prerogatives.[17] In the following theological explanation what is determinant is the break between man and God, that is to say religious disharmony, on the one hand, and the reparation of the harmony produced by prayer, on the other. Indeed, in comparing the size of the strengthening induced by music with that induced by prayer in both groups of subjects, believers and agnostics, one can observe a greater effect produced by thoughtful reading than is the case with music. From the data that has been presented, it is clear that the difference between music and prayer is greater in believers than in agnostics. From this result, one can advance the idea that there is an amplifying effect that faith induces at a cognitive level on the emotional reaction and thus on the strengthening of the effects of the pharmacological therapy.[18]



One has to explain why we denote a greater therapeutic result because of thoughtful prayer, that is to say of the dialogical relationship of man with God. The explanation it seems to me is relatively simple. Given that the *radical cause* of the loss of original justice, that is to say of the intra-personal harmony, inter-personal harmony, that is to say social harmony, and cosmic harmony, was sin, that is to say distancing from God, the absolute Highest Good, and turning towards changing and relative goods, then radical reparation is necessarily produced by a drawing close to God, the Highest and Absolute Good. In other words, if the disharmonies of God were caused by his act of religious disorder, it is obvious that the reparation of harmonies require, *at root*, an act of a *religious order*. Now it cannot be doubted that the use of prayer is this act of order, precisely because it implies a theological approach of faith, hope and above all charity. 'The revelation of prayer comes between the fall and the restoration of man, that is, between God's sorrowful call to his first children: 'Where are you?...What is this that you have done? (Gen 3:9-13) and the response of God's only Son on coming into the world: 'Lo, I have come to do your will, O God,' (Heb 10:5-7). Prayer is bound up with human history, for it is the relationship with God in histor-

ical events'.[19] In this sense, prayer is not so much an act of the spiritual faculty of the intellect as an act of the spiritual faculty of the will. The youngest doctor of the Church declares on this point: 'For me, prayer is an impetus of the heart, a simple look thrown towards heaven, a cry of gratitude and love in trial as in joy'.[20] Whatever the case, from a theological point of view it is more than evident that radical reparation is first of all and above all else an act of the will. For an authoritative confirmation of this statement let us pass to the words of St. Thomas Aquinas: 'the whole of the order of original justice was due to the fact that the human will was subjected to God. This was a submission that principally lie in the will that has the task of moving all the other faculties towards their end. Thus the will, with its distancing from God (*ex aversione a Deo)* led to disorder in all the other faculties of the soul. This is why the privation of original justice, which ensured submission of the will to God, is the formal element of original sin: whereas all the disorder of the other faculties is its material element… and this disorder can be given the general name of concupiscence'.[21] Thus does one explain in theological terms the greater strengthening of thoughtful prayer on pharmaceuticals than is the case with music therapy at a causal level. With prayer, man repairs *at a root level* the cause of the disharmony between the body and the soul. Indeed, in reconnecting a dialogical relationship with God, a living and personal relation with the living and true God, God creates man anew in a state of friendship, of intimacy with Him. The theological explanation for the greater efficiency of prayer as regards pharmacological therapy with music lies in the fact that prayer repairs the state of holiness in which the state of original justice had its origins, that is to say the subordination of the body to the soul and of the soul to God. From pneumatic subordination, or transcendent subordination, of the soul to God is irradiated the subordination of the body to the soul, that is to say to its spiritual faculties of the intellect and of the will. Our study wants to be a demonstration that salvation, already carried out by Christ and in Christ, is also manifested in the overall care and treatment of sick people.

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Bibliography

ABBAGNANO, N., *Dizionario di Filosofia* (U.T.E.T., Turin, 2001).

Agrippa, H. C., *De occulta philosophia, sive de magia libri tres* (Cologne, 1533).

ALDRIDGE, D., 'Creativity and consciousness: Music therapy in intensive care', *Arts in Psychotherapy* 18 (1991) 359-362.

AUERBACH, S., 'Beitrag zur lokalisation des musikalischen Talentes im Gehirn und am Schadel', *Arch. Anat. Physiol.*, (1906) 197-230.

AURELIANUS, *Tardarum passionum libri V* (Basle, 1529).

BARNASON, S., 'The effect of music interventions on anxiety in the patient after coronary artery bypass grafting', *Heart Lung* 24 (1995) 124-132.

BENENZON, R., *La nuova musicoterapia* (Phoenix Editrice, Rome, 1997).

BYERS, J.F. and SMYTH K.A., 'Effect on a music intervention on noise annoyance, heart rate, and blood pressure in cardiac surgery patients', *Am. J. Crit. Care*, 6 (1997) 183-191.

BRUGGE, J.F. and MERZENICH, M.M., 'Responses of neurons in auditory cortex of the macaque monkey to monaural and binaural stimulation', *J. Neurophysiol.* 36 (1973) 1138-1149.

BURTON, R., *The Anatomy of Melancholy* (Oxford, 1632)

CALVERT, G., BULLMORE, E.T., BRAMMER, M.J., CAMPBELL, R., WILLIAMS, S., MCGUIRE, P.K., WOODRUFF, P.W., IVERSEN, S.D., and DAVID, A.S., 'Activation of auditory cortex during silent lipreading, *Science*, 276 (1997) 593-596.

CARIANI, P.A. and DELGUTTE, B., 'Neural correlates of the pitch of complex tones I, Pitch and pitch salience', *J. Neurophysiol.* 76 (1996) 1698.

CARTESIO (DESCARTES, R.), 'Meditationes de Prima Philosophia' (1637), in Abbagnano, N., *Storia della Filosofia* (UTET, Turin, 1982).

Catechismo della Chiesa Cattolica (*CCC*, nn. 2752-2758) (Libreria Editrice Vaticana, Vatican City,1992).

COLUZZI, R., *Musicoterapica e Gravidanza* (Il Minotauro Editore, Rome, 2004).

I Congresso Internazionale di Venezia 'Le Neuroscienze e la Musica', organised by *zzato dalla* Fondazione Pier Franco and Luisa Mariani, Venice, 25-27 October, 2002.

DON CAMPBELL., *L'Effetto Mozart. Curarsi con la musica* (Ed. Baldini-Castoldi, Milan, 1997-1999-2002).

FREUD, S. *Die Traumdeutung* (1900), Italian edition: *L'interpretazione dei sogni* (Avanzini e Torraca, Rome, 1968).

GRIMSLEY, D. L. and KARRIKER, M. W., 'Bilateral skin temperature, handedness and the biofeedback control of skin temperature', *J. Behav. Med.*, 19 (1996) 87-94.

HEAD, H., 'Studies in Neurology', *Oxford Med. Publ.*, 2 (1920) 560-593.

HEITZ, L., SYMRENG T., and SCAMMAN, F.L., 'Effect of music therapy in the postanesthesia care unit: a nursing intervention', *J. Post.Anesth. Nurs*., 7 (1992) 22-31.

HENSCHEN, S. E., 'Aphasia, Amusia und Akalkulie' in *Klinische und anatomische Beitrage zur Pathologie des Gehirns* (Nordiska Bokhandeln, Stockholm, vol. 5, 1920).

HONINGS, B., 'Iter Fidei et Rationis. Theologica, Moralia, Iura', in *I Theologica* (L.U.P., Rome, 2004).

HUGHES, J.R., 'The Mozart Effect on epileptiform activity', *Clin. Electroencephalog*., 29 (1998) 109-119.

IWANAGA, M., 'Relationship between heart rate and preference for tempo of music', *Percapt. Mot. Skills*, 81(1995) 435-440.

IWANAGA, M. and TSUKAMOTO, M., 'Effects of excitative and sedative music on subjective and physiological relaxation', *Percapt. Mot. Skills* 85 (1997) 287-296.

JONES, J.G., 'Historical overview of pain management undermedication to state of the art', in

SINATRA, R. S., HORD, A.H., GINSBERG, B., and PREBLE, L.M., (eds.), *Acute Pain: Mechanism and Management* (Mosby Yearbook, St. Louis, MO, 1992).

JONES, R., HUX, K., MORTON-ANDERSON, K.A., and KNEPPER, L., 'Auditory stimulation effect on a comatose survivor of traumatic brain injury, *Arch. Phys.Med. Rehabil*., 75 (1994) 164-171.

KANT, E., *Kritik der Reinen Vernunft*, (1781) (Laterza, Bari ,1958).

KAAS, J.H. and HACKETT, T.A., 'What and where processing in auditory cortex', *Nat. Neurosciences* 2 (1999) 12-25.

KIRCHER, A., *Magnes sive de arte magnetica opus tripartitum* (Ed. 3, Rome, 1654)

KLEIST, K., 'Gehirnpathologishe und lokalisatorische Ergebnisse uber Horstorungen, Gerauschtaubheiten und Amusien', *Mschr. Psychiat. Neurol.* 68 (1928) 853-871.

KLEIST, K., *Sensory Aphasia and Amusia. The Myeloarchitectonic Basis* (trans. By F. J. Fish and J.B. Stanton, Pergamon Press, Oxford, 1962).

KNOBLAUCH, A., 'Uber Storungen der musikalischen Leistungsfahigkeit infolge von Geirnlasionen, Dt', *Arch. Klein. Med.*, 43 (1888) 331-352.

LEW, H.L., SLIMP, J., PRICE, R., MASSAGLI, T.L., and ROBINSON, L.R., 'Comparison of speck-evoked v tone-evoked P300 response: implications for predicting outcomes in patients with traumatic brain injury', *Am. J. Phys. Med. Rehabil*., 4 (1999) 367-371.

LIEGEOIS-CHAUVEL, C., 'Contribution of different cortical areas in the temporal lobes to music processing', *Brain* 121 (1998) 1853-1861.

MACDONALD CRITCHLEY, and HENSON, R.A., *La musica e il cervello* (Ed. Piccin, Padua, 1987).

MANAROLO. G., *L'angelo della musica* (Edizione Omega, Turin, 1996).

MCFARLAND, R.A., 'Relationship of skin temperature changes to the emotions accompanying music', *Biofeedback Self Regul.* 10 (1985) 255-267.

MENDELSON, J. R., SCHREINER C.E., SUTTER, M.L., and GRASSE, K.L., 'Functional topography of cat primary auditory cortex: responses to frequency modulated sweeps', *Exp. Brain Res.* 94 (1993) 65-74.

MOREL, J. and BULLIER, B., '*Anatomical segregation of two cortical visual pathways in the macaque monkey*', *J. Vis. Neuroscience*, 4 (1990) 555-578.

NEGRI DELLANTONIO, A., *Fisiologia e psicologia delle sensazioni* (Ed. La Nuova Italia Scientifica, Rome, 1994).

PLINIO IL VECCHIO, *Historiae Naturalis libri XXXVII* (Venice, 1513).

RATZINGER, J. and BERTONE, T., *Istruzione circa le preghiere per ottenere da Dio la guarigione*, (CDF), (Libreria Editrice Vaticana, Vatican City, 2000).

SARAIVA MARTINS, J., 'La depressione. Fenomeno clinico, antropologia biblica, fede cristiana', *Dolentium Hominum*, 55 (2004) 16-20.

SAKAI, K., 'Neural representation of a rhythm depends on its interval ratio', *J. Neuroscience* 19 (1999) 1074-1082.

SCARSO, G., ROSSI, A., MASCIA, L., and URCIOLI, R., *La musica nella terapia del coma* (Ed. Minerva Medica, Turin, 2003).

SCHEDEL, H., *Liber Chronicorum* (Nurenberg Chronicle) (Augsburg, 1497).

SCHINDLER, O., 'La musicoterapica: proposta per una sistemazione categoriale ed applicativa', *Musica e Terapia*, 2 (1993) 4-7.

SCHOPENAUER, A., *Scritti sulla musica e le arti* (Edizioni Discanto, Fiesole, 1981).

SCHUPPERT, M., and MUNTE, T.F. 'Receptive amusia: evidence for cross- hemispheric neural networks underlying music processing strategies', *Brain* 123 (2000) 546-559.

SIDTIS, J.J., and VOLPE, B.T., 'Selective loss of complex-pitch or speech discrimination after unilateral lesion', *Brain Lang*. 34 (1988) 235-241.

STAUM, M.J., and BROTONS, M., 'The effect of music amplitude on the relaxation response', *J. Music Ther.*, 37 (2000) 22-39.

STRAVINSKIJ, I., *Poetics of Music* (Jamin, Paris, 1945)

SUTTER, M. L. and SCHREINER, C.E., 'Topography of intensity tuning in cat primary auditory cortex: single- neuron versus multiple neuron recordings', *J. Neurophysiol.* 73 (1995) 190-203.

TRAINOR, U., 'Music and speech processing in the first year of life', *Music Percept*, 11 (1993) 185.

TRAMO, M. J. and BHARUCHA, J.J., 'Musical priming by the right hemisphere post-callosotomy', *Neuropsychologia* 29 (1991) 313-323.

TRAMO, M.J., 'Enhanced: music of the hemispheres', *Contemp. Music Rev.* 9 (1993) 113.

UNGERLEIDER, L.G. and MISHKIN, M., 'Visual behavior', in Ingle, D.J., Goodale, M. A. and Mansfield, R.J., (eds.), 'Analysis of visual behavior', *R.J.W.* (1982) 549-586.

VOLTERRA, V., *Melancolia e musica. Creatività e sofferenza mentale* (Ed. Franco Angeli, Milan, 2003).

WACKENRODER, W.H., *Fragment aus eine briefe* (Josephs Berlinger, 1814)

WALKER, J.S., EAKES, G.G., and SIEBELINK, E., 'The effect of familial voice intervention on comatose head-injured patients', *J. Trauma. Nurs.*, 2 (1998) 41-45.

ZATORRE, R.J. and PERRY, D.W., 'Functional anatomy of musical processing in listeners with absolute pitch and relative pitch', *PNAS* 95 (1998) 3172-3177.

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

ZUCCHI, P.L., HONINGS, B., and VOEGELIN, M. R., 'Pain, faith, prayer. Therapeutic effect of faith and prayer on subjects with painful pathologies. Blind study on a group of 1104 patients', *Compendium of Pain Semantics*, 11 (2001) 1-384.

ZUCCHI, P.L., HONINGS, B., and VOEGELIN, M. R., 'Effetto della lettura evangelica meditata sulla area iperalgesica e sulla percezione del dolore nella sindrome algica lombare', *Dolentium Hominum*, 53 (2003) 44-51.

Centres for Information on Sound

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Notes

[1] See the various tables and figures.

[2] See Catechism of the Catholic Church (*CCC*), nn. 1763-1764.

[3] See *CCC*, n. 1772.

[4] See, *Salita del Monte Carmelo*, 1, 13, 5.

[5] See *Salita*, 1, 11, 2.

[6] See Pastoral Constitution of the Church on the Contemporary Rome, *Gaudium et Spes* (*GS*), n. 14.

[7] See *CCC*, nn. 364-366.

[8] ST. THOMAS AQUINAS, *De Anima*, 1 ad 12.

[9] ST. THOMAS AQUINAS, *De Anima*, 9 ad 14.

[10] See BATTISTA MONDIN, *Dizionario Enciclopedico del pensiero di San Tommaso D'Aquino* (Edizioni Studio, Domenicano, Bologna, 1991), p. 50.

[11] See *CCC*, nn. 374-377.

[12] St. THOMAS AQUINAS, *Somma Teologica*, I, 95 ad 2.

[13] See *CCC*, n. 400; see also Jn 3:7; 3:11-13; Jn 3:16; Jn 3: 17,19; Jn 2:17; Rom 5:12.

[14] St. THOMAS AQUINAS, *Somma Teologica*, I, 95, 1 in corpore.

[15] See *CCC*, n. 373.

[16] See *CCC*, n. 398; See also Jn 3, 3-11; Rom 5, 19; Jn 3:5.

[17] See Rom 3:23; Jn 3: 9-10, CCC, 399.

[18] See Figures 9 and 10.

[19] *CCC*, n. 2568.

[20] SANTA TERESIA DI GESÙ BAMBINO, *Manoscritti autobiografici*, C 25 r.

[21] St. Thomas Aquinas, *Somma Teologica*, I-II, 82, 3.

Human Security and Health

The parable of a lost sheep is one of the most famous stories in the Scripture. A man who has one hundred sheep will leave the ninety nine in the hills and go in search of the stray, if one of them goes astray. It is not the will of the heavenly Father that one of these is lost. A good shepherd always goes to find a stray sheep by leaving a flock behind.

Ever since the emerging of modern states in the course of recent centuries, leaders of nations have been giving their priorities to state security. It is true that in the past security threats always emanated from outside of boundaries. In recent years many dangers have not come from outside boundaries. Poverty, environmental degradation, suffering from infectious diseases, transnational organized crime and terrorism are a few examples. Today a new consensus on security is really needed and we should pay more attention to a stray sheep by convincing political leaders that the small interest of a stray sheep is a core value and deserves to be given careful attention. The concept of human security is a viable framework to bring human-centered approach to the values of political leaders by making the interests of individuals a priority for governance and politics.

1. What is Human Security?

Since the end of the Cold War, the structure of international relations has changed in a drastic manner. Rapid waves of globalization coupled with economic liberalization and the progress of information technology are shaking the fabrics of the traditional approach of sovereign nations. This process accelerates the degree of interdependency of the world, having brought not only benefits to people, but troubles by widening the gap between the rich and the poor nationally and internationally.

Today, as many as 1.1 billion people are forced to live on less than one dollar a day. The unprecedented moves of people, goods, money and information sometime work to accelerate transnational problems. Trafficking in persons, arms smuggling and the spread of infectious diseases are only a few examples. Furthermore, the end of the Cold War, contrary to the hope we had at that time, has brought numerous civil conflicts whose root causes lie in religious, ethnic and economic contexts, coupled with refugees and internally displaced persons. Each of these challenges has a complex inter-linkage to one other.

In 1945, when the United Nations was created the security of a state such as the protection of boundaries and people of a state was the main concerns of those who built this system. Ever since the world order has been shaped, based upon this traditional concept. One of the main justifications for the military governments of Latin American countries in the 1960s was the concept of national security. Many innocent people were imprisoned and sometimes executed in the name of National security. Japan believes that to overcome new and direct threats, the traditional concept of state security alone is no longer sufficient.

Each human being is equal in having his or her own potential and should be respected as a human person regardless of nationality, race, gender and other identities. The basic concept of human security is a call for a paradigm shift of security from staying on the narrow state security ideas to expanding its focus to include people's perspective. Mrs. Sadako Ogata and Prof. Amartya Sen, together with other ten prominent members, submitted a report on the issue of human security to the Secretary General of the United Nations, Kofi Anan, in May 2003 and the report defines human security as protecting the vital core of all human lives in ways that enhance human freedoms and human fulfillment and calls for a strategy of protection and empowerment to secure people's lives, livelihoods and dignity.

Others sometimes wonder what the difference between a humanitarian response and human security is. I say that a humanitarian response is a concept of helping and rescuing people in enormously difficult situations, but stops there. It has sometimes paternalistic connotations. Human security is to make individuals stand on their own and the initiatives of individuals are essentially important.

2. Health and Human Security

Fr. Akio Nemoto, a Franciscan priest, who has spent many years in a hospice in South Africa looking after HIV/AIDS patients, once told me a story of a patient. A mother who knew she was dying with HIV/AIDS wrote

a letter to her beloved 3 year-old daughter. The letter had the condition that her daughter could read it when she became 16 years old, mature enough to understand the meaning of the letter in which her mother explained how she was affected by HIV/AIDS through her husband's adultery, how much she loved her daughter and she really wanted to see her daughter's first boyfriend. The story tells us that for all people health is always the primary concern and they are ready to sacrifice everything in order to get proper health care.

In spite of the fact that health is a core value of human beings the reality is far from it. In many developing countries, political leaders pay more attention to traditional state security and expenses on health care and education are the first targets to cut when a government has to economize its expenditure since many political leaders see these areas as not essential and thus expendable. We have seen many examples in various developing countries where many problems associated with non-provision of a good health-care system are more to do with a lack of political will and poor management than shortages of resources. The main challenge here is how to convince government leaders that health care should be given prior attention.

Mely Caballerlo-Anthony, Assistant Professor of Nanyang Technological University, is right in saying that "to generate political will and commitment, the stake holders in government must be convinced of the merits of human security. More importantly, they need to be convinced that health is a priority for governance and politics. The most obvious strategy, then, is to establish the clear linkage between human security and the values that appeal to power holders."

In order to achieve that goal, there must be a system in which human security is well embedded. Civil society should be included in a process of formulating health policies; unless political leaders have great awareness about the importance of health care, their popularity will not be sustained. The parallel existence of the poor willing to lose everything in order to save their lives and the lack of political will to pay due attention to the issue of medical care should be redressed.

3. Japan's Initiatives to Make the Concept of Human Security Operative

I believe that unless the concept of human security is put into action, the concept loses its validity and reference. With this conviction Japan takes a lead in translating the idea of human security into operation. This is also based upon Japan's own experiences. Former Prime Minister Ryutaro Hashimoto in his speech in South Africa in 1999 explained this background as follows: "As of today the Japanese people enjoy the longest average longevity of over 80 years in the world; however, it is only 50 years ago that the average life of Japanese people was only 50 years. There are three elements for this success. First, people have full access to advanced health care. Second, the provision of a safe water system leads to the drastic reduction of communicable diseases. The provision of safe water constitutes a fundamental condition for health. Third, eradication of parasites. I would like to point out that Japanese success is based upon the combination of a health system and a well advanced education system."

In order to fight poverty, "peace, security and good governance" are prerequisites. These three elements will convince each individual in society that "tomorrow can be better than today", and the most important keyword towards this end is "hope". Having "hope" in mind, people can make an investment, people can provide education, which is an investment for the future, and people can pay attention to health. People can afford to meet their partners with affection and respect which leads to gender equality. Japan believes that this process of development creates the sense of ownership among people based upon partnership between donors and recipients.

In the G-8 summit meetings of 1997 and 1998, Japan took an initiative for the network building to fight parasites in Asia and Africa, which led to a creation of the "international parasite study center" of the Mahidon University in Bangkok. In the year 2000, at the Okinawa G-8 Summit, Japanese Prime Minister Yoshiro Mori emphasized the importance of combating communicable diseases, which led to the creation of "the Global Fund to Fight HIV/AIDS, TB and Malaria." For the first time, Japan drew the attention of world leaders to the issue of these communicable diseases in concrete terms, thus narrowing the gap between the people in need and the agenda of world political leaders. In the past, policy-makers, even summit leaders, cared less about health than they did about depression, jobs and the exchange rate, but now world political leaders realize the importance of good health. Since the creation of the Global Fund in the year 2002, in the course of 3 years of operation the Global Fund has raised nearly 4 billion US dollars out of which Japan contributed 250 million US$. June 30th this year, Japanese Prime Minister Junichiro Koizumi made an announcement Japan's new commitment of half a billion US$ for the Global Fund for coming years. The Global Fund was established in a way to reflect the concept of human security. In each country, its country coordination mechanism was established in a process of discision making in which not only government officials but representatives of faith-based organizations and civil societies were represented.

Although States still hold main responsibilities for providing health care to people, there is also awareness that a State's capabilities are limited and thus human security must allow non-governmental actors and international organizations to provide health care. Health is too important to be left in the hands of a few people. This theory is also applicable to the awareness of the people of rich countries. In these days, medicines for HIV/AIDS, TB and malaria are affordable for common people of industrial nations and their small savings can go a long way to saving the lives of the people of developing countries. The Global Fund makes health of people in developing countries the business of developed countries. This is also the realization of human security.

4. The Primary Health Care Project (Lusaka, Zambia)

I would like to give another concrete example of a health project based upon human security concept. The Japanese government has incorporated the principle of human security into its international development assistance policy. The Japan International Cooperation Agency (JICA), an implementation agency of Official Development Assistance of Japan, which Mrs. Sadako Ogata, former UNHCR, is heading, is also working on ways to operationalize the concept more specifically.

In George Compound, close to Lusaka, the capital of Zambia, JICA has been supporting a series of health care projects, whose activities are carried out by community volunteers. Unplanned settlements were created by rapid migration from the suburbs before urban planning could catch up. These people migrated mainly from agricultural areas as a result of economic depression. Shortages of health care and luck of infrastructure development in the areas meant that the infant mortality rate for children under five was as high as 15%. This lack of a health care system caused a mass outbreak of cholera during the rainy season coupled with a rapid increase of TB and measles. Ever since the year 1994, Japan has provided a grant to build a water system. But what is more important is the starting of a community-based model of primary healthcare projects since 1997. Reducing the infant mortality rate and improving health and sanitation conditions are carried out by two main activities: a growth monitoring program by health center staff and trained volunteers from the community-based health workers. A health expert said that there has been a growing awareness in the community of the importance of health and of improving the situation in their own living areas. The success of these activities and the completion of water facilities has led to a significant reduction in the number of deaths from cholera, from seventy per 10,000 lives before the project began (1994) to one per 10,000 lives (2000). Significant improvement of health of children is also evident. The community also set up a small fund for maintenance of public toilets and the expenses of volunteers. This project illustrates that a system can be made where people in the community can be self-reliant and critical links can be sustained between the community and the government. We see here a good example of making health care everybody's business.

5. The Trust Fund for Human Security

In 1999 Japan took another initiative to translate the concept into action. It established the Trust Fund for Human Security in the United Nations and by February 2005 Japan had contributed approximately 256 million US$ to the Fund. Applying the approaches of "protection" and "empowerment" in the action, the Fund, focusing in on each individual, supports projects to protect people and empower people to enhance their resilience.

The Fund finances projects to be carried out by organizations of the United Nations system and in partnership with non-UN actors to advance the operational impact of the human security concept. Japan welcomes the participation of the "Good Samaritan Foundation" as a partner of UNICEF, WHO or any other UN organizations to carry out projects. Projects shall be selected according to the following parameters:

(1) Providing concrete and sustainable benefits to people and communities threatened in their survival livelihood and dignity.

(2) Implementing the protection and empowerment framework by comprehensively including both top-down protection and bottom-up empowerment measures.

(3) Promoting partnership

with civil society, faith based organizations, NGOs and other local entities and encouraging implementation by these entities.

(4) Advancing integrated approaches that preferably involve more than one organization in planning and implementation.

(5) Addressing the broad range of interconnected issues that take into account the multi-sectoral demands of human security, for example, conflict and poverty displacement, and health education and conflict prevention.

(6) Concentrating on those areas of human security that are currently neglected and avoiding duplication with existing programmes and activities.

The budget estimate of one project is approximately one million dollars in a year in ordinary cases, though explicit upper or lower limits are not defined. Budgetary requirements should be calculated based upon the feasibility and needs of each project. The budget can be greater when they are of a comprehensive or regional nature or multi-year projects.

6. Conclusion

The concept of human security has been already put into practice. In these difficult times of crises and uncertainties, Japan believes human securities offer hope. Hope is a key for the development of people who are under severe conditions. This is a concept that a small interest of one stray sheep will not be sacrificed in the name of state security but rather that one sheep's care is all sheep business. Partnership, protection and empowerment are key words for human security and Japan hopes that this new security concept will be widely accepted to meet new challenges.

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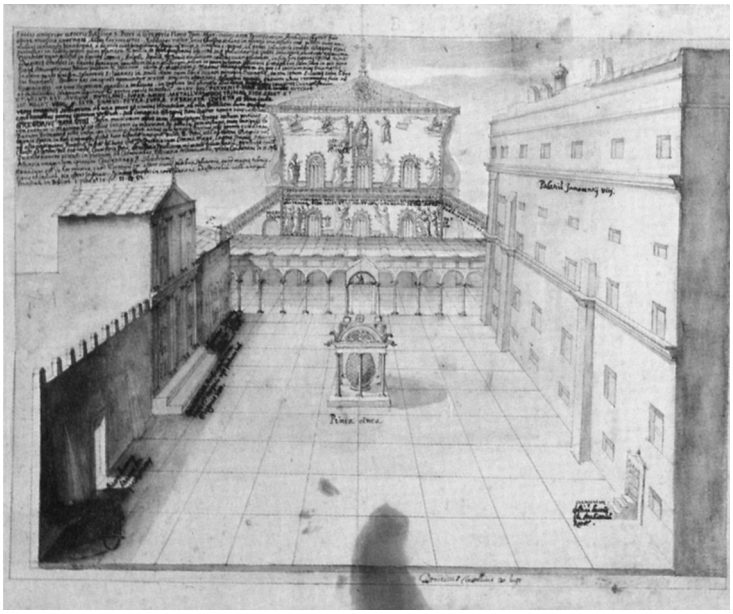
Bibliography

Human Security Now, Commission on Human Security, New York 2003

Overview of Health and Human Security Case Studies, Mely Caballero-Anthony 2002

Communicable Diseases and Japanese Foreign Policy, Kaoru Ishikawa 2004

Project: Human security, JICA FRONTER 2005, 6



Sick People in Prison, the Importance of the Pastoral Intuition

1. Introduction

The topic of the following article may suggest its sole destination is for prison chaplains. Indeed, chaplains were thought of as primary readers of this study. The more so as the subject is left unsaid in most works on penitentiary chaplaincy, focusing on typical pastoral problems. The contents of this article, however, may also be of use to volunteers visiting prisoners as much as to the prison service staff. In the case of the latter recipients, one should hope that reading this article will contribute to their even deeper comprehension of the sense of the pastoral ministry in the conditions of prison isolation.

The paper concentrates primarily on the clinical as well as pastoral aspect of the problem of illness. The pastoral aspect of the problem has been given attention in the form of encouragement for a professional perception of the conditions for certain diseases in the prison, which may result in the improvement in the pastoral ministry.

Prisoners are likely to struggle against the same illnesses as people staying temporarily out of prison or those enjoying permanent freedom. Therefore the selection of illnesses presented in this work has required careful thought. This is because the development of particular illnesses in prison may proceed differently than in the conditions of liberty.

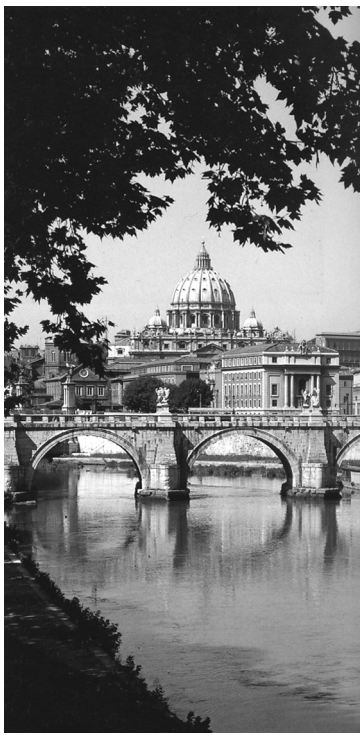
2. The neurological aspect

Many individual prisoners have committed criminal or paracriminal offences, involving the possibility of sustaining both body injuries as well as neurological injuries and disorders, before being imprisoned. Similar injuries may also be sustained during one's stay in a penitentiary – as a consequence of being beaten by fellow prisoners, for instance.

One of the common neurological units is head injury (Weiner, Levitt, 1994). Consequently, it happens that prison hospitals admit patients with self-inflicted head injuries (Szaszkiewicz, 1997, p. 114). The above group usually includes mentally handicapped or alcohol-addicted individuals, who – either thoughtlessly or in a state of delirium – bang their heads against the walls and other hard surfaces. As a result, they are likely to sustain such serious injuries as breaking the base of the skull, concussion and haematomas. A prisoner is also likely to commit acts of self-inflicted harm with the intention of landing in the prison hospital in which his accomplice has already been staying, and, consequently, engaging in a communication in order to establish the common line of defence during the forthcoming trial, for example.

Furthermore, some neurological disorders acquired already at liberty are likely to deepen even further while staying in prison. Among these, one ought to indicate headaches (cf. Diamond, Dalessio, 1986; cf. Dalessio, 1987), dizziness (cf. Weiner, Levitt, 1994), epilepsy (cf. Engel, 1989), insomnia and sleep disorders (cf. Weiner, Levitt, 1994), neurological disorders resulting from alcoholism (e.g. convulsions, delirium tremens; cf. Victor, Adams, Collins, 1971), neurological disorders resulting from internal maladies (cf. Weiner, Levitt, 1994; according to these authors, prison is conducive to the development of digestive system diseases as well as heart diseases).

Prison isolation may be described as a continual and permanent situation of danger and uncertainty (in the physical as much as psychological sense; cf. Moczydłowski, 1991, for instance), which may constitute another reason why prison-confined individuals may prove unpredictable to



an extent inconceivable to free individuals (cf. Britton, 1999; cf. Hollin, 2001, pp. 99-125; cf. Harrower, 2001, pp. 9-40; cf. Schneider, 1980). At this point, it is also necessary to direct attention to the dissimilarity between the world of free individuals and the world of the imprisoned.

Another difficulty in communicating with prisoners is likely to occur, namely the simultaneous occurrence of neurological diseases together with psychological and personality disorders.

3. Psychosomatics

The basic assumption underlying psychosomatics draws attention to the role of emotional tension, conflicting situations and psychological injuries in the genesis and course of numerous somatic diseases. A contemporary approach to the disease assumes a multifactorial perception of the etiopatogenesis of pathological syndromes, including the existence of not only biological factors, but psychological and social factors as well. Apart from their undoubted impact on conditioning the course of illness (which is of a different extent in the case of different patients), the latter factors enable the determination of the appropriate therapeutic approach (Jarosz, 1983). In the etiology of psychosomatic diseases, F. Alexander, T. French and G. Pollock (1968) indicate, *inter alia,* stressful situations of frequent complexity, linked with the central conflict. Such situations either result in the release of the somatic disease symptoms or they escalate its symptoms periodically.

M. Sufczyńska-Kotowska, A. Golczyk-Wojnar, and M. Wojnar (2000, pp. 139-155) include bronchial asthma, peptic ulcer disease of the stomach and intestines, ulcerative colitis and inflammatory bowel disease, arterial hypertension as well as headaches in the category of psychosomatic disorders. E. Ścigała (1993) divides psychosomatic disorders into three groups. The first group includes pathologies having a psychological stimulus as their etiological factor, and it encompasses the following disorders: vegetative neuroses, headaches resulting from a psychological tension (tension-type headaches), habitual vomition, mental anorexia (anorexia nervosa), as well as certain types of obesity. The main (although not the only) factor common to pathologies in the second group is psychological disorders. The group includes such pathologies as peptic ulcer disease of the stomach and duodenum, inflammatory bowel disease (inflammation of the large intestine), essential hypertension (spontaneous arterial hypertension), coronary heart disease, bronchial asthma, allergic diseases. The third group, possibly, encompasses those pathologies in which the psychological factor is the main factor aggravating the course of the pathologies. Consequently, it includes diabetes, hyperthyroidism and primary chronic rheumatism.

Psychosomatic disorders may undoubtedly deepen in prison conditions, which is connected with a broadly understood notion of prison stress. The stress is linked to a pre-stress, arising from the criminal activity and the risk it involves.

The research involving prisoners I have been conducting by means of, among other things, the method of participatory observation, has shown that the criminal prisoner does not admit his fear despite the obvious fact that his living is largely affected by fear. Such an approach to fear stems from a formula claiming that "attack is the best defense", which constitutes one of the basic rules explaining the conduct of criminals. The term "fear" seems to be absent from criminal conduct, or at least it is not mentioned during conversations with the great majority of prisoners. The latter are strict to their fellow-prisoners who are not afraid to confess to their fear. Nevertheless, the population of prisoners may be characterized by the type of fear that can be named as subcultural criminal fear (the fear of being a criminal) and subcultural prison fear (the fear which stems from being a prisoner). The former occurs while committing a crime, and it refers to the fear of bodily harm, of sustaining injuries, and, finally, of death (which is understood as the fear of being killed, and not as the fear of failing to achieve salvation). The latter refers to the fear of being inferior and of being perceived as a nonentity. Similarly, one may distinguish two types of stress, namely subcultural criminal stress (the stress which stems from being a criminal) and subcultural prison stress (the stress resulting from being a prisoner). All of this, in turn, is closely linked to psychosomatics.

4. The necrophilic character

G. W. Allport describes personality as the dynamic organization within the individual of those psychophysical systems that determine his unique adjustments to his environment (1949, pp. 43-48). According to H. J. Eysenck, it is a more or less stable and enduring organisation of a person's character, temperament, intellect, and physique, which determines his unique adjustment to the environment (1970, p. 2). Both definitions are basically identical to each other, although the latter is more detailed and more structural than the first. S. Siek puts forward a dynamic view of personality, defining it as the organization of instructions and patterns of reacting, created as a result of development and adjustment as well as being designed for adjustment (1986b, p. 14).

As late as the 1920s and 1930s, character was wrongly identified with personality. The structure of personality involves the following elements: temperament, character, psychological needs, impulses, aptitudes, attitudes, values, motives, and self-image.

According to A. A. Roback, character is an enduring psychophysical disposition to inhibit impulses in accordance with a regulative principle (1952, p. 568). W. S. Mierlin describes character as the individuality of personality. In his view, character is the organization of such psychological traits that occur in certain situations only and that condition an individual and specific way of fulfilling particular dispositions and social attitudes (Siek, 1986a, p. 121). H. Remplein endows character with an axiological dimension, considering it as an aspect of personality expressed in one's ability to sense values as well as in one's active aspiration for particular values (1963, p. 135). In his work devoted to character, J. Pastuszka links it – among other things – to will. The term "will" is still used in philosophy and idealistic psychology, while contemporary experimental psychology has replaced the term "act(s) of will" with the notion of "decisional process". In point of fact, contemporary psychology challenges the classic model of the conscious act of will (particularly the stage of thought), considering the majority of our acts as determined subconsciously. In this respect, the above theory reflects the impact of psychoanalysis and existentialism. J. Pastuszka, on the contrary, perceives character as a certain system of the will, referring to one's self-control, consistent obedience to particular rules, the constancy of one's conduct, as well as the effectiveness of the operation of one's will (1962, pp. 25-29).

The necrophilic character is shown here against the background of one's personality – on account of the fact that its fatalistic power is so mighty that it is able to take over and usurp the whole personality, subordinating its individual elements to itself. E. Fromm carries out a deep analysis of such a character (1999). The term "necrophilia", in the most general terms, stands for the attraction to all that is dead. It used to be applied in the description of two different phenomena, namely: a) sexual necrophilia, i.e. a male desire to have a sexual relationship or another type of sexual contact with the body of a dead woman; b) non-sexual necrophilia, i.e. the desire to be near to corpses, to watch and touch them and, primarily, the desire for the dismemberment of corpses. The above term, however, was not usually applied with reference to character-rooted passions. It was only Erich Fromm who went beyond the popular usage of the term as a result of his study of the biographies of brutal figures, including Hitler. According to Fromm, "necrophilia can be described in a characterological sense – as a passionate attraction to all that is dead, decaying, and sick; it constitutes the passion to transform anything alive into something unalive; to destroy for its own sake; to focus the whole of one's attention on anything that is purely mechanical. It is a passion to tear apart living structures" (1999, p. 372).

Necrophilia understood as a character disorder, and thereby a personality disorder, is a very rare phenomenon. In fact, we are more likely to encounter the traces of this character. An individual of this type may undoubtedly be found in the prison population, for which the chaplain ought also to be prepared.

5. A disordered personality

"A disordered personality" is also defined with the term of "psychopathy". The latter term, however, has ceased to be used by contemporary clinical psychology, largely due to the influence of humanism. In point of fact, the term "psychopathy" has given rise to numerous misunderstandings. To avoid these, some authors are still applying the former term, considering it as more expressive. American literature also introduces a synonymous term of "asocial personality". Some other common terms referring to the above notion are "psychopathic personality" (a term placed somewhere in between the terms of "disordered personality" and "psychopathy"), "sociopathy", "characteropathy", "sociopathic personality" and "characteropathic personality". All these terms concern a disordered personality, although each of them may put emphasis on a slightly different aspect of those disorders.

According to A. P. Sperling, a psychopathic personality is "the personality of an individual incapable, partly or completely, of understanding the existing ethical norms, which results in their antisocial or immoral behaviour" (1995, p. 379).

J. Szostak claims that "A personality disorder is not a mental illness, as people affected by this type of disorder do not show the basic symptoms of a mental illness – such as delusions and hallucinations, for instance. It is thus possible to diagnose a person-

ality disorder as a condition characterized by certain dynamics, including the changes in the particular areas of one's psychological life with the domination of emotional disorders" (2002, p. 54).

The disordered personality traits may, for example, be linked to one's psychological immaturity (including emotional immaturity, especially in the sphere of higher feelings), psychological disharmony (the existence of mutually contradictory traits within the personality), lack of respect for moral and legal standards (leading to the extreme conviction that "there is no law and no morality"), irresponsibility, simplified and desire-based social communication, inability to predict the consequences of one's own actions, the absence of realism in planning, and, possibly, internal conflicts. These, as much as a number of other traits, are linked together to form groups enabling the distinguishment of at least a dozen or so types of disordered personality (such as, for instance, the evasive-, dependent-, neurotic-, schizoid-, hysteroid-, and fanatic personality; of these, it is the necrophilic personality that, in my opinion, constitutes the most seriously disordered personality type).

The term "criminal personality" has a broader meaning than the notion of "disordered personality". This is because a criminal act may not only be committed by a personality-disordered individual, but also by people afflicted with psychosis, neurosis, or by individuals being under the influence of psychoactive agents.

6. Psychosis and neurosis

Neuroses are considered to be less serious mental disorders than psychoses and they differ from the latter in that they enable insight into one's own experiences. The main symptom of neuroses (psychoneuroses) is fear (Haslam, 1997, pp. 295-331).

The differences between psychosis (a psychotic) and neurosis (a neurotic) are expressed clearly by A. P. Sperling (1995, pp. 337-341). Neurosis makes it difficult to control reality and derive pleasure from it. A neurotic, however, comprehends reality and perceives it in the proper way. Consequently, apart from the area of symptoms he maintains a normal contact with his environment. A psychotic, on the contrary, is devoid of this contact. He cannot, or is not willing, to verify the veracity of his own judgments through confronting them with the facts to be noticed, which leads to the disappearance of the distinction between fantasy and reality. Trying to maintain the image of himself a psychotic not only distorts reality, but even denies it completely. Overwhelmed by his own distortions of the world, he does not realise his outer reality.

Psychoses can be divided into functional (when no changes to the nervous system are detected; the only fact possible to be detected is that the personality does not function properly) and organic (characterized by the occurrence of physical changes).

Prison, in fact, creates favourable conditions for the development of psychoses and neuroses. This results from, among other factors, "the second life of the prison" – i.e. specific communication between the prisoners themselves as well as between the prisoners and the prison guards. The second life of the prison offers its moral system as well as its normative and legal basis.

7. The hardship of the prison chaplain

The present article does not handle the problem of prisoners addicted to psychoactive agents (such as, among other things, alcohol, drugs, and medications). This is because the wide range as well as the high intensity of this problem provide an adequate source for a separate article. At this point, however, one needs to remember that the above-mentioned agents may constitute a favourable background for the occurrence of organic psychosis, for instance, as well as playing a significant part in the genesis of other disorders.

Pastoral psychology puts forward the suggestion that the prison chaplain ought to take pains to introduce the prisoners into a life based on a broadly understood harmony (Woźniak, 2002b, pp. 77-79). The harmony may have at

least 11 dimensions: 1) between the spiritual, psychological and bodily sphere, 2) within the sphere of one's self-image, 3) in experiencing time, 4) in the manner of existence, 5) between the mind and emotions, or feelings, 6) between the man's inner layers (a reference to transactional analysis), 7) between the needs, values and norms, 8) in the communication between man and God, 9) in interpersonal relations, 10) in relations between an individual and a group, 11) in contact with the natural environment.

The chaplain is likely to become an object of manipulation, either consciously or unconsciously. The former may be used by a prisoner to enjoy a fine reputation on the part of the chaplain, for instance. Unconscious manipulation, on the other hand, may be employed by a psychotic prisoner, for example. Considering the above conditions, the fact of possessing a feeling for manipulation means that the chaplain will undisputedly increase his positive influence on the prisoners.

The complex problems affecting prisons along with the prisoners' disorders and pathologies require the chaplain's intuition (cf. Woźniak, 2002a, pp. 465-472). The

chaplain ought to adjust his actions both to the type of the penitentiary as well as to the individual prisoners, characterized by a particular personality type, criminal type, or a specific pathology unit. In fact, it is the chaplain's responsibility to respect the law concerning the penitentiaries and the prisoners, respectively. He is obliged to conform to the rules of safety and public order and to other regulations existing in the penitentiary. He is bound by his official secret, too.

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Bibliography

ALEXANDER F., FRENCH T., POLLOCK G., *Psychosomatic Specifity,* University of Chicago Press, Chicago, 1968.

ALLPORT G.W. *Personality. A Psychological Interpretation,* Constable and Comp., London, 1949.

BRITTON P., *Profil mordercy* (orig. title: The Jigsaw Man). Oficyna Wydawnicza De Facto, Poznań, 1999.

DALESSIO D., *Wolf's Headache and Other Head Pain,* Oxford University Press, New York, 1987.

DIAMOND S., DALESSIO D., *The Practicing Physician's Approach to Headaches,* Williams & Wilkins, Baltimore, 1986.

ENGEL J., *Seizures and Epilepsy,* FA Davis, Philadelphia, 1989.

EYSENCK H. J., *The Structure of Human Personality,* Methuen, London, 1970.

FROMM E., *Anatomia ludzkiej destrukcyjnosci* (orig. title: The Anatomy of Human Destructiveness), Dom Wydawniczy REBIS, Poznań, 1999.

HARROWER J., *Psychology in Practice: Crime,* Hodder & Stoughton, London, 2001.

HASLAM M., *Psychiatria* (orig. title: Psychiatry. Made Simple Books), Zysk i S-ka Wydawnictwo, Poznań, 1997.

HOLLIN C. R., *Psychology and Crime. An Introduction to Criminological Psychology,* Routledge, Sussex - New York, 2001.

JAROSZ M., *Psychologia lekarska,* PZWL, Warszawa, 1983.

MOCZYDŁOWSKI P., *Secret Life in Polish Prisons.* Indiana University Press, Indiana, 1991.

PASTUSZKA J., *Charakter człowieka,* TN KUL, Lublin, 1962.

REMPLEIN H., *Psychologie der persönlichkeit,* Reinhard, München, 1963.

ROBACK A.A., *The Psychology of Character,* Routledge and Kegan, London, 1952.

SCHNEIDER H.J., *Das geschäft mit dem verbrechen. Massenmedien and kriminalität,* Kindler Verlag GmbH, München, 1980.

SIEK S., *Formowanie osobowości,* Akademia Teologii Katolickiej, Warszawa, 1986a.

SIEK S., *Struktura osobowości,* Akademia Teologii Katolickiej, Warszawa, 1986b.

SPERLING A.P., *Psychologia* (orig. title: Psychology. Made Simple Books). Zysk i S-ka Wydawnictwo, Poznań, 1995.

SUFFCZYŃSKA-KOTOWSKA M., GOLCZYK-WOJNAR A., WOJNAR M., *Zaburzenia psychosomatyczne.* In: A. Popielarska, M. Popielarska (ed.). *Psychiatria wieku rozwojowego,* Wydawnictwo Lekarskie PZWL, Warszawa, 2000.

SZASZKIEWICZ M., *Tajemnice grypserki.* Wydawnictwo Instytutu Ekspertyz Sądowych, Kraków, 1997.

SZOSTAK J., *Psychologia sądowa.* Wyższa Szkoła Handlu i Prawa im. Ryszarda Łazarskiego, Warszawa, 2002.

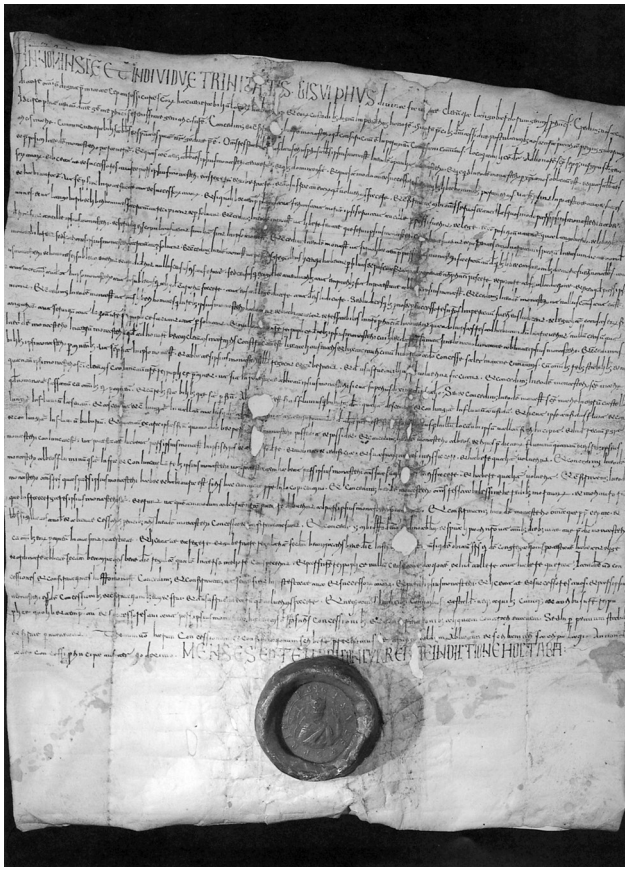
ŚCIGAŁA E., *Poznawcze uwarunkowania choroby wieńcowej i zawału serca.* Wydawnictwo Naukowe UAM, Poznań, 1993.

VICTOR M., ADAMS R., COLLINS G., *The Wernicke-Korsakoff Syndrome,* FA Davis, Philadelphia, 1971.

WEINER H.L., LEVITT L.P., *Neurology,* Williams & Wilkins, Baltimore, 1994.

WOŹNIAK W., *Duszpasterstwo Zakładów dla Nieletnich.* In: P. Kurzela, A. Liskowacka (ed.). *Umiłować Chrystusa. Program duszpasterski na rok 2002/2003,* Komisja Duszpasterstwa Ogólnego Episkopatu Polski & Księgarnia św. Jacka, Katowice, 2002a.

WOŹNIAK W., *Duszpasterstwo zakładów poprawczych a terapia.* In: J. Woźniak (ed.). *Duszpasterstwo więzienne w III Rzeczypospolitej,* Instytut Teologiczny Księży Misjonarzy, Kraków, 2002b.



Note of the Pontifical Council for Health Pastoral Care on the So-called right to Reproductive Health

Premise

In 1994 the World Conference on 'Population and Development' was held in Cairo. At this international forum the Holy See expressed the reservations of the Church in relation to the ideology of 'reproductive health', which is based upon a utilitarian and Malthusian approach. On 14 November 2001, together with the Pontifical Council for Migrants and Travellers and the Pontifical Council for the Family, we published a special Note for bishops' conferences in order to draw their attention to what was at stake in the handbook of the United Nations on 'reproductive health' in refugee camps, indicating elements of doctrine and principles of Catholic morality that are capable of helping bishops in drawing up a suitable form of pastoral care for the mission of the Church to help refugees.

Now, with the event of the *tenth anniversary of the conference of Cairo* and within the framework of the *programme of our dicastery on the universal right to the defence of health*, we propose a reflection and clarification of our Pontifical Council for Health Pastoral Care on the 'so-called right to reproductive health'.

I. Definition and Context

1. By the expression 'right to reproductive health' a certain international language tends to refer to the concept of real and proper health side by side with a series of connected rights. Everything is forcibly configured as a 'new' aspect of the panorama of fundamental human rights, in particular in relation to the dimension of human health and correlated rights. Indeed, in the international context reproductive health is connected with procreation,[1] as well as other strongly debated areas such as, for example, that of gender perspective or sexual orientation.

The sphere of reproductive health is marked by especially controversial concepts that concern some of the most intimate and private areas of the person, such as sexuality, sexual relations, and procreation (increasingly: reproduction), and also those questions that because of their nature are of decisive importance for relationships between family members. In this sense, reproductive health is connected with the profile of equality and the ending of the marginalisation of women. It is also connected with aspects of the upbringing and education of young people and adolescents, thereby increasing the presence of elements of conflict within inter-generational relationships (the right/duty of parents versus the rights of adolescents).

Not least, at the level in a very specific sense of the general theory of human rights, the fact that as a concept, with its connected rights, reproductive health has emerged from the context of demographic policies and not specifically from that of the production of law (international law on human rights) has contributed to the problems and difficulties in this area.

2. If we want to understand the 'evolution' of the so-called right to reproductive health, we may observe that a first step was provided by the recognition of a *right to reproductive choice* based on the statements of certain international declarations that proclaim the fundamental right of couples and individuals to freely and responsibly decide the number and spacing of births. The reference is to Resolution 2211 (XXII) of the General Assembly of the United Nations of 1966 on population growth and economic development; section 16 of the Proclamation of Tehran of 1968; and section 14(f) of the Action Plan of the World Conference on Population of 1974. As regards the obligatory character of the right to reproductive health, one may maintain that this becomes effective with article 16(e) of the Convention on the Elimination of all Forms of Discrimination against Women of 1979.[2]

A second period can be linked to the debate and the guidelines of the Conference on Population and Development (Cairo 1994) and the IV Conference on Women (Peking 1995), in which there emerged a direct consideration of reproductive health under the impetus of the World Health Organisation and the FNUAP. On the basis of the formulas of the Action Programme of Cairo, the concept of reproductive health – paraphrasing the definition of health contained in the preamble of the Constitution of the World Health Organisation – should be understood as: 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regula-

tion of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.'[3]

According to this definition, the right to reproductive health is presented with an all-embracing approach directed, in fact, at covering numerous contexts, different subjects, and a multiplicity of juridical situations, but it is clearly lacking in that substantial juridical consistency that is required if it is to be written into international law on human rights. Indeed, situations are outlined with reference to couples, women and unborn children, but incorporated into the same subject considered here – that of the right to reproductive health. The position expressed by the World Health Organisation in August 1994 before the Cairo conference at which the need was expressed to affirm such a 'right', leaving to subsequent practice the task of defining its contents and its limits, that is to say to juridical implementation, remains emblematic of this approach.[4]

II. Health as Full Harmony and Healthy Equilibrium and the Inherent Right to its Defence

3. In his Message for the World Day of Health of 11 February 2000, the Holy Father John Paul II provided a vision of health that takes into consideration all the dimensions of the human person, as well as his Christian vocation and the good that he should do to others. This is what the Pope wrote on the subject: 'This vision of health based upon an anthropology that respects the person in his wholeness, far from being identified with the simple absence of illness, is a tension towards a fuller harmony and a healthy equilibrium at a physical, mental, spiritual and social level. In this approach, the person himself is called to mobilise all his available energies to realise his own vocation and the good of other people'.[5]

4. *Human procreation* is of very great value and dignity because it communicates life to a new human being, that is, to a new person. From their interpersonal act of love, which is inseparably unitive and procreative, the marriage partners become not only parents but also and above all else co-operators with God in the transmission of life. Thus the ideology of reproductive health violates not only the natural right of the unborn child but is also in contrast with divine Revelation. The moral character of conjoining conjugal love with the responsible transmission of life does not depend only on sincere intention and an evaluation of motives but should also be determined by objective criteria that have their foundation in the very nature of the human person and his acts and are intended to maintain the integral meaning of mutual self-giving and human procreation in a context of true love.[6]

5. The personalised vision of health, that is, health as 'tension towards a fuller harmony and a healthy equilibrium' is in contrast:

5.1. *With a reductive vision of health and sexuality* – propagated by the ideology of so-called 'reproductive health' – which reduces health to that of the sexual organs and the enjoyment of sexual pleasure. This reduction, without rules and without commitment, devalues human sexuality and disjoins the procreative act from conjugal intimacy. It thus banalises and exploits the acts proper to generation.

5.2. *With the immoral use of contraceptive and abortifacient means* that is proclaimed by the right to reproductive health and broadened by spreading pansexualism. This use, in fact, precludes a healthy balance of the physical, mental, spiritual and social dimension of the health of the person and also precludes true love which, indeed, is harmonised increasingly intensely within the context of conjugal and family life.

6. It should be made clear that health and life are a gift from God and thus, *properly speaking, one does not have a right to it*. However, it is our duty to defend it and to steward it in a way that respects the dignity of man and the law of God: 'Life and physical health are precious gifts entrusted to us by God. We must take reasonable care of them, taking into account the needs of others and the common good'.[7] However, the full harmony of health was attained in definitive terms in the mystery of the death and the resurrection of the Lord, 'physician of our souls and bodies…who willed that his Church continue, in the power of the Holy Spirit, his work of healing and salvation'.[8]

Conclusion

What has been observed in this Note brings out the juridical contrast between *the holis-*

tic conception of health and the utilitarian conception of reproductive health, and thus of *sexuality*. The first embraces the human person in his unity, harmony, and physical, mental, spiritual and social equilibrium, and is, therefore, able not only to foster maturity at the level of sexuality but also to define responsible procreation as an expression of mutual conjugal love and of relations between a couple that are in conformity with authentic moral norms and profound human values. Reproductive health, instead, denotes the tendency to extrapolate both these values and these norms because it proposes, and without any reservations, not only the separation of sexuality from procreation but also the use of 'emergency contraception' and recourse to chemical abortion. Here is an essential difference as regards the dignity of the human person, who is the beginning, foundation, limit and end of every right: holistic health is in conformity with that dignity; reproductive health is in contrast with it. The first, because it is licit, allows a responsible regulation of the transmission of life; the second allows, although it is illicit, an irresponsible control of births.[9] Indeed, 'God, the Lord of life, has conferred on men the surpassing ministry of safeguarding life in a manner which is worthy of man. Therefore from the moment of its conception life must be guarded with the greatest care while abortion and infanticide are unspeakable crimes. The sexual characteristics of man and the human faculty of reproduction wonderfully exceed the dispositions of lower forms of life. Hence the acts themselves which are proper to conjugal love and which are exercised in accord with genuine human dignity must be honoured with great reverence'.[10]

Footnotes

[1] Cf. in this sense: The United Nations, *Population and Human Rights* (New York, 1990), Doc ST/ESA/SER.R/107, p. 10ss.

[2] On the whole question up to the conference of Cairo, see N. Fincancioglu, 'Contraception, Family Planning and Human Rights', in The United Nations, *Population and Human Rights*, pp. 87-103.

[3] *Action Programme*, chapter VII, section 7.2.

[4] Cf. the 'Summary' of the 'Position Paper' of the World Health Organisation at the Cairo conference: World Health Organisation, *Health, Population and Development* (Geneva, 1994), Doc. WHO/FHE/94.2, p. 833.

[5] Cf. GIOVANNI PAOLO II, 'Messaggio per la VIII Giornata Mondiale del Malato, 11 febbraio 2000, n. 13', *Dolentium Hominum*, 42 (1999), p. 9.

[6] Cf. *Gaudium et spes*, n. 51.

[7] *Catechism of the Catholic Church* (London, 1994), n. 2288.

[8] *Ibid.*, n. 1421.

[9] Cf. PAUL II, *Humanae vitae*, nn. 12 and 13; JOHN PAUL II, *Familiaris consortio*, n. 32; *Evangelium Vitae*, n. 13.

[10] *Gaudium et spes*, n. 51.

The Catholic Health Ministry in Canada

OTTAWA, WORLD DAY OF THE SICK, 11 FEBRUARY 2005

A powerful legacy of caring

1. From the early days of this country, the noble roots of Catholic health ministry were planted by countless women and men whose courage and devoted love for the sick and suffering still leave one breathless when that history is revisited. Women religious were at the heart of this ministry, assisted by their lay and clerical associates. The pioneering efforts of Jeanne Mance, Marguerite d'Youville, Catherine Mace, and Marie Maillet come to mind, as do Blessed Francois de Laval, the early Jesuits, and the Sisters of Saint Augustine at Quebec. Their resources were slender, yet their courage and commitment to the healing ministry of Jesus Christ never wavered, even in the face of the harsh conditions and struggles of early Canada. With their commitment to Gospel values and their flexibility to change with the times, they have left a powerful legacy that all Catholics must now preserve, build upon, and keep in trust for future generations. Indeed, the groundwork of the past bodes well for the future of Catholic involvement in health care.

Unlike perhaps in the past, caring for the sick can no longer simply be the work of a dedicated few individuals; it must now become more and more the concern and preoccupation of every Christian and the entire Christian community. As the Permanent Council of the Canadian Conference of Catholic Bishops, we direct our attention first to the general principles of the Church's healing ministry that is incumbent on all the faithful. In the second part of this letter, we address more specifically the concerns of those who, by profession and on a full-time basis, are engaged in the health care services of the Church.

Reason for this message

2. The question may well be asked: Why has the Church, the "People of God", always given so much attention to the health and healing ministry? Why must it now – today more than ever – embrace health ministry and care as a vital and integral part of her mission and life? Does the Catholic presence and involvement in health care make any difference? And if so, what might that difference be?

With this pastoral letter, we wish to make Catholics, and all Christians in general, more aware that the mission of caring for the sick in essential to the life of every Christian and of a just society. We would like all Catholics to understand their baptismal call to be healers and to become more familiar with the vision and guiding principles of Catholic health ministry. We also wish to encourage those Catholics who are directly involved in the health-care profession – whether at a faith-based or secular facility, or in the community at large – to foster even more assiduously the Gospel values inherent in their professional health care. The Gospel parable of the Good Samaritan captures well the health and healing ministry incumbent on every Christian when confronted with a fellow suffering human being who is in need. "A Good Samaritan", Pope John Paul II said, "is *anyone* who stops to attend to the needs of those who are suffering".[1]

I. ESSENTIAL FEATURES OF THE HEALTH AND HEALING MINISTRY OF THE CHURCH

New hope in Christ

3. In an earlier pastoral letter, *New Hope in Christ,* the Canadian Conference of Catholic Bishops addressed the issue of sickness and healing. That letter bears re-reading even today, as it articulates the heart and soul of the Church's health-care ministry, namely, the person and compassionate healing ministry of Jesus Christ.

With Jesus, healing of mind and body becomes the clear sign that the Kingdom of God is already present. When Jesus heals a leper or proclaims the parable of the Good Samaritan, it is an obvious sign of his compassion. But even more it points to the new life of the Kingdom: the total and permanent healing of the human person in all its dimensions and relationships. Jesus' healing word of power reaches the whole person. It heals the body, but even more important it first restores those who suffer to a healthy relationship with God and the community.[2]

Jesus the "Divine Healer"

4. From this foundational statement, one can note several important points about the health and healing ministry. *First,* as the People of God, the Church walks in the footsteps of Jesus, the Divine Healer, who came "that they may have life, and have it abundantly" (John 10.10). Catholic health-care ministry is thus modeled after the pattern of Jesus'own healing ministry, his compassion for those who suffer, and how he empowered his followers to heal. The Church has always regarded healing as one of the powers of the Spirit that Jesus left as a legacy. Thus in virtue of their baptism, all Christians are commissioned to embrace this healing ministry as an integral dimension of their life in Christ: "In so far as you did this to the least of these who are members of my family,

you did it to me" (Matthew 25.40).

Healing the whole person

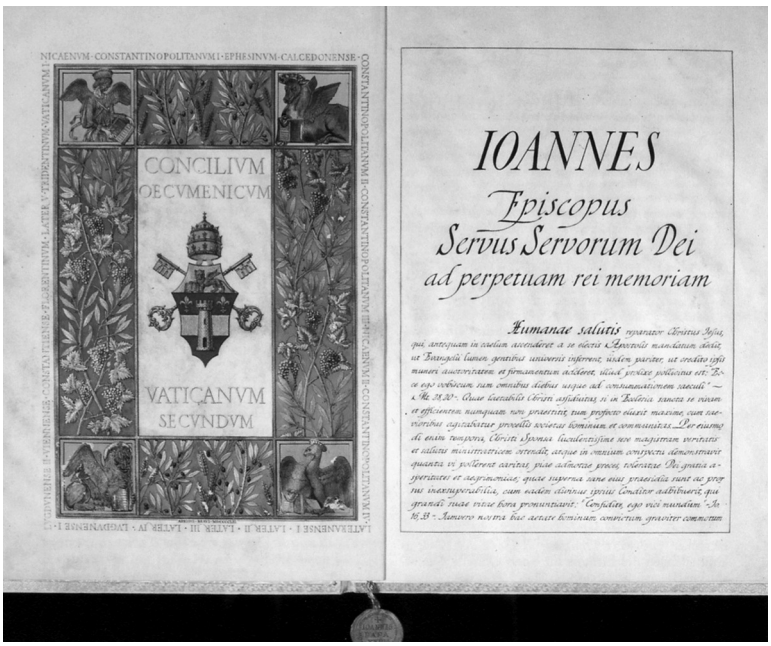
5. *Secondly,* the healing ministry of Jesus is total and comprehensive in scope; it is directed to the health and well-being of the *whole* person – in all its dimensions (physical, spiritual, mental, emotional and social). The healing ministry of Jesus leaves nothing "untouched" and therefore "unhealed" in a person. Like Jesus, the Church is solicitous of the well-being of the whole person. Like the "Divine Healer" she recognizes there are many different types of human suffering that can afflict humanity: sickness of the soul caused by personal sin; sickness of the emotions and the psyche caused by psychological hurts and traumas of the past; sickness of the body caused by physical disease or accidents; and even sickness in the social fabric of a people. Thus, the healing and health ministry of the Church encompasses the entire range of possible human afflictions; her ministry seeks nothing less than the total liberation and well-being of the human person.

Signs of the coming of God's Reign

6. *Thirdly,* the ministry of healing signals an unprecedented "in-breaking" or "coming" of the Reign of God in the very midst of humanity. Whenever Jesus cured the blind, the lame, the leper, the paralytic, it was always a tangible sign that the Reign of God was near. This explains why his ministry of healing was so central in proclaiming the Reign of God. Like Jesus, every Christian is called upon to become a healer and thus, for one's neighbour, a sign that God's reign is close at hand. The healing ministry is an attempt to remove every form of suffering and alienations that may still prevent a person from surrendering more completely to God, and an expression of the loving initiative that he is forever taking on behalf of humanity.

The mystery of suffering

7. There is yet another faith dimension in the mystery of suffering that should not be overlooked. While pain and suffering are to be relieved at all cost, when accepted in faith suffering does have redemptive value. When suffering is seen in light of the Gospel, "one is able to grasp something of its salvific meaning"[3]. Suffering is always a trial – sometimes a very severe trial – yet Catholics believe that united in solidarity to the sufferings of Christ, one's sorrows and wounds enable one to share in the saving mission of Jesus Christ.[4] In his Apostolic Letter *Salvifici Doloris,* Pope John Paul II puts it clearly: "In bringing about the Redemption through suffering, Christ has also raised human suffering to the level of the



Redemption. Thus each person, in his or her suffering, can also become a sharer in the redemptive suffering of Christ".[5] There is support for this belief in Saint Paul: "I rejoice in my suffering for your sake, and in my flesh I complete what is lacking in Christ's affliction for the sake of his body, the Church" (Colossians 1.24).

This does not mean that God takes pleasure in human pain and suffering. Nor does it mean that Christians are to be passive in accepting suffering and not to strive to alleviate or eradicate it at its source. Indeed, "part of the plain laid out in God's providence is that we should fight strenuously against all sickness and carefully seek the blessings of good health".[6] God took no delight whatsoever in Jesus' affliction, nor does he derive any pleasure in any human suffering. It was not the humanity when he suffered and died that pleased his heavenly Father. Wherever this is the case, as it was with Jesus, there is an "active endurance" of suffering, not passive acceptance.

Praying for those who are sick or suffering

8. Christian prayer has always been closely associated with human suffering – and rightly so! There seems always to be a spontaneous spiritual affinity between the two. The sick person's desire for healing in both deeply human and good, especially when it takes the form of a trusting prayer addressed to God. The Book of Sirach is explicit: "My son, when you are ill, delay not, but pray to God, who will heal you" (Sirach 38.9). During his own ministry, large

numbers approached Jesus – either directly or through friends and relatives – seeking the restoration of their health. Jesus was always deeply "moved" by their petition, often commenting on their faith, as when he says: "Your faith has made you whole" (Mark 10,52). On other occasions, by contrast, disbelief and a lack of faith prevented healing from taking place (cf. Mark 6.5-6). This relationship between prayer and healing remains a mystery. The lack of physical or emotional healing is not a sign that one's prayer is in vain or that one's faith is insufficient. It is simply a way of putting one's ultimate hope in the Lord. This is why the Christian community has never ceased to ask the Lord for the health of the sick. In her ministry, liturgy and the Anointing of the Sick especially, the prayer of the Church is both trusting and emphatic: "Heal them, O Lord, in body, in soul, and in spirit, and deliver them from every affliction".[7]

Respect for human life and dignity

9. One of the hallmarks of the healing and caring ministry of the Church is a deep respect for human life and dignity. Human life – from its very conception to its natural death – is a gift beyond all measure. Each human being, created in the image of God, has incalculable worth and inherent dignity. As such, Christians are to treat life as a most precious gift. This gift must be respected, safeguarded, and cared for, especially when life is weakest and most vulnerable. The dignity of the human person also requires Christians to respect and honour good health and well-being, and to reverence their bodies, minds, and relationships. In a profound sense, therefore, those engaged in the ministry of health and healing are called *ministers of life.*

This service to life requires fidelity to the Gospel and to the moral teachings of the Church. While the biomedical sciences offer glimpses of promising developments for the cure of serious and distressing diseases, they not infrequently present serious problems in relation to respect for human life and the dignity of the person. Not all that is technologically feasible is morally admissible. In society today, there is a strong temptation to treat life as but another commodity, something that can be used for other purposes. Commodities are valued only for the price they can command or the uses to which they can be put. Not so where human life and health are concerned. These carry an inherent dignity that is God-given and cannot simply be reduced to a utilitarian assessment. They are ordained to a person's true dignity and integral good, in conformity with God's plan and will. Illness may seem to rob people of dignity, but a patient's intrinsic dignity is never diminished.

Health-care justice

10. The healing and health concerns of the Christian community are not limited to, and much less exhausted by its focus on the health of individuals as such; it extends also to the physical and social environment in which the community lives and works. Here too, there is what might be called "collective" or "societal" suffering and pain. What this means is that every Christian must become an advocate of justice and help redress those unjust social structures that cause undue suffering to some groups of the general population. Working to promote health and well-being is not only about curing symptoms; it also means confronting the social and political causes of suffering and injustice. Today, for example, the causal relationship between poverty and poor health is increasingly recognized. The creeping privatization of health care in Canada is also fraught with dangers, as when health care is viewed more as a profit-making business than a compassionate response to human suffering and illness.

Specifically, health-care justice obliges a society to provide all its citizens with an appropriate level of health care. Maintaining both universality and the accessibility of comprehensive health care remains a prime objective of health-care justice. The grounds for deciding who gets health care cannot be based on merit, social worth, or the ability to pay. Everyone has the right to health care. Good health for all, understood as physical, emotional, spiritual and social well-being, is an essential core value. If the legitimate needs of all citizens are not met, the whole fabric of society suffers. A basic moral test of any society is how the weak and poor in its midst are treated. There are several groups in Canada who still have significant difficulty in finding suitable access to health care, not only the economically poor, but also those persons living in the more rural areas of the country. There is also a disparity in the way some of these groups have no readily available professional doctors and nurses, sometimes no clean water, let alone easy access to advanced diagnostics and specialized care. They often must be taken to medical centres far from home. We believe those who suffer must never be left alone. We also believe that health ministry is best conducted and satisfied by those closest to those who suffer.

Global solidarity and communion

11. In addition to the above, the faithful are called to a global solidarity in their health and healing ministry. If this ministry, like charity, begins "at home" here in Canada, it does not stop there. Christian compassion must extend – and extend effectively – to the suffering community around the world and to the plight of those millions in other countries and other continents who suffer from the ravages of war, hunger, drought, malnutrition,

HIV/AIDS, and the scourge of poverty brought on in part by unjust trade agreements. Together, Christians must find ways to assist and bring relief to those who suffer around the world. Without this sense of global solidarity, Catholic health and healing ministry will be found wanting. Love and compassion for the sick and the afflicted here in Canada must reach unto the ends of the world.

II. CATHOLIC HEALTH CARE SERVICES

We would now like to address the concerns of those who are professionally engaged in Catholic health-care services. There are those in the Christian community who have taken up health care as a vocation and a profession: physicians, nurses, physiotherapist, radiologists, pharmacists, chaplains, and countless other professionals and volunteers. To all these, we wish to extend our deepest heartfelt gratitude and appreciation for their dedicated and untiring service. We also wish to express our deep gratitude for the work being done on the national level by the Catholic Health Association of Canada (CHAC) and by its regional and provincial counterparts, as well as by the many Catholic health care institutions across the country.

A crucial juncture

12. Today, Canadian Catholics stand at a critical turning point in their health-care services. During the past few decades, significant changes have occurred in society, the Church, and health care. These changes, which have a direct bearing on the future delivery of Catholic health services and programs, represent both challenges and opportunities. We believe this is an opportune time to reflect on the response of the Church to these new challenges. Canadian Catholics face the increasing departure of women religious from the sponsorship and operation of hospitals and long-term care institutions which they founded, nourished and directed, first in Quebec and then across the country. As well, issues of the sustainability, identity and leadership of Catholic health care in a pluralistic society must be addressed. With growing financial constraints, government health-care reforms, increasing accountability demands, new technologies, and bioethical issues at stake, Catholics must be creative to ensure that the Church's distinct voice, presence and mission are maintained in this important field of health care.

New challenges and opportunities

13. Health care today has taken on new orientations and services. While hospitals remain an important reference in any health-care system, long-term care needs and facilities are increasingly in demand. Today, health care reaches out beyond the walls of publicly funded hospitals and is becoming increasingly community-based. It entails care for those who suffer from prolonged illness and those who die at home. It includes care for family members and the homeless; care for the needs of the elderly, the lonely and shut-ins; for those who are handicapped, addicted or who suffer from dementia. Nor must Catholics forget the caregivers who need pastoral assistance, faith formation and support. Good stewardship recognizes that caring for the caregivers has a direct impact on those receiving care.

More than ever, all hospitals and long-term care institutions must be experienced as beacons of hope, centres of warm welcome and excellence, where compassion, holistic care, ethical reflection, and faith-driven leadership are palpably and conspicuously in evidence. This is precisely where Catholic care-givers can and must make a difference. This is where their voice, their presence and their advocacy role on behalf of the sick can make a distinct and altogether indispensable contribution to the existing Canadian health care system. Like the "inn" in the parable of the Good Samaritan, health-care institutions must be havens where even the marginalized and disadvantaged are admitted and find care.

The increasing role of the laity

14. Over the years, the responsibility for Catholic health-care services has increasingly shifted to the laity. This is a source of real hope since many lay persons have a sincere desire to serve, and possess the necessary skills, enthusiasm and dedication to take a leadership role in these new directions of Catholic health care. The laity at large, including youth, must be encouraged to become better informed and interested in all these new aspects and challenges of Catholic health care. The commitment to develop faith-based leadership programs in this area is of vital importance. Lay leadership in health care must be diligently recruited, fostered and strengthened. Only when Christians are so empowered can they hope to preserve and promote the sacred legacy they have received from the past. Every Christian member of the community must therefore become better informed about the expanding areas of "outreach" in the health-care system. Where possible, depending on one's gifts and talent, members of the community must be encouraged to embrace health care as a vocation and to assume greater responsibility in this field. It is at the local community level that this call to greater involvement in health care can best be heard and encouraged. In every parish and diocese, greater awareness of the health and healing needs should be fostered. Those already in the health-care profession must be given greater support, encouragement, pas-

toral assistance, and faith formation.

A faith-driven mission...

15. Catholic health care, today as in the past, has a distinct mission and contribution to make in the nation's health and health-care services. The basis for this is the healing ministry and compassion of Jesus. When this faith convictions is sufficiently reflected upon, is thoroughly lived out, and is granted sufficient public exposure, then the identity and mission Catholic health care can never be in doubt. Commitment to health care will continue to make a "difference" in the general scheme of things. This difference stems from the fact that faith permeates and imbues the "special quality" of Catholic health care services and the manner in which these are professionally managed, conducted, and delivered. The hallmark of Catholic health care is conspicuous in several respects: a deep respect for the dignity of every person; just and appropriate treatment afforded to everyone without distinction; spiritual and religious care; ongoing reflection on the ethical questions of the day; compassionate end-of-life care; and a readiness to reach out to the vulnerable and sick in society, who are frequently left behind and are least able to fend for themselves. The Church brings her religious faith to bear on all these aspects of her health and healing care.

...In close partnership with others

16. Catholic health care does not operate alone or in isolation. It seeks ways to collaborate closely with other faith-based institutions and other health-care organizations where Catholics share common values and goals. United with fellow Christians and believers from other faith groups, Catholics can address the flaws that mark the public health care system and bring about meaningful policy changes at the local, provincial and national levels. A good example of this is the collaboration that has been involved with the Ecumenical Health Care Network (EHCN) and its introduction of the notion of "covenant" in the final report of the Romanow Commission, in order to provide a clear statement of the values and objectives of Canada's publicly funded health care system, as well as a set of guiding principles for policy makers, health-care managers, and health providers.

Conclusion

Taken together, the above dynamic principles and constitutive elements are a "living" testament of the ongoing commitment of the Church to health care and ministry. "Let us go forward in hope", Pope John Paul II urged at the onset of the new millennium. We do have reason to hope. Yet the credibility of Christian hope – and therefore of the Church's health and healing mission – comprises two elements: word and action. Words must be supported by action. Matthew 25.36 captures this dynamic well: *"I was sick and you took care of me"*. The credibility of Catholic health ministry and care ultimately stems from the dedication of all those caregivers who risk and give their lives to this service. This is what makes them so *believable*. They are not content merely to utter nice words. They *keep their word* by caring effectively for the sick, the afflicted and the poor.

THE PERMANENT COUNCIL
OF THE CANADIAN
CONFERENCE OF
CATHOLIC BISHOPS

Notes

[1] JOHN PAUL II, *Message for the 10th World Day of the Sick,* 11 February 2002.

[2] Canadian Conference of Catholic Bishops, *NewHope in Christ: A pastoral message on sickness and healing*, 1 September 1983, p. 10.

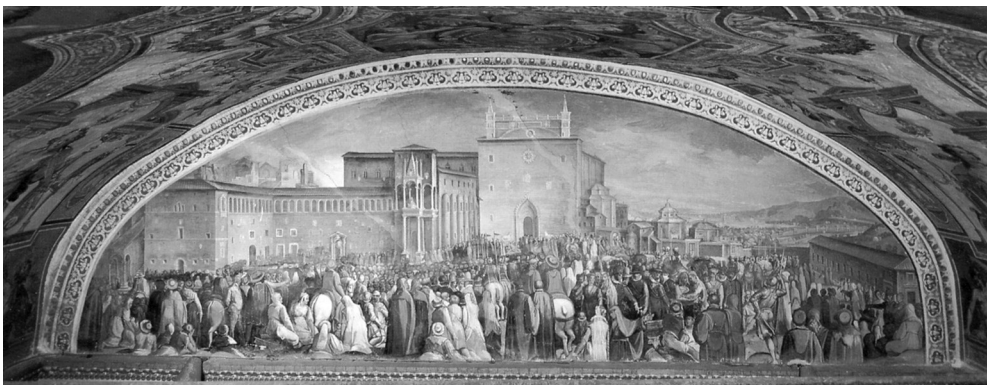
[3] JOHN PAUL II, *Message at the 12th World Day for the Sick,* 11 February 2004.

[4] Cf. *Catechism of the Catholic Church,* no. 1521.

[5] JOHN PAUL II, Apostolic Letter *Salvifici Doloris,* no. 19.

[6] *Rituale Romanum, Ordo Unctionis Infirmorum eorumque Pastoralis Curae,* no. 3.

[7] *Rituale Romanum, Ordo Unctionis Infirmorum eorumque Pastoralis Curae,* no. 75.



The Health-care Professionals: we Need them and they Need us

Presentation

Health-care professionals are a numerous and necessary category. In Spain there are over a million health-care professionals. They are all those people who practice their profession in the world of health and illness. We all know what they mean for sick people and their families, and what they represent in the health care world in the achievement of the goal of educating people in health and promoting health, preventing illness and caring for and treating the sick.

This is a category that needs help. The health-care professionals need, and feel that they need, to be listened to, nearness, support and help so as to live out their work in a healthy and health-inducing way. Many of them are wounded healers because of the stress and strain that is generated in them by the work that they are engaged in.

This category is a concern of the Church. Taking care of those that take care of the sick is an indirect way of caring for sick people themselves. The Christian community feels the imperative necessity to take care of those who care for and treat, to welcome and accompany health-care professionals, to recognise their work and the charism of healing, to listen to their difficulties, and to know about the possible crises connected with their work.

We owe them acknowledgement and gratitude because of the work that they perform, we must pay attention to them, we must listen to them and we must enrich ourselves through the contribution that they offer so as to promote the welfare of a Christian laity that is involved in the world of health and health care.

With this material of education in the faith we *intend*:

To draw near to the contemporary reality of health-care professionals: who they are, what they do, what their goals and tasks are, what their values and attitudes are, the challenges that they have to face, what their needs and concerns are.

To promote and develop the relationship between the Christian community and health-care professionals. To give an impulse to dialogue and mutual collaboration. To reconsider and strengthen the attention, the care and the training that the Christian community offers to these professionals.

To promote a significant presence of Christians in the world of health and health care, to provide an impetus to their mission and witness, and to strengthen the Association of Christian Health-Care Professionals in Spain, a body that was officially approved by the Bishops' Conference of Spain on 19 November 1993.

The contents of this paper are organised into three parts: the first part, which is the longest, draws us near to the health-care professionals so as to know them, in fundamental terms through their own testimony; in the second part we address the relationship that exists between the Christian community and these health-care professionals; in the third part we dwell upon Christian professionals and their role in the world of health and health care and we offer as an example the integrating framework of the Association of Christian Health Care Professionals. Lastly, we bring together a selection of texts from the Magisterium of the Church which refer specifically to health-care professionals, this is followed by a prayer and a summarising bibliography.

The people for whom this paper is intended are nurses and their families, Christian communities and their teams of pastoral care in health, the services that provide religious assistance, the health-care religious congregations and other congregations, health-care and socio-health care institutions, and in a special way all health-care professionals whether they are Christian or otherwise.

1. The Health-care Professionals

The health-care professionals make up an immense and diverse category. In Spain there are over a million of them. They are all those people who practice their profession in the world of health and illness: medical doctors, nurses, physiotherapists, psychologists, chaplains, laboratory technicians, auxiliary staff who work in clinics, social workers, pharmacists, managers, administrative staff, porters and such figures, maintenance staff…They are all equally important and all of them and each one of them is absolutely necessary. If one part does not function, this is felt by all the rest of this body. A patient cannot undergo an operation if the cleaning staff has not cleaned the operating theatre in a suitable way and if the nurses and the auxiliary personnel are not well trained. The pharmacist ensures that the patient has available to him or her drugs and medicines; the staff in the kitchens provide the food that is necessary; and thanks to the people in the laundry the sick person and the professionals have clean laundry and so forth.

A patient looks for healing from his or her medical doctor. He or she expects the friendly hand of the nurses who is taking care of him or her, the loving sentences of the cleaning lady, the sensitivity of the orderly when he arranges his or her invalid body in his or her bed and takes him or her down the long corridors of the hospital. The patient relies on the fact that today it will be easier to ingest his or her food, that the air will fill his or her lungs, that his or her pain will go away, and that that arm or that leg which does not want to move will begin to obey its owner. Inside himself or himself, and often without knowing it, the patient hopes that the medical doctor who has been entrusted to him or her will know how to tell him or her what is happening to him or her

* Data elaborated by the department of Health Pastoral Care (Spain) in preparation of the World Day of the Sick 2005.

and provide him or her with the remedies that can alleviate his or her state. The patient yearns for all the professionals that are thronging around him or her to see him or her as a person, as a human being.

Drawing near to the world of health-care professionals

As a first step we draw near to the world of health-care professionals so as to know about their work, about the services that they provide to the sick and to society, about their values and attitudes, about the challenges they have to face, about their needs and expectations, and about their sufferings and their joys. Let us listen to what they themselves have to say to us.

The tasks of health-care professionals

– In the health centre where I work patients arrive on their own or accompanied by a family relative. The patient's illness, generally speaking, is not grave but for the sick person that illness is very important because it does not allow him or her to lead his or her normal life in a normal way… At times the patient has certain symptoms that lead me to expect that he or she is afflicted by something more serious. I send that patient to have a number of tests, analyses, x-rays…Sometimes I am happy to see that these suspicions have not been confirmed, at other times, on the other hand…With a certain frequency I visit AIDS patients in their homes. These patients join to the physical pain of an illness, which they know could be fatal over a period of time of varying levels of duration, the pain of social rejection which, fortunately enough, is now declining on our society. More than anything else they need to feel loved and they ask me to accept them in their illness and to console them. (A family doctor).

– I perform my work in a clinic or at person's home or anywhere that I have to help someone. I always do things so that they receive from me a personalised treatment. Every day, before beginning my work in the clinic, I engage in ten/fifteen minutes of 'health school', where we speak about any subject connected with its concerns: current news, donations, last testaments, tolerance, preparing for death, dealing with mourning, or the providing of information to terminal patients. Once a week I go to the school to address various subjects with children and their teachers: good diet, aesthetic care, hygiene, relaxation techniques, self-presentation and interpretation. (A country doctor).

– In the emergency department we have to work with people many of whom are in extreme situations because of their terminal state or because of their personal, family or social situation. People who suffer not only from illness but also from fear, from having been abandoned, from loneliness or from marginalisation. Some arrive with problems of alcoholism or drug addiction, others with mental illness, in acute or violent crises. We have to take care of the victims of attacks, and abandoned elderly people, sick people worried about their health and afflicted by pain, even though their lives are not at risk. (An auxiliary worker in a clinic).

– I love my work. Because the family relatives of the patient have to go out so that I can clean the room this allows me to ask the patient how he or she is; what happened to him or her, or to speak to him or her about something. While I am cleaning the room I see medical doctors and nurses suffer when they are unable to do anything in certain cases when no remedy can be found. They do well to have courses for the management of mourning and to make mourning easier for people. Poor people, on the other hand, could not do this. I like my work but I realise that we do not know how to do it well, that we are too 'tense', and that all of us who wear a uniform like to have the attention of patients and their family relatives…We correct people or provide them with information in an unwilling way as though we were always burdened with work or irritated by visits. (A cleaning lady).

– I wander round the ward taking care of people here and there, understanding their pain. I help parents not to involve children in a big lie but rather to know how to enjoy them until the end and how to allow themselves to express all their affection for them. When a child dies and after attending to the parents I go to their homes. This is because when a child dies the parents feel it deeply and suffer at the loss. I speak about death with naturalness, as a part of life, and I remind the parents of the importance of accompanying this experience with sensitivity so as to foster the management of the mourning of the other siblings. I believe that it is better to communicate the truth in a simple way, that it is necessary to express one's feelings and to allow the child to tell

everything that he or she has inside him, answering in a truthful way to all his or her doubts. (A child psychologist).

– In the neonatal service of the hospital complex there works a group of professionals who have years of experience. Helping many children born prematurely or sick newborn children has enabled us to discover the need to work on their quality of life: to treat them in the best possible conditions, to help parents to accept their own children, and to heal the minds of our professionals who at times are closed up within the circle of their lack of success or suffer from a lack of belief that one day they will see these children lead a happy and full life. (A paediatrician).

– I am a lecturer at a nursing school. The work with young people is fascinating. I teach them that to hold a dying hand, a loving gesture and a smile are more important than all possible medicines. I teach them to be competent and dedicated servants, the promoters of the humanisation of assistance, the defenders of the rights of sick people, workers in a healthy society and witnesses to Jesus in the world of health and health care. In order to teach all of this I myself have to live it, and this is not always easy. I, too, have my limits, and at times I need hope

and enthusiasm in large doses. (A lecturer in a nursing school).

The meaning and purpose of health-care professionals

Health-care professionals provide a vital service to society: that service that is to say, of knowing about, diagnosing and treating illness, curing those that are ill, promoting their health and educating them so that they can have better health. Health-care professionals are dedicated to the carrying out of this task that society has entrusted to them.

Ways of understanding the medical profession during the course of history have been different and they have had their consequences in a variety of circumstances. At the beginning of the twenty-first century it is advisable to remember what the real *purpose of medicine* is. This purpose was emphasised in a perceptive way in a report issued by the Hastings Center: the prevention of illness and the harm it causes, and the promotion and maintenance of health. The relief of pain and suffering caused by illness and suffering. Caring for and curing sick people and looking after those people who cannot be cured. The avoidance of premature death and acting for a death that takes place in peace.

Over the last twenty-five years my concern as a professional female nurse has been to learn the art of caring because the central axis of nursing is the practice of care. To care for someone means to accompany a sick person in a suitable way, to come to know about his or her values and beliefs, his or her needs, and his or her resources. To care for people means to help patients to be autonomous, to fulfil their own lives, to protect themselves on their own. To care for people means to accompany patients along their journey in a way that respects their rhythms. To care for a sick person is a responsibility; it is an obligation dictated by justice. However, this is not an easy task because it involves, with tact and respect, knowing about their lives, their problems, and their interior worlds. This task requires great qualities as regards listening and paying attention, silence, tact and respect. (A female nurse).

A *professional vocation* that is authentically convinced of its own *responsibilities* is absolutely necessary. This vital impulse is the *moral duty* to act at the service of a human being as a primary duty, to help that human being in relation to his or her need for healing and treatment. This ethical duty is similar for everyone because it is the core of the health-care professions. However, the levels of need are not the same. Each person must discover the true sense of their vocation, what it is supported by, and with what nourishment it is strengthened, so that that person does not fall into discouragement and stress. In my case, with the passing of time a process of discernment, maturation and on-going choice was produced, which has still not yet come to an end. Life led me to the practice of medicine, and above all medicine connected with assistance, but also to dedicate major work to the formation and development of bioethics. I feel this to be a gift and a task, a privilege and a commitment. In my case, to believe does not exempt me from thinking with rationality and prudence in the field of morality, even if I thereby run the risk of falling into error. (A medical doctor who is an expert in bioethics).

I study to serve, to be a good professional, and to exploit my possibilities to the utmost. It is my obligation to assist those people who place their lives and their suffering in my hands in a better way every day, not for vainglory but in order to improve, to the extent that this is possible, the use of the resources that we have available. When I am not successful in my intentions, I try not to feel opposed or disturbed. And when I am successful I try not to be haughty and to make sure that such success does not distance me from God. (A resident internal medical doctor).

Down the years I have broadened my knowledge in the field of my specialisation but I have had to learn other forms of knowledge and capacities that were not taught to me: the mechanisms for forming and maintaining a relationship with a sick person; how bad news should be communicated; how accompany in pain and joy or to comfort those who have need of comfort…(An internist medical doctor).

The challenges with which we are faced

The challenges that face us are many in number and diverse in character. In his work 'The Health-Care Professions at the Crossroads: Challenges to the Health Professional in the Twenty-first Century', Juan Viñas states: 'we live in a world that is in a state of constant and rapid technological, social and cultural change. We health-care professionals must know and address the challenges that this change raises for us, for our health, for our lifestyles, for our life projects and for our search for happiness, and we should do this so as to offer patients and their family relatives care of high quality, taking into account the overall character of the person and his or her life needs with professional skill and expertise'. And amongst others this author points to the following challenges:

– To link in the right way specialisation with a necessary overall vision of the person. First and foremost, there is the overall vision of the person and his or her needs and then there is specialisation. Only in this way can we understand a sick person and help him or her with greater efficacy.

– To overcome scientific positivism. This does not explain love, human relationships, the emotions, sufferings, feelings, beliefs and doubts. There is something more than materialism. To believe in the welfare of humanity is not irrational but helps to give meaning to life and to our happiness.

– To face up to illness and death in a different way, as a part of the life cycle.

– To be prepared to provide information and above all education to the sick person, to his or her family and to society in general.

– To struggle for a better form of medicine, to use resources well without wasting them and to ensure that assistance reaches everybody.

– To prepare ourselves to offer patients of other races, cultures, religions and customs an assistance of high quality.

– To make the health-care system sustainable and one of

high quality. We must use the resources that are available to us in a better way and take part in those organisations that are dedicated to the improvement of the quality of assistance, bearing well in mind that each sick person is an end in himself or herself, whether or not he or she is receiving a curative treatment, whatever the resources that he or she may cost, whether or not he or she returns or work and being useful to society.

– To dedicate time and resources to updating ourselves as regards all the aspects, both technical and human, of our profession.

– To provide an account to society of our activities and about the resources that society has placed in our hands.

– To help in our capacity as citizens to improve society. Our conduct and the example that we set through our lives outside work have an impact on other people.

The Needs of health-care professionals

It is obvious that health-care professionals are necessary. In the Book of Sirach we read: 'And give the physician his place for the Lord created him; let him not leave you, for there is need of him' (Sir 38, 12-13). In their turn the health-care professionals need, and feel that they need, to be listened to, nearness, support and help in order to live out their work in a healthy and health-inducing way. Many of these people are wounded healers. What now follows is an analysis that a group of professionals have made of their respective situations:

– Today we live in a situation characterised by a crisis of values, uncertainty and worry, that has been provoked by the profound changes that are taking place in the progress of the medical sciences, in the relationships between health-care professionals and patients and the health care institutions that employ them, and in the impact of new administrative, legal and political directives.

– We are afflicted by frustration and disappointment in the face of professional difficulties, and we are dismayed by the advances in science and technology that require constant discernment, a requirement that is not always met.

– We feel powerlessness within a society that asks the impossible of us, that is to say to treat everyone and to defeat death as well, and we feel loneliness in a world that ignores, when, that is, it does not despise, what is radically human.

– Even if we health-care professionals are esteemed in a laudable way by the great majority of sick people and their families, nonetheless – and this is a paradox – the level of dissatisfaction, frustration and other painful feelings that afflict a considerable increasing number of us is more than evident.

To sum up: health-care professionals need:

– Relief and suitable channels, given the systematic repression that they must engage in their repeated contact with the suffering of sick people and of their family relatives;

– To counter and compensate for the complaints and claims that they receive from sick people and their family relatives, some of which are due to negligence or bad practice on the part of health-care professionals but many of which are caused by defects in the health-care system, of which health-care professionals are also the direct victims.

– To find a feeling of satisfaction for hard work which does not usually offer much gratification.

Questions

In the UCI where I work there are patients with the same pathology and the same age. The same techniques are employed, the same forms of treatment are administered, but some of these people live and some die. I am beginning to ask myself why such situations exist. It is certainly the case that for some people their hour has come and for others it has not. Some time was needed for me to understand this...We pose ethical questions to ourselves: up to what point should one go on trying to resuscitate a patient? Seven times, as was the case once and the man involved walked out on his own legs and came to thank us? What limits apply in the administration of curative forms of treatment when we know scientifically that they may not be effective and can increase suffering, not so much for the patient, who is sedated, but (and first and foremost) for his family? Why no administrative palliative cures? (A female nurse).

When in the emergency department I see so much pain, so

many questions without an answer, so many defeated families, so many neglected lives, and at the same time you see yourself immersed in a hospital complex that is so very large, so cold, so depersonalised and demotivating…you pose very many questions to yourself. (A male nurse in an emergency department).

The Stress and suffering of health-care professionals

What stresses and causes suffering to health-care professionals, according to what they themselves say is the following: stress, which is the consequence of work overload; personal powerless to change the environment; a lack of human and material resources; a lack of support from the management of the centres where they work, and the low level of appreciation of the work that they perform; problems at work; a lack of enthusiasm; the constant changes in rules and regulations which make it difficult to work well; the lack of training and resources for the practice of their profession; being in constant contact with a world of suffering and pain, and so forth.

– I find a great deal of difficulty in working in a rural environment. There are various reasons for this. The shortage of health care and social means with which to face up to the problems that exist. The blindness of the health-care hierarchy towards the problems of health-care professionals in the rural area: it does not know about our needs in a direct way and does not have a direct relationship with us; the quality controls are totally unreal: the incentives are not fair; on-going training does not exist…but above all else there is the cost of pharmaceuticals. The economies that are made with a great deal of effort and dedication are not appreciated, for example the exhaustive and continual care for, and following of, chronic patients in their homes, thereby avoiding transferring them to hospital. My real problem is my loneliness in the performance of my work. I am unable to see to what point I should involve myself. This has repercussions for aspects of my life, principally the life of my family and my friends. (A country doctor).

– A hospital is a very special undertaking; it functions three hundred and sixty five days every year, morning, evening and night. People are the basis of a hospital. As people they can make mistakes, at times mistakes that are inevitable however much all the possible precautions have been taken. When this happens great anxiety is generated because of the fact in itself and because of the approach to be adopted towards the professional concerned. The complexity of the daily problems obliges you to take rapid decisions which, in hindsight, make you have strong doubts about whether the decision you took was in fact sensible. But a hospital is like that. A complex labyrinth where the sick person is the most important element, and it is precisely because of this, because we are dealing with human lives, that the complexity and suffering of such management reach at times levels that are difficult to explain. (A manager).

– I suffer when I make mistakes at a technical level or if the surgery goes wrong or a part of it goes wrong because of a breakdown in the machinery; when patients are treated without the respect that is due to them; when with overbearance some professionals have their family relatives or their friends jump the queue ahead of sick people who are suffering, are waiting and see this injustice; and when I understand that a large number of professionals do not appreciate themselves, lack self-control, are not at peace and are losing their self-esteem. (A radiological technician).

– I am struck in a special way by the death of young people and the pain that I see inside the hospital. The PROSAC bulletin and my experience in a grass-roots Christian community have helped me a great deal. (An internist).

– One of the most difficult moments for me is when the inexorable final moment of a terminal patient makes me feel a failure as a professional of medicine. I share my powerlessness with the pain of the family. After a fashion, I feel a part of that family and feel that the sick person is my neighbour. (A family doctor).

– Today in this environment one breathes the temptation to throw in the towel, to give everything up. One notices the tiredness that in some people is more than evident. For too long one has been fighting against the chronic character of mental illness and the psychiatric hospital. Patients and professionals are tired of the fact that mental health continues to be the object of discrimination in medical assistance and in the allocation of socio-health care resources. They are discouraged by having to abandon projects and possibilities that perhaps would have made the lives of people more worthy. They are frightened that efficacy and the efficiency are being transformed into the sole indicators by which to confer value on the quality of a life, whether the life of a patient or the life of a professional who takes care of that patient every day. (A psychologist who works with the mentally ill).

The joys and satisfactions of health-care professionals

The thing that most enriches health-care professionals – as they themselves maintain – is contact with the sick person and his or her family, and the same is true of their witness which helps them to contextualise their own problems and exhorts them to go on working with joy. Of equal importance is to live the profession with vocation, to be aware of work that is well done, as well as a spirit of camaraderie and sound attitudes amongst the various health-care professionals when they exist.

– Like many sick people I feel the anxiety and the suffering that are caused by uncertainty about what will happen tomorrow. I feel their struggle, which is at times heroic, for life. I share their efforts and their desperation. I strive to draw near to them with my soul and to transmit my energy through my hands and my words. I rejoice at their joys. Making myself seen and presenting myself to them as I am, with my virtues and my defects, has made drawing near to them possible. I have learnt that hope is a very great pharmaceutical and affection is the best balsam there is for moments of misfortune. I have understood that listening is the best remedy for examples of negligence and errors and I have re-

alised that I am a human being like they are. (An oncologist).

– Our profession offers us the possibility to experience encounter with a human being in his or her fragility, and in the final analysis the possibility of encounter with the best of oneself in one's commitment to alleviate the sufferings of other people. Contact with the sick person and with his or her family, like his or her witness, help to contextualise problems and encourage a person to work with enthusiasm. (A medical doctor).

– The patients teach me new things every day; they help me to grow and they never stop giving me a smile, a look, an embrace…They do not tire me; on the contrary: they stimulate me. I love my profession; I look at it every day with more respect and I practice it with dedication and passion. I am grateful about being where I am and doing what I do: bringing love, a great deal of love. Only in this way can one achieve 'small victories' which for me are 'great' victories: drawing out a smile, alleviating loneliness, calming a pain, holding a person's hand at the moment of passing over to the other life, and sharing fears that always turn out to be less frightening than they appear. (A country medical doctor).

– I am passing my last night with my colleagues, with whom I have shared so many things and from whom I have learnt so much. I am grateful for the camaraderie that I have experienced in the UVI and for these years of work which have helped me to discover what is essential in life, the essential reality of human beings, of myself, and of other people. This helps me to go on sharing my life and giving hope at home, in the street, and in the hospital. I will never be able to forget the expression on the face of Marisol when she awoke after many days of fighting against death. I had spent many years speaking to her, uttering simple sentences. Now her eyes transmitted gratitude and love. Her expression gave me peace and made me feel good. (A female nurse).

Health-care professionals also fall ill

Health-care professionals also live through the experience of illness and vulnerability in their lives, in the lives of their family relatives or that of their colleagues. How does it afflict them? What does it mean for their professional behaviour?

– Some months ago I was diagnosed as having a tumour at the fourth stage of development. I then began a pharmaceutical treatment because an operation was not indicated. This is something that is difficult to accept for a surgeon but there was no other effective solution. With a hopeful approach to the future, accompanied and surrounded by people who love you, some of whom are also unknown to you, and remembering the verse of Teresa d'Avila – 'let nothing trouble you, let nothing frighten you, who has God lacks for nothing' – we began, albeit not without some doubts, the pathway towards the Mystery. When my physical condition allows me to do so I continue my activities involving assistance, teaching and research as a surgeon, except on the days when I take pharmaceuticals. As a sick person I have experienced the fragility of my body and my mind and I feel more united to those people who through their treatment and suggestions at the level of therapy strive to secure my recovery or at least to reduce my symptoms. During these moments of difficulty the words of the Garden of Olives are of comfort: 'let your will be done'. (A surgeon).

– I am a female nurse and if I were to be born again I would choose the same profession. When I decided to study nursing the only thing that I had clear in my mind was my desire to be useful to other people. I worked for four years in the internal medicine department. Because I was young and enthusiastic about my work those were the best years of my life. Not only did I care for sick people but I also made great friends. One day I fell sick. They diagnosed me as having a peripheral polyneuropathy. I then met the Christian Brotherhood of Sick People and Invalids, in which I discovered that however great the limitations of a sick person or an invalid, his or her capacities are much more important. I discovered also that the most important thing is personalised treatment for the patient and listening to that patient. For this reason in my work I try to help the sick person so that he or she is 'the protagonist of his or her own recovery'. (A female nurse).

– I would like to express to you my deep gratitude for the care that you gave me during the period when I was in hospital. That was my first experience as a hospitalised patient. I experienced it with intensity and with serenity of spirit. I remember the staff that looked after me when I was in the resuscitation unit. I was able to experience your professional skill and expertise, your approach and you aptitudes. You confirmed for me the importance of something to which sufficient value is not given: readiness to help and good will in one's work. Even though at times your dejection, the conflicts in the world of work or personal problems worry you or oppress you, you know how to draw near to us with a smile, an expression of helpful welcome and words of encouragement. Faced with immobility and physical dependence I appreciated your hands, both when you attended to my wound and when you acted as a support for me when I had to move. And all this you did with

perfect naturalness and in a way that respected the modesty of another person. Continue along these lines, do not let routine defeat you, do not let discouragement get you down, and may renewed enthusiasm be your vital horizon on your daily journeys! (A medical doctor).

How patients see health-care professionals

My vast experience of being in hospital for many months gave me an opportunity to be a spectator present at a varied parade of professionals. I saw those who:

– Demonstrate great competence or inexperience and uselessness.

– Form a real human and professional relationship or treat you as an object.

– Carry out their work with a will and enthusiasm or unwillingly and with boredom.

– Help each other or withdraw from work and responsibilities and place these on the shoulders of their colleagues.

– Suffer with your suffering, worry about your complications and are joyful when you improve, or do not allow themselves to be involved and pass by.

– See the sick person as a person and treat him or her as such or see you solely as an interesting case or just another number.

– Worry about and take into account the mood changes of the patient, his or her lack of appetite, his or her loneliness, his or her inner suffering, his or her spiritual needs…or do not pay any attention to you or see this as their responsibility. (A patient).

2. The Christian Community and Health-care Professionals

After drawing near to the reality of health-care professionals, we will now ask ourselves what the relationship between the Christian community and the health-care professionals is. Taking as granted the legitimate autonomy that the health-care world should have, we may say that this relationship is necessary to the welfare of the sick person whom we serve and is beneficial to the community and health-care professionals. This relationship can be one of dialogue and of collaboration, of care, of treatment, and of education.

Dialogue and collaboration

The promotion of dialogue and collaboration with health-care professionals is a task of priority importance for Christian communities. It is important to achieve dialogue and collaboration by adopting and cultivating, among other things, the following approaches: trust, respect, openness, the abandonment of dogmatic ways of doing things, of condemnations and of the apportioning of blame, the recognition of one's own limitations, etc.

We will now analyse certain fields in which this dialogue and this collaboration are possible, to be welcomed, are advisable and are necessary, although certainly not easy to achieve.

1. *The promotion of a more responsible culture of health*

Our loyalty to the Gospel leads us to help people to live out their existence in the most human way possible, cultivating health in all the dimensions of a human being. It leads us to ask society about the ideal of man that is expressed in this predominant model of health, which, indeed, is so technical, medicalised and bureaucratised. It also leads us, beginning with faith, to illuminate such very important questions as the defence and care for life; the human contents of real quality of life; health as a responsible task directed towards the overall growth of the person and understood as harmony within his or her environment; the rational consumption of health care services; the Christian meaning of illness; the donation of organs and blood; the human experience of ageing; and the human and Christian meaning of dying.

2. *The promotion of overall assistance for patients*

A patient needs overall care. This assumes awareness of his or her real needs. Patients are people, not things, and their recovery requires intense meetings and repeated dialogue. Recovery does not only come about because of the administration of drugs and medicines. Sick people ask for assistance that is increasingly human, personal, comprehensive and near.

One is not dealing with illnesses but with ill people. Assistance for sick people is becoming increasingly complex in character. We are moving towards team medicine where different kinds of professionals have their own space, namely medical doctors, psychologists, social assistants, and priests, so as to thereby understand the complex reality of man – his somatic, psychological, social cultural and religious realities.

3. *Ethical illumination*

We must disseminate the ideas and reflections of Christian bioethics, that bioethics that assures the dignity of people and defends them against all forms of aggression, use, and manipulation, especially in cases where that dignity is at its weakest: at the beginning of life, during illness, in physical and mental deterioration, and in proximity to death. This obliges us to know and discern the concrete ethical problems that are raised in the health-care world, in relation to which health-care professionals must take decisions. And to know the basics of the question involved in the frontier subjects of life: the day after pill, gene therapy, embryo and adult cells, cloning, the manipulation and use of embryos, care for sick people at the terminal stage of their lives, euthanasia (procedures that are declared and those that take place in silence), and the distinction between means and ends.

4. *Care for people who receive the least assistance*

The need of these people for health occurs in situations of marginalisation, which also imply a lack of health care. These are situations of economic poverty, of social indifference, of loneliness, of old age, of alcoholism, of drug addiction, or situations involving people who are not autonomous or the chronically ill in general. The Church cannot ignore this world of those who are most in need of health. Our offer of health includes a commitment to the most suitable health care possible for these people and their defence against all kinds of social marginalisation. Here, too, we work together with health-care professionals because this is an undertaking that raises their awareness and sensitivity in a direct way. We can work together in a united way not only to treat specific pathologies but also to fight against the causes that give rise to such pathologies

Attention and care for health-care professionals

Within society the Christian community must be the pool of Bethesda (JB 5), that is to say a community that cares for people and cures them. The healing mission of this community has its roots in the Gospel itself, in what God said and did. Jesus is where man is, where the human being in pain is: he went on his way doing good and healing (Acts 10:38). The health that Jesus offers begins with physical health, but it does not stop there but reaches the whole of man in all his dimensions. It is not limited to the body or the individual. It is an individual and communal health; it requires freedom and meaning, and it is placed within the unfolding of values and disvalues.

In the light of the healing model of Jesus it is important to reappraise and strengthen the attention that the Christian community pays to health-care professionals, whose work involves making the source of health present. The Christian community can provide them with attention, care and training:

1. *Drawing near to health-care professionals*

Contact with health-care professionals continues to be the most privileged form of attention paid tow them. It cannot be programmed but expresses itself in the most unimaginable ways and at the most unimaginable moments, and it produces unforeseen results. Readiness to establish contact and to engage in conversation that is not shallow in character are propitious occasions to discover and attend to their personal needs.

2. *Being at their side*

Being at the side of health-care professionals, above all at moments of difficulty and pain, demonstrating an interest in their lives and offering disinterested help, is, today, a simple and gospel-based form of caring for them at a pastoral level. There are a large number of occasions which allow the practice of such pastoral care in the life of a hospital, of a home or of an institution, and in the parish community: acts and celebrations of friendship; festive events; accidents and ill-fortune; the moment of illness or the death of a member of the staff or his or her family relatives, and so forth.

3. *Discovering together the meaning of their action*

Helping them to discover and appreciate the ethical and gospel-based values of their profession and to recognise the charism of their profession (1 Cor 12:9). In their clinical practice, in their bureaucratic work or in their administrative decisions, they can express the values of solidarity and compassion, respect, mutual help, justice, self-giving, and reconciliation.

4. *Supporting them and taking care of them*

Health-care professionals, as people who provide care, should themselves receive care. An increasing number of these people are suffering from professional exhaustion. They are wounded healers who need to receive attention and care. The Christian community, feeling the imperative need to take care of those who provide care, should support health-care professionals so that they can live out their work in a healthy way. The Christian community must accompany them in the exhaustion that comes from their work, listen to their difficulties, their tensions and their stress, understand their possible crises, and offer them the resources so that they can avoid burnout and then recover from fatigue. Health-care professionals have families, life needs, friends, and time for recreation. In order to obtain the necessary personal balance between their profession, their families, their recreation and their personal (physical, psychological, social and spiritual) growth, mere help is not enough. The Christian community must provide them with a major contribution through advice and spiritual support, warmth, and friendship.

5. *Offering them suitable channels and instruments for their overall training*

Health-care professionals need a sound grounding and on-

going training in order to maintain the skills and expertise that are required. They need opportunities for encounter where they can reflect, be trained, pray, celebrate their faith, strengthen the meaning that they feel for the Church and for the care and treatment they provide, as well as their communion with other professionals. The Christian community can provide various kinds of help: places for meetings; the offer of materials for anthropological, theological and pastoral thought about health, illness, dying and assistance; accompanying so as to throw light on the grave ethical problems – which are increasingly complex in character and large in number – that are raised both at the beginning and the end of life; and information on the already existing systems and instruments of training to which access can be gained.

6. *Praying with them and for them and celebrating their service to the sick*

The Christian community prays for and with health-care professionals and celebrates their role and their service to sick people: 'for they too will pray to the Lord that he should grant them success in diagnosis and in healing, for the sake of preserving life (Sir 38:14); 'blessed is he who considers the poor! The Lord delivers him in the day of trouble' (Ps 41:1).

7. *Relying on them*

A trained health-care professional can contribute his or her knowledge, his or her experience and his or her points of view to the Christian community and enrich it in its tasks of educating people in matters relating to health, taking care of sick people and their family relatives, training visitors, offering its views on human and ethical problems, in a word: evangelising the world of health, something, indeed, that cannot be achieved without the incorporation and the participation of health-care professionals

Experiences

The parish

During the years 2004-2005 we have sought to demonstrate the nearness, the gratitude and the support of the parish of 'The Supper of the Lord' towards health-care professionals who care for and treat the sick people of our neighbourhood. The group dealing with pastoral care in health got into contact with the health-care centre and at Christmas we wrote a personal letter to all the professionals who work in this centre which expressed our admiration. This letter was accompanied by a present. This initiative surprised them in a pleasant way and they thanked us. The parish community prays for these professional people during the Eucharist and at funerals. At the time of the communal anointing of the sick we send these professionals the following letter: 'Dear Friends, many sick people whom you care for and treat regularly at your centre belong to our parish. Through their testimony we have come to know about and admire the generous and constant work of health-care professionals who day after day care for the sick of the community and their family relatives with an overall concept of care. Our parish – which accompanies and helps the sick and their family relatives in the neighbourhood – wishes to express to you its gratitude for this service and demonstrate to you its nearness and its support. We know that your work is not always easy, that it is very arduous and tiring. We also know that you experience moments of pain when you fall sick or when one of your family relatives falls ill or dies. On the Sunday of Pentecost, when we celebrate the communal anointing of the sick, we will be thinking of you all. We thank you for your work, for the concern that you demonstrate for the health problems of our relatives and our friends. And we ask the Lord to help you in your valuable and delicate work of caring, alleviating and consoling. We are ready to collaborate with you in anything you think fit for the welfare of the sick people of our community. With our most cordial greetings, the Parish, Madrid'.

Hospitals

In the hospital a large group of Christian health-care workers work with the chaplains of the Service for Religious Assistance. We offer them nearness and friendship. We recognise and appreciate the service that they give to sick people and professionals. Beginning with our jobs, we facilitate contact with sick people and their families. To the extent that this is possible, we prepare a suitable environment for the administration of the anointing or the baptism of newborn children. We collaborate in the management of mourning experienced by families (parents who have lost a child, etc.). We often take part in Holy Mass in the hospital. We co-operate in the celebration of the Day of the Sick. We co-operate in the preparation of the monthly bulletin published by the Service for Religious Assistance, a bulletin that is for all the health-care professionals, the sick and their family relatives. In doing this we are present in the health-care world as members of the Church. The Group of Christian Health-Care Professionals, Orense.

3. Christians in the World of Health and Health Care

There is a good number of Christians amongst the professionals of the world of health and health care who try to live out their faith in the practice of their profession. However, despite the advances that have been made, the contemporary situation presents worrying data. José María Rubio, in his article on 'the identity and the mission of the Christian health-care professional', states in a critical way that 'the presence of lay Christian professionals in the health-care world is on the whole of a low level, not very involved and often unnoticed. To a lesser but significant extent this presence takes the form of witness and is expressed through responsible and well-carried out professional practice, dedication, human treatment, consideration for the dignity of people, and commitment and participation in relation to committees and platforms for the defence of the rights of sick people. In some cases, in truth there are a small number of such cases, this is expressed through explicit reference, through the witness of their lives, to God the Father who loves us and wants the wellbeing of everyone'.

Experience of faith

The faith of Christian health-

care professionals is located within the contemporary debate amongst those people who interpret religion as something that is anachronistic and private, on the other hand, and those people who see it as being of contemporary relevance and necessary to society, on the other. 'For them religion is out of date, belongs to the kingdom of memory and folklore and is inadequate and obsolete, unsuited to advanced countries, ruinous for science, contrary to the practical and positive meaning of life. It is a private thing which does not concern society'; 'it is something to be lived privately, just as someone smokes where he cannot be seen'; 'there are still, however, many Christian health-care professionals who strongly believe that faith is of contemporary relevance and is as necessary as it has ever been: for science to be really at the service of man and progress to be on behalf of the weak, to cement the culture of love. Faith is necessary for a depersonalised and disorientated society and there is no point in living it privately as though it was an indoors plant; for faith to go on being able – and it will always be able – to transform in a peaceful way and in a way far from every form of fundamentalism, structures and society, we must express our faith and live it publicly, believing that it is a health-inducing proposal, the best there is for men and women down the ages'.

Their mission and the world of health and health Care

The place that belongs to Christian health-care professionals is the world of health and illness. In that world the fundamental experiences of human beings are lived out: birth, illness, recovery, and death. In the extreme experiences where pain and powerlessness are gone through, the fragile and vulnerable condition of the human being is revealed, the ultimate questions of existence are raised and the person is questioned in a radical way about his or her identity. This is a world that undergoes constant transformation and development, it is full of light and shadows, admirable successes and painful failures, exemplary actions and flagrant injustices.

In this world the Christian health-care professional is present not as the worker of a service that provides religious care to patients but as a professional who carries out the mandate of Jesus: 'heal every disease and every infirmity' (Mt 10:1). Jesus proclaimed and promoted the Kingdom of God by making himself a part of the world of illness and by healing the sick and those possessed by evil. Jesus did not separate his activities involving healing from the proclaiming of the Kingdom. On the contrary: *the proclaiming of the Kingdom and the healing of the sick* were two aspects of the same evangelising mission: 'And he went about all Galilee,

teaching in their synagogues and preaching the gospel of the kingdom and healing every disease and every infirmity among the people' (Mt 4:23). Healing was the sign that Jesus offered so as to validate the authenticity of his mission: 'the blind receive their sight and the lame walk, lepers are cleansed and the dead hear, and the dead are raised up, and the poor have good news preached to them' (Mt 11: 2).

The mission of the Christian health-care professional, in fundamental terms, lies in serving the sick person as Jesus himself did, *anointed with the power of the Holy Spirit*, going about *doing good and healing all that were oppressed by the devil* (Acts 10:38); in experiencing today once again the Gospel of Jesus; in being like him the *good news of God* for the sick and the infirm; and in being at their service in introducing gospel-based values into the health-care world by conforming curative action to the spirit of Christ proclaiming with 'health-inducing actions' God the healer who wants only the welfare of human beings. The Christian health-care professional is present in the world of health and health care by helping human beings in the processes involving the recovery of life, the overall growth and development of health, dominion over the body, and victory over the forces of evil, all of which are privileged experiences by which to reveal God as 'the friend of life' and to communicate hope that there is a God who is a Saviour.

Their witness

Christian health-care professionals are called upon to be *salt, light and yeast* within society through their life witness: 'the Gospel images of salt, light and least, although they concern indistinctly all the disciples of Jesus, find special application to the lay faithful' (John Paul II, *CL*, n. 15). Their task is not only to make the Church present in the world but also to make the world present within the Church, to which they must bring their secular experience, and the problems, the questions and the worries of today's men and women. The Second Vatican Council urged members of the laity to bring 'their problems and the problems of the world to the community of the Church' (*AA*, n. 10). Christian health-care professionals must offer information and consultation to the Church about health-care problems, and about documents and declarations connected with scientific questions or moral conflicts that arise in the health-care world.

The Association of Christian Health-Care Professionals

Although 'all members of the laity are called to and obliged to engage in a personal apostolate, which is always and everywhere productive, indeed in certain circumstances it is the only suitable and possible apostolate' (*AA*, n. 16), the associative apostolate is a 'sign of the communion and the unity of the

Church' (AA, n. 18), and requires to be implemented through shared action: supporting and training her members; ordering and guiding their apostolic action (*AA*, n. 18). In contemporary circumstances it is necessary to act in an associative way if we want to achieve our goals and to shape the collective mentality and social conditions.

The Association of Christian Health-Care Professionals was born within the framework of pastoral care in health and was established during the course of the LX Plenary Assembly of the Bishops' Conference of Spain which approved its statutes on 19 November 1993.

Its goals:

1. To promote a Christian laity involved in the world of health and health care that provides gospel-based witness in its professional activities.

2. To create methods and opportunities for encounter, reflection and commitment amongst Christian health-care professionals.

3. To help health-care workers in their human, spiritual and religious growth and development and in their education and training in the sphere of bioethics.

4. To collaborate in the promotion of health, overall care for the sick and the humanisation of health care at all levels.

5. To contribute to the defence of the rights of people, in health or in sickness, without any form of discrimination based on any element.

It is inter-professional

Medical doctors, nurses, auxiliary staff who work in clinics, administrative personnel, orderlies and all professional people who work in health care at the service of the sick belong to the Association.

Its activity

Periodically, the Association celebrates days, seminars on bioethics and other training courses, as well as meetings at a national, regional, diocesan and local level; it organises groups of study and reflection in order to clarify questions or issues of an ethical, religious, professional or scientific character; it publishes its own bulletin, PROSAC, every three months; it disseminates documents and materials to do with training and professional development and which provide information about the participation of professionals in the improvement of the world of health and health care; and it co-operates with other groups and organisations.

It must be promoted

Amongst the conclusions that were approved during the Church and Health Congress which took place in Madrid in 1994 we may read the following: 'to promote the Association of Christian Health-Care Professionals and the goals it sets itself, to develop further its inter-ecclesial collaboration (consultation for pastors; collaboration in training), its active participation in the humanisation of care, the ethical illumination of medicine and the creation of a culture of health that is more consistent with Christian values'. The Report on the Church and Health, which was presented to the Plenary Assembly of the Bishops' Conference of Spain (1995), proposed that 'the diocesan delegations of pastoral care in health support the Association of Christian Health-Care Professionals, which has been approved by the Bishops' Conference of Spain'.

For personal or group work

1. In your view what is the mission of Christian health-care professionals in the world of health and health care? What should be their specific contribution?

2. How do they live out their faith? What witness do they provide?

3. What does the Christian community do to promote a Christian laity involved in the world of health and health care?

4. Do we know about the Association of Christian Health-Care Workers? What can we do to spread it and support it?

The Magisterium of the Church and Health-Care Professionals

A selection of texts

– Professional honesty and competence are without doubt an indispensable condition which can only with difficulty be compensated for by another kind of apostolic zeal (Rite of Anointing, n. 57)

– Anointing is not extraneous to health-care and similar personnel because it is the expression of the Christian meaning of technical action. For this reason, it is very much to be hoped that health-care personnel take part in the celebration of the anointing of the sick so as to be able in a better way to open the whole of therapeutic action to the supernatural dimension, which, indeed, is specific to this sacrament (Rite of Anointing, n. 67)

– Medical doctors, other health workers and voluntary workers are called upon to be the living image of Christ and his Church in love towards the sick and the suffering (John Paul II, *CL*, n. 53).

– As medical doctors, that is to say servants of life, you will find in the practice of your profession a privileged opportunity to contribute to the construction of a world that increasingly responds to the dignity of human beings…Vivify service with constant prayer to God, 'the lover of life' (Wis 11:26), always remembering that healing, in the final analysis, comes from the Most High (John Paul II, Letter to those Taking Part in the XXIII National Congress of the Association of Italian Catholic Doctors, 2004).

– Jesus was an untiring *promoter of health*…two duties deserve special attention on the part of the Christian. 1. *The defence of life*. With the birth and the ever more widespread development of bioethics thought and dialogue are fostered – between believers and non-believers, and between believers of different religions – on ethical problems, of a fundamental kind as well, which affect the life of man…Believers are called to develop a look of faith at the sublime and mysterious value of life, even when it is fragile and vulnerable. 2. *The promotion of health worthy of man*. The Christian vision of man is in contrast with a notion of health where health is reduced to mere exuberant vitality satisfied by its own physical efficiency and which absolutely precludes any positive view of suffering. Health is a movement towards a fuller harmony and healthy balance at a physical, mental, spiritual and social level. (John Paul II, Message for

the World Day of the Sick, 2000).

– It is precisely at the moment of illness that the need is raised, with most urgency, to find suitable answers to the ultimate questions about the life of man: questions about the meaning of pain, suffering and death itself. In Christ is to be found the hope of true and full health; the salvation that he brings is the real answer to the ultimate questions of man. (John Paul II, Message for the World Day of the Sick, 2005).

– The effective treatment of the various pathologies, commitment to further research and the investment of suitable resources are the admirable objectives pursued with success in vast areas of the planet. Although applauding the efforts that have been made, one cannot, however, ignore the fact that not all men have the same opportunities. I thus address a pressing appeal so that efforts are made to foster the necessary development of health-care services in those countries, which are still large in number, which find it impossible to offer their inhabitants decent conditions of life and a suitable defence of health. (John Paul II, Message for the World Day of the Sick, 2001).

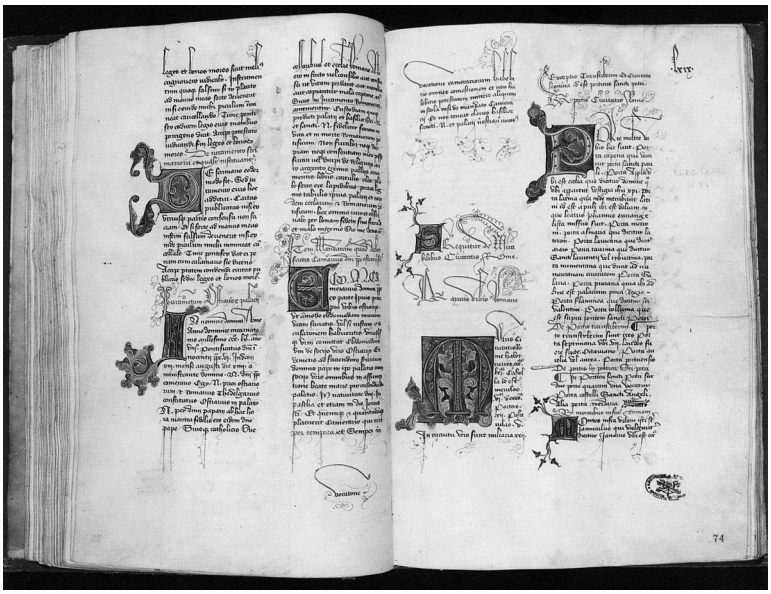
– The ethical-social dimension is an essential element of Christian witness: one must reject the temptation to offer a privatised and individualistic spirituality which ill accords with the demands of charity, to say nothing of the implications of the Incarnation and, in the last analysis, of Christianity's eschatological tension. While that tension makes us aware of the relative character of history, it in no way implies that we withdraw from "building" history. Here the teaching of the Second Vatican Council is more timely than ever before: "The Christian message does not inhibit men and women from building up the world, or make them disinterested in the welfare of their fellow human beings: on the contrary it obliges them more fully to do these very things"' (John Paul II, *NMI*, n. 52).

– Profession, vocation and mission meet and, in the Christian vision of life and health, they are mutually integrated. Seen in this light, health care assumes a new and more exalted meaning as "service to life" and "healing ministry." …To serve life is to serve God in the person: it is to become "a collaborator with God in restoring health to the sick body" and to give praise and glory to God in the loving welcome to life, especially if it be weak and ill. (The Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers*, n. 4).

– The Church and health care must draw near to one another, recognise each other and collaborate with one another in the service that both provide to the sick. Beginning with the words and practice of Jesus and her own rich tradition of care, the Church brings a series of beliefs about the significant aspects of health care. For example: the dignity of the human person as such, the primary value of the resources of each human being, within him or her, in his or her attitudes and forms of behaviour, to care for and treat himself or herself and to care for and treat other people; the importance of a personal and direct relationship between the person who provides care and the sick person; the impossibility of providing care and looking after a sick person without giving of oneself and without taking upon oneself his or her sufferings and fears; assistance as the task and responsibility of everyone; and the great utility of the harmonious integration of science and pastoral action in the recovery of a sick person. Lastly, the Church brings a new horizon of the meaning of the realities that are experienced in health care: illness, suffering, recovery, assistance and death. (Episcopal Commission for Pastoral Care, Message for the Day of the Sick, 1992).

– We hinder the access of lay people that want a secular involvement in, and dialogue with, the world, when we assert ourselves in an institutional way and seek the power of the Church with overly rigid and secure positions in relation to certain points of doctrine or discipline that in reality allow greater flexibility or, at the least, attitudes involving dialogue. We must reflect with lay people and discern with them problems, concerns and experiences. Let us avoid the temptation of only allowing the participation of those lay people who have a certain intellectual training, thereby underestimating experience, commitment and witness. We need to strengthen the action of the health-care laity beginning with their work as professionals. (Msgr. Javier Osés to the pastoral delegates).

– Take off your working clothes when you are in church but when you are at the workplace put on your baptism clothes. Strive to analyse the deep needs of people: the search for meaning, the yearnings for peace, the thirst for justice, the hunger for dignity, hope for a new economic order that assures every human being the most elementary rights. Abstain from 'simplifying' problems. May the Lord give you a



taste for essential things! May he make you ministers of the happiness of people and faithful collaborators of your bishop and your priests! Love and serve your Church, not to obtain glory from her but so that she may be a faithful servant of the Kingdom of God. Be concerned to have relationships with other Church groups, acting in a way so that the complementary character of everyone shines forth. Respect the inner laws of technology and science but act in a way so that all the temporal realities direct their gaze towards 'he who was pierced'. (Msgr. Tonino Bello to the diocesan heads of Catholic Action).

Prayer of the Health-Care Professional

Lord Jesus, Divine Doctor,
Who during your earthly life
Paid special attention
to those who suffer,
And entrusted your disciples
With the ministry of healing,
Ensure that each one of us
– aware of the mission that
has been entrusted to him –
Always strives to be,
in daily service,
An instrument
of your merciful love.
Enlighten our minds,
Guide our hands
Give us careful
and compassionate hearts.
Ensure that we know how
to discover in every patient
The features of your divine
countenance.

Grant that we be
Good Samaritans,
Ready to welcome,
to treat and to console
Those people we encounter
in our work.

Help us to offer
our generous contribution
To the constant renewal of
Health-care structures.

Order it that after loving you,
And constantly serving you
In our brothers who suffer,
At the end of our earthly
journey
We can experience
The joy of the meeting
with you
In your Kingdom of joy
and peace.
Amen.

THE DEPARTMENT
FOR PASTORAL CARE
IN HEALTH
Spain.

Bibliography

Pontificio Consiglio per la Pastorale della Salute, *Lettera agli Operatori Pastorali* (1995).

Dipartimento di Pastorale della Salute, *Congreso Iglesia y salud*, (Edice, Madrid, 1995).

ALARCOS F. J., *Bioética y pastoral de la salud* (San Pablo, Madrid, 2002).

AYERRA M.P., *Querido Dios. Cartas de Esperanza* (Sal Terrae, Santander, 2004).

BERMEJO J. C., 'El desgaste en i professionisti della salute', *Labor Hospitalaria*, n. 274 (2004).

CLAVÉ E., *Ante el dolor. Reflexiones para afrontar la enfermedad y la muerte* (Temas de hoy, Madrid, 2000).

CONDE J., *Introducción a la pastoral de la salud* (San Pablo, Madrid, 2004).

FRANCISCO DEL REY C., *Memorias de una enfermera* (La Esfera de los Libros, Madrid, 2003).

DE LLANOS F., La Iglesia y los profesionales de la salud: hacia una colaboración imprescindible' *Labor Hospitalaria*, n. 274 (2004).

GRACIA D., 'Medice, cura te ipsum. Sobre la salud física y mental de los profesionales sanitarios. Discurso en la Real Academia Nacional de Medicina, 2004' *Labor Hospitalaria*, n. 274 (2004).

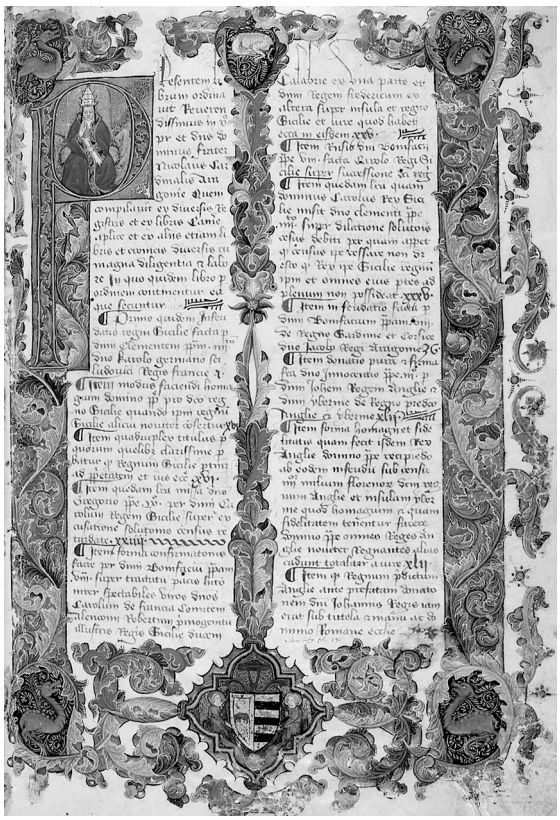
PAGOLA J.A., 'Claves para desarrollar la identidad y misión de PROSAC', Documentos PROSAC n. 1 (2000).

REDRADO J.L., 'Ser profesional en un mundo en cambio. Claves evangélicas', Documentos PROSAC n. 2 (2003).

RUBIO, J.M., 'Identidad y misión del profesional de la salud cristiano', *Labor Hospitalaria*, n. 274 (2004).

SANDRIN L., *Ayudar sin quemarse. Cómo superar el burnout sin quemarse* (San Pablo, Madrid, 2005).

VIÑAS J., 'Las profesiones sanitarias en la encrucijada. Retos del profesional de la salud del siglo XXI', *Labor Hospitalaria*, n. 274 (2004).



Homosexuality and the Campaign against Homophobia in Mexico

The Catholic Church Defends, Respects and Promotes the Dignity of All People and Every Individual

1. We know that a campaign is underway at a national level against homophobia. The term 'homophobia' is a relatively new one and is used to refer to an 'obsessive aversion to homosexual people'. 'Homosexuality refers to relations between men or between women who experience an exclusive or predominant sexual attraction towards persons of the same sex'.[1]

2. An intense campaign to promote the acceptance of homosexuals deserves to be appreciated. The *Catechism of the Catholic Church* says that 'homosexuals…must be accepted with respect, compassion and sensitivity. Every sign of unjust discrimination in their regard should be avoided'.[2] A homosexual person has all the dignity that is his or hers by virtue of being a human person. The Catholic Church does not insult or attack anyone, nor does she incite people to engage in discrimination towards any person. On the contrary: the Catholic Church defends, respect and promotes the dignity of all people and every individual, and this includes the dignity of homosexuals.

Homosexual Acts are Intrinsically Disordered

3. Once a person has been accepted with his dignity as a person, it is necessary to distinguish between the homosexual inclination and homosexual acts. This inclination is disordered in itself, but it does not constitute in itself a sin if there is no intention to nourish this inclination through homosexual acts.

4. On the other hand, 'Basing itself on Holy Scripture, which presents homosexual acts as acts of grave depravity, Tradition has always declared that 'homosexual acts are intrinsically disordered'. They are contrary to the natural law. They close the sexual act to the gift of life. They do not proceed from a genuine affective and sexual complementarity. Under no circumstances can they be approved'.[3] We can see this, in fact, in Genesis (19:1-29), which speaks about the perversion of Sodom and Gomorrah, or in St. Paul who says to the Corinthians: 'Do not be deceived; neither the immoral, nor idolaters, nor adulterers, nor homosexuals, nor thieves, nor the greedy, nor revilers, nor robbers will inherit the Kingdom of God'.[4]

The Anthropological Context of the Campaign against Homophobia

5. The campaign against homophobia seeks to present the homosexual inclination of a person to society as a legitimate personal choice, with a 'right to be different', and adopts an approach of apparent humanity and respect for the human person, seeking to base itself on the criteria of pluralism, tolerance and non-discrimination. However, this campaign is based upon false and deceptive anthropologies, with the separation of concepts and language. One cannot argue that just as some people have the disposition to a heterosexual relationship and to heterosexual love so other people have the right to a homosexual relationship and to homosexual love in the same way that a person must have acceptance and respect whether he or she is left or right handed or has a different skin colour.

6. In ontological terms, it is impossible to treat as equal that which is not equal: marriage based upon the heterosexual relationship of a man and a woman is one thing; unions between people of the same sex are quite another, and they are very different. Only the sexual diversity that exists between a man and a woman allows natural affective and sexual complementarity and the possible gift of a new life. None of these aspects exist in unions of people of the same sex given that they are intrinsically sterile unions, and the apparent unitive aspect of their sexuality is achieved at the cost of forcing anatomical structures and simulating natural physiological and psychological activities, not to speak of the use of the most diverse chemical and mechanical products.

7. In addition, in the policy of the adoption of children by homosexual couples the person (the child) is not seen as someone who assures the continuity of the family and the renewal of the generations but as the duplicate or the projection of a person's self; that is to say it is believed that there is a right to possess a child.

8. Although homosexuals are accused of homophobia, in reality homosexuals experience 'heterophobia', that is to say fear of the other sex, fear of sexual difference, which, however, is the source and root of legitimate and healthy otherness.

9. A campaign of this character, of legitimation, that is to say, of the homosexual, who is seen as being natural, forms a part of the increasing diffusion at a global level of a movement – which is accompanied by strong pressure of a social, political kind and exercised by the mass media – that does not speak about 'sex' (sustained at a biological, psychological, social and moral level) but of 'gender', and sees this as something that is solely social and cultural, and because of this modifiable according to the criteria of a person, who is able, indeed, to choose between five or more genders: man, woman, homosexual-lesbian, bisexual, transsexual.

10. This approach operates within a context of the rejection – or merely the absence – of God the Father and Creator of human beings in His image and likeness (and thus in the sexed reality of being a man or a woman), but it also operates within the context of moral relativism, which holds that objective and universal values do not exist. In this scheme of things, there are only subjective and

personal preferences: each person has the right to think, choose and act as he or she wishes. To this is added hedonism, which sees sexuality as a mere consumer good and a means by which to achieve pleasure. Sexual abstinence, in contrary fashion, is sees an being unnatural.

11. To recapitulate: the Church defends and promotes the acceptance of, and respect for, the homosexual person, with all the dignity that belongs to him or her because of the fact of being a person. But on the other hand the Church offers herself and tries to help that person to redeem, and adopt, his or her own sexual identity as a man or as a woman.

The Origin of the Homosexual Impulse

12. In this process of providing help it is important to examine the origin of the homosexual impulse. The idea has become widespread that homosexuality is an innate impulse which has genetic bases. From a scientific point of view there are no certain conclusions to demonstrate this. Whatever the case, although a genetic origin is to be encountered the causes of homosexuality are to be attributed to many factors and amongst these are those of an intrapsychic and environmental character. It would certainly not change the ethical aspect of the question referred to above to see the homosexual tendency as objectively disordered and to hold that homosexual acts cannot be approved in any circumstances. It should be borne in mind that not everything that is genetically determined is normal: for example, albinism. A human being is a genetic project with a life ideal to be realised, that is to say he or she is not determined by his or her genes.

13. One may state that the following factors, amongst others, can be connected with the tendency to be a homosexual:

– The homosexual male child had an intimate relationships with his mother that was characterised by a certain erotic thread which was hidden to various degrees of intensity. For her part, the mother often preferred her son to her husband. Often, in this case, the mother was demanding and hyperprotective.

– The relationship between the father and the son, on the other hand, was distant, lacking in care, indeed marked by aggression and hostility.

– Deep hatred and fear of the homosexual boy towards his father, but at the same time an enormous desire for affection and acceptance by his father.

– A lack by the parents of the practice of upbringing as regards the sexual identity of the child as a man or a woman.

– Sexual abuse; rape.

– Loss of the parents because of death or separation (divorce).

– The separation of the parents during critical stages of the growth and development of the child.

– Social phobia.

– Depression, anxiety, suicidal tendencies, very accentuated pathologies.

– Drug abuse.

The Expression of Homosexuality

14. Another aspect of this subject that should be borne in mind in the process of providing help to a homosexual person is that in reality homosexuality has a very broad gamut of ways of manifesting itself. Three basic forms may be distinguished which are of use in contextualising the situation of a homosexual person:

– *Real and open homosexuality:* the primary and fundamental reason for attraction towards a person of the same sex is sexual gratification, and reasons of affective dependence and/or power or dominion over another person are of secondary importance. In this case, the sexual desire is impersonal. In practice, all people of the same sex who are relatively attractive can become the object of sexual desire. In addition, people may not be satisfied with just one person and may search for others.

– *False homosexuality*: here the situation changes. What is important is not the gratification of sexual desire but the need to satisfy affective dependence and/or power over the other person. The tie tends to be with one person or with a few and well defined people.

– *Imaginary or feared homosexuality*: this is the fear of being homosexual – without being so really – for the most varying reasons: for example, because of insecurity about one's own sexual identity as a man or as a woman; because of the residual affects of an adolescent stage that was not overcome well; because of unfounded fantasies and thoughts in this direction; or because of abuse carried out by another person of the same sex on a person which gave the idea to that person that he or she, too, was homosexual.

Homosexuality Can be Treated

15. Contrary to common opinion, including that of professionals in the field, who admit the paradox that one can move from heterosexuality to homosexuality but not from homosexuality to heterosexuality – and as a result decide to suggest to a person that he or she should accept his or her situation and adapt to gay culture – there can be no doubt that homosexuality can be treated. This is stated by many medical doctors, psychiatrists and priests who have helped people in this way.

16. It is certainly true that there are cases where homosexuality is irreversible, but they are few in number. Amongst these there are cases, obviously enough, where the homosexual is happy with his or her condition and does not want to be treated. The same happens in every other field of medicine: a person who does not feel that she or he is ill will only with difficulty follow the treatment that is prescribed to him or her.

17. One is not dealing here necessarily with a hundred per cent cure. And one is not dealing, either, with a situation where a person continues to be at the mercy of his or her tendencies. Rather, one is dealing with that person achieving a certain level of dominion over such tendencies which can incline some people more than others to the sexual act but which cannot, in fact, force anyone to engage in them.

18. If God has created us in His image and likeness, that is to say in the condition of being a man or a woman, God Himself helps us to resolve the homosexual disorder. Jesus Christ came to redeem us. 'And 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. While we were yet helpless, at the right time Christ died for the ungodly. Why, one will hardly die for a good man – though perhaps for a good man one will dare even to die. But God shows his love for us in that while we were yet sinners Christ died for us' (Rom 5:58).

19. Homosexuality is a disorder. But one should receive and welcome the homosexual person with understanding and serenity, placing within that person that there is a reasonable hope of effective help as well.

A Person with Homosexual Tendencies Should Accept Himself or Herself and Love Himself or Herself

20. With respect to a person with homosexual tendencies, he or she will be helped by accepting the following: he or she should accept himself or herself and he or she should love himself or herself; he or she should have a genuine wish, in general, to overcome problems and difficulties in his or her life; he or she should accept his or her homosexual tendency as a problem that he or she wants to deal with; he or she should wish to work on it with perseverance; he or she should accept individual help of various kinds – physical, psychological, pastoral and spiritual help; he or she should accept being integrated into a support group; he or she should trust in the fact that the redemptive Sacrifice of Christ is universal; thus he or she should unite every suffering and difficulty to the Sacrifice of the cross of the Lord.

Called to Chastity

21. In addition, 'homosexual persons are called to chastity. By the virtues of self-mastery that teach them inner freedom, at times by the support of disinterested friendship, by prayer and sacramental grace, they can and should gradually and resolutely approach Christian perfection'.[5]

Parents should Commit Themselves to Providing a Real Sexual Education

22. As a work of prevention, parents should be concerned to be near their children; they should be committed to knowing them, and entering into dialogue with them, as an example of authentic sexual education; they should know the books, the subjects and everything that happens in the schools of their children, and in the relations between young people of the same age, at the level of sexual education.

The Church, Faithful to her Mission

23. The Church wants to be faithful to the mission that has been entrusted to her by Jesus Christ. It is necessary to respect the homosexual as a person, who has all the dignity of every human being, so as to help him or her to redeem his or her identity as a man or a woman, and to make that identity grow and develop, so that he or she may become, to the full, in the image and likeness of God the Creator.

H.E. Msgr. RODRIGO AGUILAR MARTÌNEZ,
Bishop of Matehuala,
President of the Episcopal Commission for Pastoral Care of the Family,
Mexico

Notes

[1] *Catechism of the Catholic Church*, n. 2357.
[2] *Ibid.*, n. 2358.
[3] *Ibid.*, n. 2357.
[4] 1 Cor 6:9-10.
[5] *Catechism of the Catholic Church*, n. 2359.

Protocol of Agreement Between the Regional Government of Lombardy and the Ecclesiastical Regional Government of Lombardy for the Regulation of the Service of Catholic Religious Assistance in Accredited Public and Private Health-Care and Assistance-Providing Bodies

In the year 2005, on the twenty-first day of the month of March at the Fondazione Istituto di Ricovero e Cura a Carattere Scientifico (IRCCS) Ospedale Maggiore Policlinico, Mangiagalli e Regina Elena, Via Francesco Sforza, 28, Milan,

Between

The *Regional Government of Lombardy* (C.F. 8005005014), represented by the *pro tempore* President of the Regional Executive, Roberto Formigoni, born in Lecco on 30 March 1947, with his home address for the purposes of this act in Milan, Via Pola, 14, who is authorised to sign this Protocol of Agreement by the DGR n. 20593 of 11 February 2005

And

The *Ecclesiastical Regional Government* of Lombardy (C.F. 97179710153), represented by the *pro tempore* President of the Bishops' Conference of Lombardy, which by its statutes is the legal representative of the Ecclesiastical Government itself, Cardinal Dionigi Tettamanzi, born in Renate (MI) on 14 March 1934 and with his home address for the purposes of this act in Milan, Piazza Fontana n. 2, who is authorised to sign this Protocol of Agreement by a decision of 7 February 2005 of the Bishops' Conference of Lombardy, and with the assent of the Bishops of the Dioceses of Novara, Tortona, Vercelli and Verona, whose area covers a part of the territory of the Regional Government of Lombardy, and, lastly, this Protocol of Agreement having obtained the due '*recognitio*' of the Holy See;

Given that

1. The Constitution of the Republic of Italy recognises the dignity of the human person and assures his freedoms and inviolable rights, including those relating to the religious sphere, both as an individual and in social formations where his personality is expressed;

2. article 7 of the Constitution regulates the relations with the Catholic Church;

3. the agreement with an addition protocol between the Holy See and the Republic of Italy, which was signed in Rome on 18 February 1984, and then ratified and implemented by the law of 25 March 1985, n. 121, and which effected modifications to the Lateran Concordat of 11 February 1929, established in its article 11 that the '…Republic of Italy assures that…stays in hospitals, public nursing homes or homes providing care…cannot give rise to any impediments regarding the exercise of religious freedom or the carrying out of the practices of worship of Catholics' and that '…spiritual assistance to the same is assured by ecclesiastics appointed by the competent Italian authorities on the designation of the ecclesiastical authority and according to the juridical status, personnel and modalities established by agreement between such authorities';

4. with special reference to religious assistance in health-care structures, article 38 of the law of 23 December 1978, n. 833, which established the national health care service (SSN), envisaged that in the structures of care of the SSN there should be '…assured religious assistance in a way that respects the wishes and the freedom of conscience of citizens' and that to such an end the local health-care units should provide 'for the organisation of a service of Catholic religious assistance in agreement with the competent diocesan ordinaries of the territory';

5. the regional law n. 48 of 16 September 1988, at article 15, lays down that '…those who have been admitted must be enabled to take part in the exercise of their worship and can receive the visit from a minister of religion or from religious of their choice';

6. article 11 of the regional law of 11 July 1997, n. 31, in establishing that the relations between the regional health service, including all the public and private subjects operating within the field of the same service, and citizens, are characterised by principles of respect for, and the defence of, the person, makes clear that the local health care companies (ASL), the hospital companies (AO) and all the accredited subjects, are obliged to have full respect for the directives to be found in the appeal 1. r. n. 48/1988;

7. with regard to the arrangement and organisation of the personnel engaged in providing religious assistance, law n. 132 of 12 February 1968, at article 19, envisaged that the service of religious assistance figures amongst what are necessary hospital structures and made clear in the next article that personnel dedicated to the provision of religious assistance belong to the staff of hospital bodies, personnel, that is to say, made up of ministers of the Catholic religion and those people involved in the provision of assistance to patients of the Catholic confession, as also confirmed by article 1 of the decree of the President of the Republic of 27 March 1969, n. 130;

8. article 35 of the decree of

the President of the Republic of 27 March 1969, n. 128, further regulated the service of religious assistance in hospital bodies, in particular envisaging that the arrangement '…of the service of Catholic religious assistance in hospital bodies is determined by internal regulations, decided by the hospital bodies, in agreement with the competent diocesan ordinaries of the territory' and further regulating the modalities and the forms of the performance of that service;

9. the juridical status of the personnel engaged in the service of religious assistance was in particular regulated by the decree of the President of the Republic of 20 December 1979, n. 761, n. 761, and now finds its regulation in national collective labour contracts, following the privatisation of the (previously) public work relationship in the health-care sector;

10. in the light of the legislative competences confirmed in relation to the regional governments by the reform of the V title of the second part of the Constitution, effected by the Constitutional law of 18 October 2001, n. 3, and given the continuing exclusive competence of the state as regards the relations between the Republic and religious confessions, the Regional Government of Lombardy is obliged to assure the provision of the service of religious assistance in local health-care companies, hospital companies and other accredited public and private health-care structures;

in order to regulate the service of Catholic religious assistance in accredited public and private health-care and assistance-providing structures operating in the territory of Lombardy,

given all these premises,

It is agreed

To proceed to an Protocol of Agreement between the Regional Government of Lombardy and the Ecclesiastical Regional Government of Lombardy as follows:

Art. 1)

1. The premises constitute an essential and integral part of this Protocol of Agreement.

Art 2) *The subjects of the service of religious assistance*

1. In this Protocol of Agreement:

a) the local health-care companies, the hospital companies and in general all the other accredited public and private health-care structures, as well as accredited public and private structures dedicated to the provision of services to the person, of an assistance-providing character as well, are referred to only with the phrases 'managing bodies' or 'care structures';

b) by the phrase 'diocesan ordinary' is meant the diocesan ordinary for the Catholic religion who is responsible for each individual care structure;

c) by Catholic religious assistance is meant the service guaranteed by the action of religious assistants or by a 'chaplainry' understood as the expression of

the pastoral care provided by the Christian community in health-care institutions and those institutions more generally dedicated to services to the person, of an assistance-providing character as well, made up of one or more chaplain-priests to whom can be associated other priests as well, deacons, male and female religious, and secular people, who work as voluntary workers.

Art.3) *General principles and the recipients of the service of religious assistance*

1. The Regional Government of Lombardy assures the provision of the service of Catholic religious assistance in the care structures referred to above in article 2.

2. The service of religious assistance has the purpose of fostering the exercise of religious freedom, the carrying out of the practices of worship and the meeting of the spiritual needs of ill people of the Catholic confession and their family relatives, as well as of those who work under any heading in the same structures, in a way that is compatible with the performance of the specific obligations of service, and in a way that respects the wishes and the freedom of conscience of citizens.

3. The performance of this service in the sphere of spiritual and pastoral action is the prerogative of the competent ecclesiastical authority.

4. This Protocol of Agreement, in conformity with what is laid down in the norms of the Concordat and the national and regional laws in this area, defines the directions and the directives for the regulation of the service of religious assistance, as laid down in this article.

5. Religious assistance, as regards the apostolate and pastoral action, is carried out by religious assistants in full operative autonomy who are in exclusive dependence on the diocesan ordinary.

6. As regards activities extraneous to the religious and pastoral sphere, the religious assistants depend on the managing body. As regards needs concerning the functional connection of the service of religious assistance with the other services, the managing bodies make their own decisions in agreement with the religious assistants.

Art. 4) *The relationship between the managing bodies and the diocesan ordinaries*

1. On the basis of, and respecting, the directions and the directives contained in this Protocol of Agreement, and in response to a request that may be made by only one of the parties, the managing bodies and the diocesan ordinaries may sign suitable conventions for the regulation of the service of religious assistance to be performed in the individual care structures.

Art. 5) *The aims of the service of religious assistance*

1. The service of religious

assistance has as its subject those activities directed towards the administration of the sacraments and the sacramentals, care for souls, the catechesis and the practice of worship.

2. In addition it involves:

a) Support for the therapeutic process of the sick person;

b) the promotion of cultural activities of a religious character;

c) spiritual and human accompanying and help relationships;

d) contribution in matters connected with ethics and humanisation in the training of personnel in activities of service and possible participation in ethical committees;

e) the promotion of voluntary work, in particular for the humanisation of structures, services and interpersonal relationships;

f) attention being paid to inter-confessional and inter-religious dialogue;

g) services of an administrative character for the organisation and needs of offices (certifications, correspondence, archive work, looking after places of worship, their furniture and sacred furnishings).

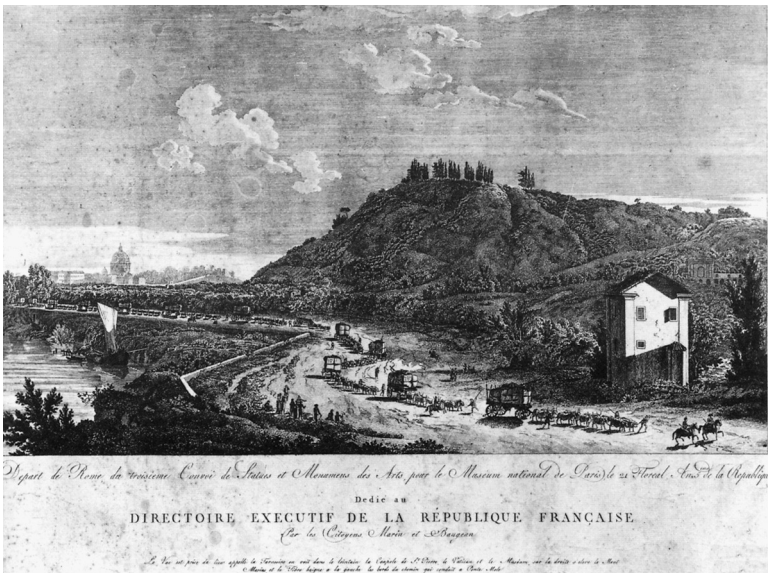
Art. 6) *The employment of personnel for religious assistance*

1. For each managing body there must be envisaged at least one religious assistant. The number of religious assistants varies according to the reception capacities of the care structures.

2. For a number of up to three hundred hospital beds, one religious assistant is to work. From three hundred and one up to seven hundred hospital beds, two religious assistants are to work. In the case of over seven hundred hospital beds, the number of religious assistants can increase by one for every three hundred and fifty hospital beds. The parameter is rounded up to the next hundred.

3. In response to a request made by a diocesan ordinary, within the framework of the convention referred to in article 4 as above, the parameters of reference established by this article can be modified taking into account the location of presidiums and effective needs, and in relation to the structures dedicated to the provision of services to the person.

4. With the exception of what is envisaged in section 3 of this article, the agreements, the contracts and the conventions in operation at the moment of the effective coming into force of this Protocol of Agreement which envisage a number of religious assistants higher than that determined through the application of the parameters established in this article continue to apply until their natural termination.



Art. 7) *The employment and the ending of employment of religious assistants*

1. The employment of religious assistants gives rise to the creation of a special relationship regulated by the laws in operation and by this Protocol of Agreement. Their contractual framework and their economic treatment are determined according to what is envisaged by the national collective contract agreement of the relevant category.

2. The religious assistants are employed by the managing body in response to a designation by the diocesan ordinary with a contract that does not have a fixed limit of time and involves full-time or part-time work. As regards employment, reference is made to the requirements envisaged by the laws and rules in force and the national collective contracts in operation.

3. The designation of religious assistants and their replacement is the responsibility of the diocesan ordinary. In cases where the local area of the managing body includes more than one presidium, and the relative buildings etc. are to be found in different dioceses, the responsibility for the designation and replacement of religious assistants lies with each diocesan ordinary as regards the religious assistants to be assigned to the presidium of territorial reference.

4. The faculty to withdraw employment from religious assistants lies in the hands of the diocesan ordinary, who also has the faculty to request the managing body to end the work relationship. The exoneration from service of religious assistants, for grave and documented motives indicated by the managing body, is effected in agreement with the diocesan ordinary in line with modalities and forms set out in the convention referred to in article 4 above.

5. The service of religious assistance can also be assured by religious assistants employed by contractual instruments to be defined by the convention referred to in article 4 above, in the following cases:

a) when the employed religious assistants intend to continue the performance of the service, in the absence of the diocesan ordinary, beyond the age established for the receiving of an old age pension;

b) when the service of reli-

gious assistance has to be provided in care structures that have a number of used hospital beds up to the figure of three hundred, and in special cases in response to a request made by the diocesan ordinary.

6. In the case of religious assistants employed in this way, their economic remuneration must be correspond to that given to personnel in line with what is envisaged by national collective contracts and by the company contracts, and in relation to the commitment that is guaranteed as well.

Art. 8) *The rights and duties of religious assistants and the collaborating personnel*

1. The ordinary diocesan has the task of appointing the chaplain-religious assistant who is responsible for the 'chaplainry', the other religious assistants, and their permanent collaborators (priests, deacons, male and female religious, secular people). Such appointments are communicated to the managing body.

2. The religious assistants can be aided by other subjects, occasionally as well, without this involving financial burdens for the managing body, except in the case of the possible refunding of expenses that have been really met and documented. The names of these people are communicated to the managing body by the person in charge of the chaplainry.

3. The collaborators of the religious assistants, the diocesan ordinary and the ministers of religion have access to the rooms of the care structures by the same modalities as the same religious assistants.

4. The religious assistants have the right to take part in the initiatives involving optional up-dating that are envisaged by the laws and rules and/or by the national collective contracts and the company contracts that are in force, with the modalities established by the convention referred to in article 4 above between the managing body and the diocesan ordinary.

5. The religious assistants, after learning about the presence of patients of a religious confession different from Catholicism, have the right to point out the presence of these patients, should they so wish, to those responsible for the religious confession to which such patients belong.

6. The religious assistants and the other subjects who help them have the right to eat meals (breakfast, lunch and dinner) provided by the managing body, with costs and forms of special treatment equal to those enjoyed by the employees of the same managing body.

7. No payment on the part of the recipients is due for the individual provisions of the service of religious assistance.

Art. 9) *The hours of service, the availability and the replacement of religious assistants*

1. Given the nature of this service, the religious assistants normally perform their tasks in flexible working hours, which, as far as this is possible, are communicated to the managing body, for a time that anyway is not less that the due monthly period envisaged by the laws and rules in force and by the national collective contracts of the category of personnel employed by the managing bodies and/or by the convention referred to in article 4 of this Protocol of Agreement, and they are always to be available during night hours for urgent cases.

2. In care structures to which two or more religious assistants are assigned, their availability for urgent cases outside their service hours is guaranteed, in turns, by the same assistants.

3. Through the convention referred to in article 4 above, the managing body or the diocesan ordinary regulate the cases of replacement (in the case of illness, holidays etc.) of the religious assistants, and if possible with replacements that will assure the continuity of the service. The replacement has the same economic treatment as that envisaged for the religious assistant that is replaced, in a way that is proportionate to the number of days of actual service provided. In cases of urgency, the same convention can envisage the possibility of the replacement being directly arranged by the religious assistants with an immediate communication to this effect being given to the managing body and the diocesan ordinary.

Art. 10) *Structures and goods given to the service of religious assistance*

1. For the carrying out of the service of religious assistance the managing body assures areas that are suitable to the functions of worship (a church or a chapel and sacristy), for religious activity connected with mortuary services, for use as an office, for the religious assistants and their collaborators, and with related furnishings, equipment and accessories. The service of religious assistance is also assured – during times that are agreed upon – the non-exclusive use of other company areas for meetings.

2. The managing body will usually make available to the religious assistants suitably furnished accommodation which will usually be located within the care structure or anyway connected with it.

3. In the case of the temporary unavailability of the areas referred to in the above sections, the managing body will guarantee the activation of the service of religious assistance with structures that are provisional but which are in any case suited to the needs of that service, at the same time establishing the time by which the same managing body should make available the areas envisaged by this Protocol of Agreement.

4. The usual expenses of worship, as well as the maintenance costs of the furniture, furnishings and equipment that are needed for the working of the service, the ordinary and extraordinary maintenance of the areas that are used, cleaning (excluding that of the accommodation if it is outside the structure), as well as the lighting and heating costs of all the areas dedicated to the service of religious assistance, are the responsibility of the managing body. The religious assistants are the recipients who are responsible for the real and personal property employed for the provision of the service of religious assistance.

Art. 11) *Area of application*

1. The managing bodies are obliged, within six months of the signing of this Protocol of Agreement, to regulate the ser-

vice of religious assistance in conformity with what is envisaged by this Protocol of Agreement. In the case of delay or a failure to observe this commitment, the Regional Government of Lombardy will act in relation to the managing bodies that are responsible in the forms allowed by the laws and rules in force.

2. The Regional Government of Lombardy considers the service of religious assistance in public and private managing bodies as a humanising factor that is able to contribute to an improvement in the services that are provided and is committed to fostering their presence in health-care structures and in structures of a socio-health care and social assistance character that are subject to official agreements, are authorised and are accredited.

3. In relation to private managing bodies, on which the Regional Government of Lombardy cannot impose the acceptance of this Protocol of Agreement, this is an act of orientation and a general directive.

Art. 12) *The joint commission and the resolution of controversies*

1. Within three months of the signing of this Protocol of Agreement, a specific joint regional commission will be established made up of four components, of whom two will represent the Regional Government of Lombardy and two will represent the Ecclesiastical Regional Government of Lombardy.

2. This regional joint commission will be entrusted with looking for a solution, that is mutually approved, of controversies that arise from the interpretation and the application of this Protocol of Agreement, in cases, as well, of delay and/or failure to observe what is established in article 11, section 1 as above. The same commission will also be entrusted with the resolution of controversies that may arise between the managing bodies and the diocesan ordinary, in relation to the interpretation and application of the conventions referred to in article 4 as above as well.

Art. 13) *Final regulation*

1. The Regional Government of Lombardy and the Ecclesiastical Regional government of Lombardy commit themselves to the periodic verification of the contents of this Protocol of Agreement, with the aim, as well, of possibly overcoming any difficulties and examples of absence of congruency that may be manifested during the first stage of its practical implementation, and, whatever the case, in response to a request that is made by one of the parties.

Milan, 21 March 2005

For the Regional Government of Lombardy
The President
ROBERTO FORMIGONI

For the Ecclesiastical Regional Government of Lombardy
+ DIONIGI TETTAMANZI

Testimonies

I have Recovered my Body
that was 'Lost'
Because of Illness:
an Experience

Alzheimer's Disease:
an Experience of Suffering
and of Growth

A Note on the World
Mental Health Day

Together for Life and Health

I Have Recovered my Body that was 'Lost' Because of Illness: an Experience

Such was my cry, on exactly 22 March, that is to say Holy Tuesday, 2005, after a process involving illness – I had contracted malaria – when I rediscovered my body, I felt that it was mine again after a month when it seemed that I had lost it. Cured, I found it again. In these pages I will tell you about my experience.

1. Ten Years Ago

It was the year 1995. After a journey in India I began to feel unwell; my body was not in a good condition; I felt that something was happening to me – 'duodenal ulcer' was the diagnosis that was made. After an emergency operation, I underwent intensive care. I spent many days in hospital and underwent a large number of tests until the phrase was spoken: 'you are cured'. Although they give you a lot of advice you go back to your normal life as though nothing had happened. And you go on because your body has been 'taken care of'. And because you do not feel anything, you believe that everything is going well until, once again – after a period of ten years – once again your body does not function, and something happens to you.

2. What is Happening to me?

Even though I had been on a thousand trips to Africa, without ever taking any precautionary steps, nothing had happened to me. This time, however, after the celebration of the World Day of the Sick, that is to say 11 February, I returned from Cameroon with malaria. The first steps that were taken were not the right ones. I thought that I had influenza, which was 'making the rounds' at the time, until, in the end, I decided to go to the emergency department where I began to have test after test until they told me that I had to be admitted to hospital because, from what I had been able to read from the numerous papers about me, I had contracted *Malaria da Plasmidium Falciparum*.

I then began very intensive treatment, first in the resuscitation unit, where I spent a whole week, and then in the department of medicine, where I spent a further number of days.

3. The Itinerary of my illness

For the whole of Lent and Holy Week I underwent medical tests and received nursing care. As the Pope said in those days, I was 'sick amongst the sick', followed, 'watched over', so that nothing escaped attention.

3.1 *The first stage - resuscitation*. During the first moments of the illness I was almost unaware of what was going on, and this was so much the case that I asked myself: am I in such a bad state that they are 'forbidding' me to receive visits, telephone calls, and so forth? They told me that I sweated a great deal. I think this is true because once I had been discharged I found a very large number of pyjamas. So many changes, so many checks, and so many medical tests, now this, now that, and then having 'to obey' because the situation was grave. My body translated this without any strength, without wanting to do anything. It was no longer my body, it was very tired, it needed everything, and it belonged to other people, to the medical doctors, to the nurses…

Although I did not feel physical pain I could not do anything on my own; I did not have any strength and I was totally dependent on other people, I was dependent on them even to have food put in my mouth. I had been so strong and so autonomous and now I was so dependent. I was no longer the same person.

Then my body reacted, the results of technology, medication, the tests…they soon provided positive results, which, indeed, I felt in my body, and my body, although it needed to be supported, began to react, to regain its strength.

3.2. *The second stage*. They discharged me from the resuscitation unit and I was the transferred to the *department of medicine*. This was then followed by nursing care in the orthopaedics section on the fourth floor of the hospital. I was hospitalised in that place perhaps in order to be near the home of my community and to be near my home.

Here they followed me meticulously and rigorously; everything was recorded and noted down. With the passing of time, I began to notice a very major improvement. They began to take the tubes out of my body and to cease the probes…; then I managed to get out of bed, even though I was still being helped, and then, almost like a miracle, I felt strong and I no longer needed other people's help in order to get out of bed and to deal with my body – this was a liberation. My body told me this and it was confirmed by other signs – my complexion, my voice, and the lower levels of tiredness that I felt. My body began once again to be my body. The words of my medical doctor, however, were 'don't run', and I was told the same by other friendly voices. I had to take things slowly and to recover my lost strength.

3.3 Having arrived at this point, after being discharged, I went on to the *third stage*, which saw me in my community, in my home, but always rigorously following the indications of my medical doctor, and I went on being, so to speak, 'controlled'. I somewhat delayed matters in restarting my normal life. But the battle against malaria had been won and for this I give thanks to God, to the medical doctors, and to the nurses.

4. The Experience of my Illness

In the previous section – 'The Itinerary of my Illness' – I de-

scribed a part of my experience, the first steps that were taken, what I felt through my body. It felt as though my body was another body, a different body, a sick body.

4.1. *The encounter between the technical and humanity*

When passing through our hospital which is located on the island in the Tiber in Rome, as a sick person I realised the importance of technical knowledge and know-how: how much technology, how much science, are placed at the service of sick people – a veritable bombardment. This was one of the realities that I was able to 'touch with my own hand'. And if this is a reality which provides you with a feeling of security, I should also say the same about the people that I met in the different services and who were for me the best medicine there was. At the same times as their technical expertise and training, I was also able to appreciate their professional responsibility, their welcoming attitude and their cordiality, their respect for the individual, the humanisation of their care, and their readiness to help.

4.2. *My Easter of 2005*

I, too, 'sick amongst the sick', to employ the phrase of the Pope, experienced Easter without being a 'protagonist', without being a celebrant or a concelebrant. For the first time, I experienced both Lent, Holy Week and the first days of Easter, with my illness as my starting point, with only a few presences, the less tiring ones that is to say, in the celebrations. I experienced them, however, with serenity and peace, asking the Lord to come to my aid, because my heart was beating more than usual and I lacked strength (Psalms 21 and 37). I cried out to the Lord and he cured me (Psalm 29). My Good Friday was transformed into Easter Sunday. I was not able to take part in the Easter vigil but I celebrated the Eucharist with the sick on the evening of Easter Sunday. I wanted to proclaim that Christ was risen, and it was true; I myself noticed this in my own body, which had improved. The Church, joyful at the triumph of Christ, sang out full of joy: 'Brightly shines the Sun of Easter, the Earth is full of joy…the Lord has risen'. Rise again with the One who rose again, run, turn it into an experience! He is alive. He has risen again. This paschal reality coincided with my rapid cure, with the statement, which was repeated many times by my medical doctors, that the results were positive. These were statements of life, of resurrection, and I noticed this in my body, which, indeed, was increasingly becoming my own.

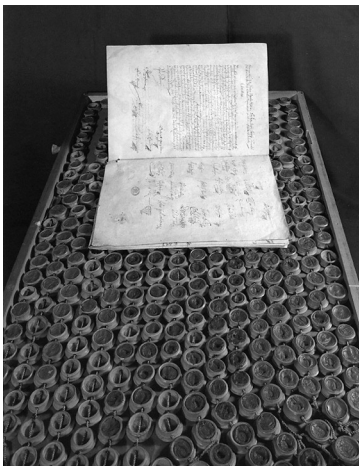
4.3. *In illness you discover other values*

In my letter expressing my gratitude, which was sent to the management of the hospital, I said that my illness had been 'beneficial' for me because it had helped me to reflect and had been an opportunity to apply the brakes to my agitated and 'stressed' life. And also because it had been a moment of friendship and a moment to realise that around us there are many good people. New people are discovered in a hospital, in one's own community, in one's working life. During my illness I was accompanied by the Superiors of the Hospital Order to which I belong. The three communities of the island on the Tiber, the service of pastoral care, the Superiors and my companions at the Pontifical Council for Health Pastoral Care in the Vatican, were all very near to me; many religious communities and members of the lay faithful who prayed for me were also very near to me. I felt near to me a river of prayers, a great deal of solidarity, a large number of friends – all of them were medicine for my body and for my spirit. They helped me to overcome my illness with peace and serenity.

Pain and illness give rise to prayers; they are a time for the raising of supplications to the Lord. As I have already said, I felt that many people were praying for my recovery. I prayed as well, as, indeed, one prays when one's body is 'broken'. Every day, during prayer, an infinity of faces and of institutions passed through my mind. I did this again in a special way the first day that I began to reintegrate myself into my work, on 4 April, by offering the Eucharist as an action of grace for my recovery and for all those people who had contributed to that recovery: the medical doctors, the nurses, the community, my family and the friends who had all been near to me with knowledge, solidarity and friendship. I prayed for all of them.

4.4 *Therapy through reading and music*

I love reading. By the end of the year I had read about fifty books, both long and short in length. Reading is as necessary as food. St. Bernard said that 'a good book teaches you what you have to do, it instructs you on what you must avoid and shows you the goal to which you should aspire'.



Once the first 'torment' of the illness had finished and I had recovered my strength, I began, in a very gradual way, to engage in light reading: reviews offering information; the last two documents of the Pope addressed to priests and to those responsible for social communications; the reflections of Msgr. Ravesi on Holy Week, with texts by Bernanos, Claudel, Unamuno, and Turoldo...; and the letter of the Pope to Paolo Mosca; 'Memory and Identity'. This was because 'I had nothing to do' and the only thing I had to do was to look after my health. This was a 'privileged' opportunity to read and also to listen to good music. I went through the great masters of music once again: Mozart, Beethoven, Bach, Vivaldi. Choirs and organs. Russian folk songs, music for meditation and relaxation. Gregorian chants, classical pieces for Holy Week and Easter ('Mandatum novum'; 'Ubi caritas'; 'Exultet'; the 'Messiah', the Halleluiah of Händel...). How much this music helped to

'distract me', to give me serenity, to raise my spirit, and to heal me! How much good music heals! It is good medicine.

4.5 *'The Lord is my strength and my power, he has been my salvation!'*

During the most critical and difficult period of illness, a great powerlessness is experienced not only in one's body but in the whole of one's person. One does not want to do anything, not even to pray 'officially'. A book falls from one's hands. Neither one's spirit nor one's mind reacts to the large number of psalms, readings and prayers. And a weak and simple prayer is raised up, helped by brief thoughts from Holy Scripture and at times also by sentences from the saints.

I remember that in my hospital room, when I had begun to read a little once again, until, that is, my eyes clouded over, I went to get a book containing the Confessions of St. Augustine. That 'late I loved you' or 'you made us for you and our heart will not be at peace until it rests in you' seemed to me to be 'vibrant' and appropriate. And then St. Augustine once again: 'why are you troubled. He who made you is looking after you'.

Later, in the complete works of St. Teresa d'Avila, I greedily sought that '*Nulla ti turbi*, that is to say poem n. 30 in which the saint invites us to raise our thoughts and to aspire to heaven.

I was passing a good, positive, reflective time of prayer, and I slowly went over, on a number of occasions, the following poem of the great Teresa:

Nothing troubles you,
Nothing frightens you,
Everything passes,
God does not change,
Patience
Obtains everything;
He who has God
Lacks nothing:
God alone is enough.

For me, during those moments, this poem was spiritual medicine.

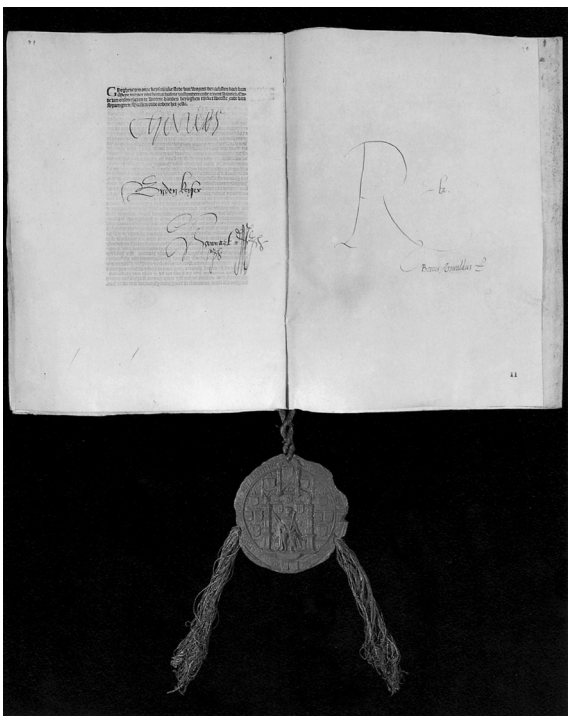
Although it is true that I trusted a great deal to medicine and to people of knowledge, and that I 'held onto' them, so to speak, in order to escape the illness as soon as possible, it is equally true that I experienced the presence of God within my own person through a very large number of 'mediations', the very many people that I came into contact with during those days of my life who encouraged me and gave me their advice. Such 'mediations', such short texts from Holy Scripture and from other authors, were medicine for me, because they gave me strength, hope, and the desire to walk.

I cannot but quote here a thought of Teilhard de Chardin which I 'chewed the cud' over many times. That thought says:

Do not be troubled at the difficulties of life,
At its ups and downs, its disappointments,
At its varyingly dark future.
WISH FOR WHAT GOD WANTS.
Live happy. I beseech you. Live in peace.
Let nothing disturb you.
Let there be born, and always conserve on your face, ,
A sweet smile, a reflection of the smile the Lord continuously addresses to you..
When you feel afflicted and sad,
WORSHIP AND TRUST.

I could go on for page after page giving an account of my experience. I believe, however, that I have addressed what most surprised me and what, with most intensity, I experienced. A shared experience and shared memories. Many human things, but also many things of God: God writes, as Pope Lucani said, 'not in bronze or marble but in the dust of the earth, so that it is clear that everything is the work of and, everything is to be attributed to, the Lord alone'.

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



Alzheimer's Disease: An Experience of Suffering and of Growth

ROME, JANUARY, 31 2005

1. I think it is incumbent upon me, even though I will run the risk of saying something that is obvious, to state at the outset that I accepted the invitation to speak at this highly qualified international conference not because I have a specialised medical training in the field, which of course I do not, but because of my daily experience as an ordinary man with a priestly ministry that has been exercised over many years, even though not always in direct contact with sick people and in particular with these kinds of patients.

Alzheimer's disease, in fact, has a major relevance for our society, as is made clear by the statistics that are well known to those taking part in this conference The experts tell us that 'it is the most common cause of dementia in the elderly population of Western countries'. It is estimated that Alzheimer's disease afflicts 5% of people beyond the age of sixty and about 20% of people over the age of eighty. It is estimated that in Italy the number of people afflicted by this disease is seven hundred thousand, of whom fifty thousand live in Lazio, and that this figure is destined to increase with the continued rise in life expectancy.[1] In the United States of America, once again according to the statistics, there are about three to four million people who suffer from Alzheimer's disease. The public expenditure to care for these patients is about 500 milliard dollars every year and the annual costs for caring for a patient afflicted with Alzheimer's diseases is about 47,000 dollars.[2]

This disease is often a silent tragedy but it is a very imposing one for those who have to endure it, for family relatives and for those who help them and take their place in caring for patients, for medical doctors and for society as a whole.

Last year the mass media attracted the attention of the world to this malady by reporting the death of a former President of the United States of America who had been suffering for a number of years from this disease, whose slow progression can last for up to eight to ten years after its initial diagnosis.

Important figures of the economy, of politics, of medicine and of religion can be reduced during the final stage of the illness to an at least apparently vegetative condition of life after a long-lasting period of varying durations involving a progressive loss of the use of the cognitive faculties and the faculties of the will.

Alzheimer's disease emerges at about fifty to sixty years of age and it is connected with processes that injure the cerebral cortex. A family factor is to be found in 25% of cases. The onset of the malady is insidious and marked by a modest deficit in some of the symbolic functions (difficulties in speaking, in writing, in reading and in the use of instruments), by a certain disorientation as regards time and space, and by impairment of the memory as regards recent events. This impairment grows rapidly worse at the same time as intellectual decline becomes more marked, especially at the level of critical judgements and assessment. The inability to orient himself or herself on the part of the patient in relation to time and space is made more dramatic by the tendency to draw away from his or her home. The symbolic functions are greatly altered. Activity is disordered, incongruous, absurd or reduced even to abulia. Signs of a psychotic character can appear (prejudice deliria) as well as crepuscular phenomena. In these patients one can also often observe a widespread lack of interest, neglect of their person, a folding in on themselves, and a tendency to hypochondria. It is also frequently the case that there are expressions of anxiety, easily provoked irritability, emotional incontinence, and behaviour disorders (especially sexual behaviour disorders). For some time a partial awareness of the illness can remain and this aggravates the suffering of the sick person and leads him or her to engage in a series of subterfuges in order to escape the observation and the initiatives of his or her family members. The disease lasts a long time and is in some instances marked by partial or transitory remissions. 'The self with dementia is characterised by a compromise not only of the instruments of the mind but also of its mental patrimony…For this reason one could well say that dementia is the gravest psychiatric form of the 'dehumanisation' of man. Although the person with dementia is not fatally condemned to this dehumanisation, one cannot deny that the attempt to secure his or her recovery is extremely difficult and in general disappointing.

2. This clinical picture, which I have presented here not in order to teach something to the distinguished men and women taking part in this conference (who without doubt could modify it, correct it and supplement it thanks to their knowledge and experience), but rather in order to focus in on the problem, helps us to understand further the devastating effects of this terrible malady on those who are afflicted by it. These can be summarised under the following headings: the physical profile – progressive general decline; the mental profile: anxiety, depression, memory loss and loss of self-awareness; the moral profile: humiliations and frustration because of disabilities that are perceived as long as the use of reason remains, which is then followed by the (at least) apparent total loss of the rational faculties of the patient.

I observed in the first person the struggle against the inexorable advance of this evil by a fellow member of my religious order who had occupied posi-

tions of great responsibility in Church diplomacy. I learnt of the dramatic experiences of a very large number of other people above all through the private communications of family relatives who needed comfort and support, above all of a moral and religious character.

Indeed, the suffering of patients is accompanied by the suffering of their family relatives – first of all the moral humiliation of witnessing the progressive devastation of the personality of their loved ones who become morally unrecognisable to them (very loving and very balanced as fathers and mothers during the previous part of their lives, they come to accuse their loved ones of betrayals and violence; university lecturers who are the authors of numerous publications of a high value become reduced to a total incapacity to think and to express themselves; and famous scientists become capable only of a permanent smile); then the malaise and discomfort that are caused by the need to provide sensitive and tiring care; the heavy consequences for professional, political and cultural activity; the economic burden that has to be borne; impatience in relation to the reactions of the sick person; and even the temptation to engage in a drastic abandonment and rejection of the patient.

The negative impact on those people who are called to look after patients, by helping the family relatives or at times by partially or totally replacing them both at home or in specialised structures, is also negative in character.

But the treatment of these patients is difficult and frustrating for medical doctors as well, both from a human and a professional point of view. This is because a specific therapy for this illness does not exist and because anyway the primary aim of treatment is the achievement in the long term of an improvement in the disturbances and the limiting of the progressive and inexorable destruction of the human person as regards the qualities that define that person in a specific way (intelligence and will).

Alzheimer's diseases calls on society itself, and society is called upon to sustain, supplement and, if necessary, replace the work of the family relatives of the patient, as well as to make available means and structures for care and assistance that are on a human scale.

The level of civilisation of a society is measured by the way in which that society attends to the needs of its members, in general, and above all of patients and in a very special way *these* patients.

3. Is the devastating tragedy of Alzheimer's disease, which is the cause of so much physical and moral suffering, an opportunity for growth for those who are in some way involved in it? Can it be such an opportunity?

An answer of realistic hope and not merely consoling hope cannot be separate from a shared anthropological premise in which those people who, although they have a position of doubt and difficulty in relation to religious matters are not the prisoners of ideological aphorisms, can also identify.

The humanistic tradition of our culture, which also inspired our Constitution (which, however has not always been interpreted rightly), recognises that the human person throughout the whole span of his or her existence is endowed with a transcendent original dignity on which are based the inalienable rights of that subject and his or her inescapable duties.

According to this broadly shared vision, and despite deviations and episodic or even to a certain extent permanent regressions, the human person is valuable for what he or she is and not only for what he or she does or has. Because of the single fact that he or she exists, the human person has a value, a meaning, a purpose and a mission to do good to himself or herself and also to others, given that he or she has an inevitable social dimension.

In this perspective, even if solely a *human* perspective, the person can never be nor ever feel useless for himself or herself or for other people. Nor can anybody else see him or her as being useless. 'Specifically because of his being as a person, man, amongst all the creatures, is endowed with a unique dignity. Every individual man is an end in himself and can never be used as a mere means to achieve other goals, not even in the name of the wellbeing and the progress of the whole community'.[4]

The anthropological vision derived from *Christian faith*, which is rooted in our people notwithstanding appearances to the contrary and which emerges specifically during the difficult moments of personal life and in the dramatic situations of associative life, tells us that 'God, in creating man in His image, wanted to make him a participant in His lordship and His glory. When He entrusted to him the task of stewarding the whole Creation, He took into account his creative intelligence

and his responsible freedom.

The Second Vatican Council, peering into the mystery of man, opened up to us, in the light of the words of Christ (cf. Jn 17:21-22), horizons that are impervious to human reason. In the Constitution *Gaudium et spes* the Council specifically referred to 'a certain similarity between the union of the divine persons and the union of the children of God in truth and charity' (n. 24). When God turns His gaze to man the first thing that He sees and loves is not only the works that he manages to do but the image of Himself, a image that confers on man the ability to know and to love his own Creator, to govern all the creatures of the earth and to use them for the glory of God (cf. *ibid.*, n. 12). It is for this reason that the Church recognises the same dignity in all men, the same fundamental value, independently of any other consideration of circumstance. Independently, therefore, and this is of the utmost importance, of when this ability

cannot be implemented because it is hindered by mental disturbance.

This conception of man as being in the image and likeness of God is not only confirmed by Revelation as presented by the New Testament but is also massively enriched by the New Testament. As St. Paul affirms: 'when the fullness of times came, God sent His son, born of a woman, born under the Law, to redeem those who were under the Law, so that they could be adopted as sons' (Gal 4:4-5). Man, therefore, in virtue of grace, really shares in this divine filiation, becoming a son of God in the Son'.[5]

Configured in baptism to the suffering Christ, who was crucified, died and rose again, the sick Christian is in a very special way the image of the suffering Christ, who in dying destroyed death and in rising again gave to the whole of the man, both soul and body, a new life.

On the occasion of the international conference organised by the Pontifical Council for Pastoral Assistance to Health Care Workers on the subject 'In the Image and Likeness of God: Always? Disturbance of the Human Mind', Cardinal Josph Ratzinger spoke in the following way about people subject to mental suffering. They are: 'images of Christ to be honoured, to be respected, to be helped so far as this is possible, certainly, but above all images of Christ who are bearers of an essential message about the truth of man. A message we tend too much to forget: our value before God does not depend on the intelligence or on the health that allow us to engage in a multiplicity of activities of generosity. These aspects could disappear at any moment. Our value before God depends solely on the choice that we make to love as much as possible, to love as much as possible in truth.

To say that God created us in His image means to say that He wanted each one of us to manifest an aspect of His infinite splendour, that He has a plan for each one of us, and that each one of us is destined to enter, through an itinerary that is specific to the person involved, blessed eternity.

The dignity of man is not something that is impelling for our eyes, it is neither measurable nor quantifiable; it escapes the parameters of scientific and technical reason. But our civilisation, our humanism, have only made progress to the extent to which this dignity has been universally and more fully recognised as belonging to an increasing number of people. Each step backwards in this movement of expansion, every ideology or political action that removes some human beings from the category of those who deserve respect, would mark a return to barbarity. And we know that unfortunately the threat of our barbarity always hangs over our brothers and sisters who suffer from a mental limitation or illness. One of our tasks as Christians is make their humanity, their dignity and their vocation as creatures in the image and likeness of God fully recognised, respected and promoted.'[6]

4. On this premise one can draw up a strategy for growth for those afflicted by Alzheimer's disease and for those who in one way or another are involved. Obviously enough, this is a growth in *humanity* and *spirituality*. In the sick person this can come about, and often comes about, before the terminal stage of the illness.

Suffering – like, indeed, all other human conditions – is in itself ambivalent: it can draw a person nearer to God if it is 'read' with the eyes of faith and upright reason; it can distance a person from God if it is seen according to the logic of wellbeing as an end in itself. If pain is a mystery, the relationship of a person with pain is also a mystery, which, indeed, only God can unravel.

In relation to the enigma of pain, God 'has answered the question about its meaning which we carry in our hearts at these moments not through rational explanation (author's note: or better rationalistic explanation) but through compassionate sharing. Christ who was made man died to defeat our deaths'.[7]

'Where were you Lord when I was suffering so much?', St. Catherine of Sienna asked Jesus when he appeared to her in a vision. 'I was next to you to carry your cross', was the reply.

The growth of the sick person takes place with the retrieval or deepening of faith, which leads the patient to accept his or her own condition of disability and to 'discover with joy the special mission that has been entrusted to him in the mystical Body of Christ: in union with the suffering Christ he can co-operate in the salvation of mankind, endowing his prayer with the offering of suffering (cf. Col 1:24)'.[8]

Seen in this perspective, suffering is an opportunity for an inner journey that purifies and repairs, in virtue of union with the redemptive Passion, one's own malady and that of others. It becomes salvific to the point of leading that person into the mystic life, as the great figures of saints of the past and also very recent ones teach us in their writings: St. Theresa of Avila and St. Theresa of the Child Jesus St. Faustina Kowalska, the Blessed Gatano Catanoso, the Servant of God St. Theresa Benedetta of the Cross (Edith Stein), and St. Maximilian Kolbe.

The deepening of faith broadens the boundaries of love. One could quote on this point the words of St. Augustine: '*Si angustiantur vasa carnis, dilatentur spatial caritatis*',[9] and open up to that supernatural hope which leads a person to exclaim: 'I believe, I will rise again, this body of mine will see the Saviour'.[10]

And during the terminal stage of illness as well, when the poor body of the sick person seems to be reduced to a mass of living flesh with only a vegetative life, that body is always an icon of Christ, a temple of the Holy Spirit, which should be honoured, respected and loved even more than a temple of stone.

The Church expresses this respect after death as well by burning incense around the person's mortal remains at the moment of the last farewell.

Each one of us through the experience lived out by other people knows that this is difficult: 'I know what I should say', said the saint, 'but I do not know what I will do'. But with the grace of God this is possible.

A similar approach also applies to the family relatives of

the sick person and to those who help him or her or replace the family relatives in providing care and assistance to him or her.

To see Christ in a loved one who is sick, to dedicate oneself to that person following the example of St. Catherine of Sienna, of St. Francis of Assisi, or of Damiano Veuster, the apostle of lepers, to launch that person and accompany them along the paths of Christian hope: here we have a school of growth in humanity and spirituality!

Thanks to God there have been very many examples of such hidden heroism and I have been a moved witness to them thanks to my ministry.

A medical doctor as well can grow in treating those people who are afflicted by this disease, as for that matter he or she can in treating all sick people, both from a professional point of view, by enriching his or her knowledge and experience, and from a human point of view, by increasing his or her empathy for the patient, and in perceiving the dignity of the patient as a human person and as a brother or sister of Christ.

But also civil society can and must grow by providing adequate specialised structures for the care and treatment of the sick person at the level of support and supplementary action, and, where this is necessary, at the level of replacing the family in line with the principle of subsidiarity and endowing those structures with staff who are trained specifically for such work. Indeed, the Church community itself can and must grow by assuring that people suffering from Alzheimer's disease who are at home or in specialised centres receive loving pastoral care not only through priests but also through pastoral workers (for example through extraordinary ministers of the Eucharist and through people who visit the sick people and give them advice, comfort and support).

This strategy for growth does not exclude the sick people of other confessions or of other religious denominations or of different ideological beliefs. This is because God calls everybody to His home without violating their will, which He wants to be free to respond, but also to be responsible in that response.

This response remains open even to those who momentarily or permanently refuse it, for whom our respect and our love remains whole, even if they are united to pain at the rejection of an opportunity that is decisive for that person's destiny.

On this point I am very happy to remember what was said about a Belgian priest, Edoardo Poppe, who was raised by John Paul II to the honour of the altars. In the locality in which he exercised his pastoral ministry there lived a sick person who was very far from having an interest in religion. This priest went to visit him and out of respect for his beliefs discussed various cultural subjects with him. After a little while, the person he was speaking to asked

him in a very direct way: 'when will you decide to talk to me about God'? On another occasion the interlocutor was closed to the religious approach, even though out of courtesy he had received the priest, and he allowed the priest to light a candle in front of a holy image that he had in his home. This was something that Don Edoardo did every time that he paid him a visit. One evening the man realised that the priest did not have any matches and said to him: 'do you want a match'. And from that question the religious dialogue began.

5. In conclusion I would like to emphasise the special sensitivity that John Paul II dedicated to human pain in general in his encyclical *Salvifici doloris*,[11] as well as in speeches given in various contexts, and by establishing the Pontifical Council for Pastoral Assistance to Health Care Workers on 11 February 1985.[12] He also addressed these kinds of illnesses in particular in significant speeches that he made to those taking part in the international conferences organised by this Pontifical Council of the Roman Curia, for example the international conferences on 'mental disturbance' (28-29-30 November 1996);[13] on 'depression' (13-14-15 November 2003);[14] and on 'palliative care' (11-12-13 November 2004).[15] The message of John Paul II for Lent 2005 follows the same lines.[16] His words, some of which were reported, can also direct our reflection of Alzheimer's disease, which leads us to kneel before our suffering neighbour with the spirit of the Good Samaritan, following the words of Christ spoken to the lawyer: 'Go, and do you likewise'.[17]

H.E. Msgr. BRUNO BERTAGNA
Secretary of the Pontifical Council for Legislative Texts, the Holy See.

Notes

[1] L. GATTANI, *Vademecum Alzheimer*.
[2] T. BIRD, 'Malattia di Alzheimer e altre demenze primarie', in Harrison (ed.), *Principi di medicina interna*, pp. 2673-2677.
[3] *Ibid.*, p. 2674. Internet: *Alzheimer*, edited by AFaR.
[4] JOHN PAUL II, 'Discorso in occasione della Conferenza Internazionale sul disagio mentale', Pontifical Council for PAstoral Assistance to Health Care Workers' (Rome, 28-30 November 1996), *L'Osservatore Romano*, December 1996, p. 5.
[5] *Ibid.*, p. 5.
[6] *Dolentium Hominum*, n. 34 (XII, n.1), p. 19.
[7] CARLO CAFFARINI, Archbishop of Bologna, homily on the occasion of the Holy Mass for the victims of Crevalcore, 14 January 2005.
[8] JOHN PAUL II, speech to the plenary assembly of the Pontifical Council for Pastoral Assistance to Health Care Workers, *L'Osservatore Romano*, 22 January 2005.
[9] ST. AUGUSTINE, *Sermon*, 69, I, PL 38.
[10] Nella Casa del Padre, *Io credo risorgerò*, n. 600, p. 480.
[11] *AAS* 76 (1984), pp. 235-23.
[12] Motu proprio 'Dolentium Hominum', in *AAS* 77 (1985), pp. 459-41.
[13] *L'Osservatore Romano*, 1 December 1996, p. 5.
[14] *L'Osservatore Romano*, 15 November 2003, p. 5.
[15] *L'Osservatore Romano*, 13 November 2004, p. 5.
[16] *L'Osservatore Romano*, 28 January 2005, p. 4.

A Note on the World Mental Health Day

10 OCTOBER 2005

On the occasion of the World Mental Health Day, whose theme this year is "Mental and Physical Health Across the Life Span," I as the President of the Pontifical Council for Health Pastoral Care, would like to make a reflection, in order to express the keen interest with which the Church follows the problems of mental and physical health. Health is an inestimable treasure and health for all is a basic requirement of justice and peace among all peoples.

The health condition of single persons, families, communities and nations is determined by variable and interacting environmental, biological, psychological, socio-cultural, spiritual, economic and political factors. Economic factors affect planning for health and its realization, access to health care, the responsibility of health providers, the quality and outcome of treatments, the intensity and amplitude of research, as well as training. Health promotion, the prevention of diseases and the sharing of health related risks (environmental, risky behavior including smoking, sexually transmitted diseases, drug abuse and addiction, violence and diseases) in the wider sense, are all correlated responsibilities of national plans for health, business, governments, and health providers.

In the area of mental health, such issues assume particular importance. The World Health Organization reports that 450 million people in the world are affected by mental, neurological or behavioral problems, and that 873,000 people commit suicide every year. Mental disorder constitutes a serious socio-health emergency: 25% of the world nations have no legislation on the subject; 41% have no defined policy on mental health; in over 25% of the health centers the patients have no access to essential psychiatric drugs; and 70% of the population has less than one psychiatrist for every 100,000 people. Mental disorders affect more frequently those populations that are intellectually, culturally and economically less fortunate. Millions of people have to physically and mentally bear the consequences of poor nutrition, armed conflicts as well as a succession of colossal natural catastrophes with their heavy burden of morbidity and mortality.

There is an urgent need for stronger action for the prevention of mental illness. Early diagnosis, intervention at the first symptoms of disorder and suffering, and the realization of specific measures of intervention are basic instruments for mental health protection. There is a need to guarantee the diffusion of a proper education in health and the promotion of healthy life-styles based on a culture of values. Medical science itself acknowledges a close link between the appearance and worsening of some mental disturbances and illnesses and the contemporary crisis of values. There is a confirmed link between AIDS, drug addiction and the disorderly use of sex. We cannot be silent in the face of the continued aggression against serenity and mental equilibrium procured by social models that lead to the manipulation of man and the dangerous conditioning of his freedom. The crisis of values and the affirmation of dysvalues which increase loneliness, destroy traditional forms of social cohesion, breaking up groups of aggregation, especially on the cultural level and discredit the well-deserving institution of the family. Even the dominant mentality of our society, which is ever more egoistic and closed, leads to the removal of suffering and its marginalization, causing serious consequences for the mental health of citizens.

The Catholic Church has always offered her contribution to the prevention of and care for the mentally ill and their families at the medical-assistance, social, spiritual and pastoral levels. We are conscious of the existence, especially in mentally ill people, of the precious image of God, which in the suffering Christ, as said by Prophet Isaiah, "has no form or charm to attract us, no beauty to win our hearts" (Is 53, 2); it is there so that the redemptive power for all humanity may be found. Consequently, there are many projects and programs for education, prevention and assistance, care and pastoral accompaniment of the sick, being carried on by the local churches, religious institutes and lay associations with love, a deep sense of responsibility and a spirit of charity. They demonstrate through their work that mental illness does not create insurmountable ditches nor prevent relationships of authentic Christian charity with its victims.

I therefore address this reflection to all civil authorities who are responsible for vigilance over public life so that they may try to find urgent help for these patients, the majority of whom are on the streets or in families, where they cannot receive the technical and scientific assistance they need. They should put in place effective instruments of intervention to defend the basic right of access to health care and equity in health, in full respect of the integrity and dignity of the sick person.

H.Em. Card. JAVIER
LOZANO BARRAGÁN
*President of the Pontifical Council
for Pastoral Health Care,
The Holy See*

Together for Life and Health

WORLD DAY OF THE SICK,11 FEBRUARY 2005:
EPISCOPAL COMMISSION FOR PASTORAL CARE IN HEALTH
OF THE CENTRAL AFRICAN REPUBLIC,
SUMMARY OF THE CONASAN (NATIONAL CO-ORDINATION FOR HEALTH)
OF THE RCA/ACERAC

A Profile of the Identity of the Country

Surface: 623,000 km2; three and a half million inhabitants; location on the HDI (Human Development Index): number 172 out of 182 countries; life expectancy: 49 in 1988 and 44 in 1998; literacy rate: 67% in primary schools and 20% in secondary schools, of whom 40% are girls; female deaths at childbirth: 683 out of every 100,000 births in 1975; 948 out of every 100,000 births in 2000; infant mortality rates (children under five years of age): 19.40% in 2000; absolute poverty levels before the destruction of a third of the country (2002-2003): 64% of the population.

Context

The prevalence of HIV/AIDS in the Central African Republic, with an incidence rate of 21% in the urban areas and 34% in the rural areas, is the highest to be found in all the Sub-Saharan countries of francophone Africa. A decade of military and political revolts and disorders, and the civil war, have not favoured an intense, concerted and constant action on the part of the state in the fight against AIDS.

What the Church and CONOSAN have Done

An ecumenical network of the Churches to promote health exists (this is the ASSOMESCA, which has 170 health care specialisations) and within this operates in particular the CONOSAN (the Catholic National Co-ordination for Health). This has a national office and nine diocesan co-ordination teams for health and also has a total health care staff of 486 people who work in 114 health care specialisations. For fifty years the Church has always given strong and direct support to the government structures with investments and the presence of twenty-two female religious in the same number of public hospitals. In 2004 an agreement was signed between the State/Ministry of Health and the Church/CONASAN to regulate co-operation between these two partners who work for the health of the population. The Church is the bearer of the words, the voice of those without a voice, and works to assure financial access to care and treatment for the poorest inhabitants of the Central African Republic (two-thirds of the population).

During and after the civil war (2002-2003), it launched a project of emergency health care called 'TALITA KUM' which ensured the survival of a million people who were treated and cared for in about a hundred hospitals or health care centres (these were largely public in character). This project met with great success and operated through a consortium of six international financial backers (CRS, UNICEF etc.). The thanks that were received from people often took the following form: 'everybody forgot about us, but God did not abandon us: the Church stayed with us and tore our lives from the jaws of death!'.

The National Episcopal Committee and AIDS in the Central African Republic (CENFAS)

Since 2001 the ACERAC, the co-ordinator of the CONOSAN, has brought together as a mainstreaming office nine socio-pastoral committees. This launched the EVA programme ('Education for Life and Love') not only in schools and amongst groups of young people but also in parishes and various movements within the country. This programme has as its target group couples that are presented as models for the accompanying of young people and the promotion of a culture of sharing within the family and between parents and young people who are going through puberty. During the last three years, 118 educators have been trained, of whom two-thirds are couples. More than 5,700 people afterwards took part in sessions that lasted between one and seven days. Planning for the whole of the year 2005 has been engaged in that deals not only with the assessment of the activities of the Church in all its nine dioceses as regards AIDS, but also provides for better co-ordination and the mobilisation of the parishes.

Our Priority Concerns and Actions

To assure that the population has financial and geographical access to medical care and treatment; to improve the quality of preventive and curative medical care and treatment; and to promote physical, spiritual and moral health through responsible social and sexual behaviour ('Where is your brother?').

Our Challenges

The material and educational reconstruction of most of the population; the rebuild-

ing of two dioceses after the looting and destruction; the reliability and self-financing of the health care services of the CONASAN; and the durability of the services and human resources (Africanisation).

Witchcraft, False Beliefs, Marginalisation and AIDS

In the Central African Republic the people infected with HIV/aids die more from loneliness, from depression, from fear and from marginalisation than from opportunist infections – this is something that concerns us as a Church. The Church, indeed, has its own specific contribution to make by working for the growth and development of the souls of our sick sections of the population. Its specific response, following the example of the Good Samaritan (who was not even a nurse!), must go well beyond caring for bodies and offer spiritual support to sick people.

It would be advisable and helpful to utilise *two specific Catholic instruments* on a large scale. Was the Sacrament of the Eucharist not perhaps given to us so as to strengthen our understanding of the fact that our God even allows Himself to be eaten to as to reassure us of His presence and protect us against every kind of evil even more than a shield? Was the Sacrament of the Anointing of the Sick not perhaps given to us as strength and grace so as to direct our lives towards God (and not as an announcement of death)?

Who should be done so that prayer, Holy Mass, and words and concrete acts of solidarity between Christians become a single reality?

In this way we can show all those people who suffer that 'where two or three are gathered in my name, I (Jesus, God) am amongst them' (Mt 18:20).

Dr. REGINAMARIA EDER,
National Co-ordinator.

Pontifical Council for Health Pastoral Care

Pontificio Consiglio per la Pastorale della Salute

Pontifical Council for Health Pastoral Care

Message of His Holiness Benedict XVI for the XIV World Day of the Sick (.

December 23, 2005

HEADLINES

Message for the World Day Against AIDS - 1 December 2005

Message for the World AIDS Day - 1 December 2004

Catholic Women Nurses Faced with the Challenges of Health in Africa

HIGHLIGHTED

Message of His Holiness Benedict XVI for the XIV World Day of the Sick

«*Duc in altum!* This invitation of Christ to Peter and the Apostles I address to the Church communities spread throughout the world and in a special way to those who are at the service of the sick, so that, with the help of Mary *Salus infirmorum*, they may bear witness to the goodness and the paternal solicitude of God.» (Benedict XVI). [View more]

WORD OF THE POPE

Message of His Holiness Benedict XVI for the XIV World Day of the Sick

Message of the Holy Father John Paul II for the XIII World Day of the Sick

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

Search