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Telegram

TO CARDINAL JAVIER LOZANO BARRAGÁN,
PRESIDENT OF THE PONTIFICAL COUNCIL
FOR HEALTH CARE WORKERS,
VATICAN CITY

8 FEBRUARY 2008

The Supreme Pontiff sends cordial greetings to the faithful gathered together in the Basilica of St. Peter's in the Vatican on the occasion of the feast of the Blessed Mary Virgin of Lourdes and the World Day of the Sick and while he formulates vows that this praying meeting increases in those present fervid hope in the crucified Christ who always supports those in tribulation he invokes on each one from the Holy Virgin copious celestial graces and from his heart sends to all those present with a special thought for the sick his implored apostolic blessing.

Cardinal TARCISIO BERTONE
Secretary of State of His Holiness

XVI World Day of the Sick

11 february 2008

Introduction: UNITALSI at the Service of the Sick

UNITALSI is an association that was created in 1903 and offers moral and material support to a very large number of people who are in situations of difficulty, above all sick people, accompanying them and helping them at all levels during the pilgrimages that UNITALSI organises to Lourdes and to the most important sanctuaries in Europe.

With the passing of time the requests made have diversified and although pilgrimages are kept as the privileged activity of the association we have striven to meet in an adequate way all the various social needs by opening a large number of family homes, courses for treatment with a smile, and so forth.

Through the proposal of an experience of faith pilgrimages remain the reality that characterises UNITALSI, and we try to live the charism of service in the same way as Christ is the servant of Man.

On the occasion of the one hundred and fiftieth anniversary of the apparitions to St. Bernadette of the Virgin Mary at Lourdes, for the first time ever the relics of this saint left the sanctuary where they are kept and were taken to Rome. The Bishop of Lourdes, in entrusting these relics to UNITALSI, strongly stressed the need (and it was also his hope that this would come about) for our association to be an increasingly tangible sign of the presence of the Church at the side of the sick, of the suffering, of the least, who, in carrying their personal and at times very burdensome cross, bear witness to us that faithfulness to God is always possible and is the pathway to salvation.

On 7 February, therefore, we solemnly received these relics and took them to the Roman parish that is named after this saint. By now there were a large number of the faithful of UNITALSI as well as many members of this parish, and in particular a very large number of sick people, who, indeed, experienced this event with evident transport and devotion.

On 8 February His Excellency Msgr. Brambilla presided over the Holy Mass for all the sick people there who then remained for a brief moment of conviviality which is something that is always very much appreciated, especially by the very many sick people who live permanently in institutions.

On 9 February we organised a party day with all the children of UNITALSI and of the neighbourhood who had an opportunity to explore the life of Saint Bernadette through animated games. After the floral homage to the relics made by the children we carried the relics through the streets of the neighbourhood.

The children were certainly fascinated by the story of the life of Bernadette who was little more than a little girl when the Virgin appeared to her. This saint accompanied them during the UNITALSI pilgrimage of June, 'Children of Peace', to Lourdes. This was an event that certainly profoundly enriched their human experience and their faith and encouraged a new hope in their hearts.

On 10 February the relics were taken to the prison of Regina Coeli where they were received by the prisoners with great emotion. For all of those present this was a very intense and involving moment.

A large number of people took part in the event in a calm way and all those who had an opportunity to take part in this event were captured and fascinated by this saint who in her humble simplicity was able to meet the wishes of the Virgin Mary and make Lourdes a holy place and the destination of very many, truly very many, pilgrims.

On 11 February, the day of the sick, the feast day of Our Lady of Lourdes, we carried the relics to St. Peter's Basilica in a procession that began at Castel Sant'Angelo, escorted by the fanfares of the Carabinieri who were mounted on horseback but above all by the prayers and the emotional participation of the very large number of sick people who were present.

We were received in the basilica by Cardinal Comastri who presided over the saying of the Angelus, a prelude to the celebration of the Eucharist in the afternoon which was presided over by Cardinal Javier Lozano Barragán, the delegate of the Holy Father and the President of the Pontifical Council for Health Care Workers.

For everyone there this was a very intense experience, celebration rich in signs. Some people received the sacrament of the Anointing of the Sick from the hands of Cardinal Barragán. This was certainly an appreciated gift and an example of riches that strengthened them in their faith and their hope.

To live the Day of the Sick having in front of one's eyes the relics of St. Bernadette, and to have in one's heart a little of her simplicity, her humility, and her charism, was an immense joy, a gift that the Lord wanted to give to UNITALSI and to all those who took part in this event. It was above all an occasion to experience with even greater intensity the large number of commitments of this year of grace.

Angelus

ST PETER'S SQUARE FIRST SUNDAY OF LENT, 10 FEBRUARY 2008

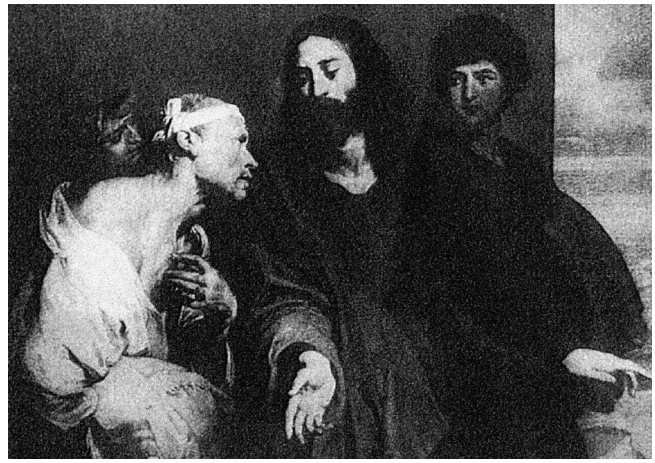
Dear Brothers and Sisters,

Last Wednesday, we entered Lent with fasting and the Rite of Ashes. But what does "entering Lent" mean? It means we enter a season of special commitment in the spiritual battle to oppose the evil present in the world, in each one of us and around us. It means looking evil in the face and being ready to fight its effects and especially its causes, even its primary cause which is Satan. It means not off-loading the problem of evil on to others, on to society or on to God but rather recognizing one's own responsibility and assuming it with awareness. In this regard Jesus' invitation to each one of us Christians to take up our "cross" and follow him with humility and trust (cf. Mt 16: 24) is particularly pressing. Although the "cross" may be heavy it is not synonymous with misfortune, with disgrace, to be avoided on all accounts; rather it is an opportunity to follow Jesus and thereby to acquire strength in the fight against sin and evil. Thus, entering Lent means renewing the personal and community decision to face evil together with Christ. The way of the Cross is in fact the only way that leads to the victory of love over hatred, of sharing over selfishness, of peace over violence. Seen in this light, Lent is truly an opportunity for a strong ascetic and spiritual commitment based on Christ's grace.

This year the beginning of Lent providentially coincides with the 150th anniversary of the Apparitions in Lourdes. Four years after the proclamation of the Dogma of the Immaculate Conception by Blessed Pius IX, Mary appeared to St Bernadette Soubirous for the first time on 11 February 1858 in the Grotto of Massabielle. Another three Apparitions accompanied by extraordinary events followed in succession and finally the Blessed Virgin took her leave of the young seer, in the local dialect, by disclosing to her: "I am the Immaculate Conception". The message that Our Lady continues to spread in Lourdes recalls the words that Jesus spoke at the very beginning of his public mission, which we hear several times during these days of Lent: "Repent, and believe in the Gospel", pray and do penance. Let us accept Mary's invitation which echoes Christ's and ask her to obtain for us that we may "enter" Lent with faith, to live this season of grace with inner joy and generous commitment.

Let us also entrust to the Virgin the sick and all who take loving care of them. Indeed, the World Day of the Sick will be celebrated tomorrow, the Memorial of Our Lady of Lourdes. I wholeheartedly greet the pilgrims who will be gathering in St Peter's Basilica, led by Cardinal Lozano Barragán, President of the Pontifical Council for Health Care Workers. Unfortunately I shall not be able to meet them because this evening I will begin Spiritual Exercises, but in silence and recollection I will pray for them and for all the needs of the Church and of the world. To all who desire to remember me to the Lord, I offer my sincere thanks from this moment.

BENEDICT XVI



Homily for the Celebration of the XVI World Day of the Sick

ST. PETER'S BASILICA, 11 FEBRUARY 2008

On the occasion of the Sixteenth World Day of the sick, which is celebrated every year on 11 February, the liturgical memorial of Our Lady of Lourdes, the Holy Father Benedict XVI has sent a special Message to the whole of the Church. The contents of this Message are very rich and profound. His Holiness writes that this Day is propitious for reflecting on the meaning of pain and the Christian obligation to care for the sick. This Message points out to us that this celebration takes place within the framework of this year 2008 when two great events are being celebrated: the hundred and fiftieth anniversary of the apparitions of Our Lady at Lourdes, which falls precisely today, 11 February, and the International Eucharistic Congress, which will be celebrated in Quebec, Canada, in June of this year. Indeed, in the Message it is stated that there is a profound union between Mary and the Eucharist: the body of Christ which Mary gives us is the body that is found in the Eucharist, and the attitude of Mary that arises from her Immaculate Conception, an absolute 'yes' that associates her intimately to the redemptive sacrifice of her son, is an attitude that offers the sole way of understanding the meaning of pain and the meaning of the care that we owe to sick people. She is the compassionate mother who spreads care and tenderness to all her sick children. The only comprehensible response to pain is to experience it together with Mary, in intimate union with the pain of the passion and death of Christ, which we celebrate in the Eucharist. Thus suffering becomes highly positive, redemptive and creative, to the point of coming to generate wellbeing and happiness. 'Thus', the Pope continues in his Message, 'chapels in health-care centres should become the beating heart in which Jesus offers himself unceasingly to the Father for the life of mankind'.[1]

I would like to take the liberty of emphasising, and engaging in a modest commentary, on certain points of special significance in this very rich reflection which the Holy Father offers us today, in the light of the apostolic letters *Salvifici Doloris* and *Novo Millennio Ineunte* of his venerable predecessor, the Servant of God Pope John Paul II,

There is a fundamental statement: suffering is creative. In *Salvifici Doloris* reference is made to the 'creative character of suffering' because through his suffering on the cross Christ redeemed us and installed a new creation.[2]

What, then, is the naturalness of this suffering? Its intensity is very great because through the hypostatic Union it is the divine person of Christ who suffers with his human nature. Indeed, the intensity of this suffering is revealed in paternal abandonment on the cross. This intensity is interior and also exterior in relation to the suffering of Christ. It is exterior because it is extended to every kind of pain that can arise for mankind – it is the suffering that mankind has borne, is bearing and will bear; it is not only physical pain but also mental, social, spiritual and moral pain. Each one of us can say: what I suffer today, Christ suffers; my pain is also suffered by Christ.[3]

The pain of Christ, however, is not a desperate and sad pain, a pain of defeat. On the contrary: it is victorious pain.[4] This suffering is the greatest achievement of Christ, it is his 'hour', his greatest glorification.[5] Christ on the cross was happy and in pain. He was joyful at all the happiness of the Trinity and at the same time experienced the total suffering of the sin of the world. The Cross and the Resurrection are inseparable. The cross is glorious. Suffering is converted into joy. In his apostolic letter *Novo Millennio Ineunte* Pope John Paul II wrote: 'In the Dialogue of Divine Providence, God the Father shows Catherine of Siena how joy and suffering can be present together in holy souls: "Thus the soul is blissful and afflicted: afflicted on account of the sins of its neighbour, blissful on account of the union and the affection of charity which it has inwardly received. These souls imitate the spotless Lamb, my Only-begotten Son, who on the cross was both blissful and afflicted'. [6]

Taking a further step forward, is it possible to experience the pain of Christ in our pain in order to find happiness and joy in them? Only the Holy Spirit can give an answer, by fusing our pain with that of Christ through his infinite Love.[7] Thus the possibility is opened up only in an absolutely special experience of suffering. The sole way by which fully to find Christ who attends to our pain is his pain and his death, lived in our pain and our death.[8]

The pathway may be outlined thus: to make oneself a participant in the same pain as Christ and be aware that our pain is a part of the pain that Christ experiences, that our death is also 'a part' of the death of Christ. This is possible only when Christ enters our will and intention through the Love of his Spirit. This is the mysterious reality of the Mystical Body in which the union of the members with the Head is carried out by the same Spirit with the amalgam

of his Love, to which one should respond freely.[9]

Thus to enter the pain and the triumph of Christ we must unite ourselves to the highest human and divine love (a special grace) and respond to the Love of the Holy Spirit with the totality of the life from the abyss of its maximum weakness in pain and in death.[10] Then is achieved the paradox of triumphant and happy pain, the happiness of Christ who rose in death itself. In this way pain becomes positive, indeed creative, redemptive, certainly without adding anything to the total and unique efficacy of the redemptive pain of Christ. This one sees because Christ suffers our pain and he makes it his own and redemptive. Through this pathway we understand the statement of St. Paul of achieving in our bodies what is lacking in the passion of Christ.[11] This means that we make our own what he made his own, taking it from our pain and our suffering. Christ says to us: 'follow me! Come! Take part with your suffering in this work of the salvation of the world that is carried out through its suffering! Through my Cross'. At the same time, however, from this level of Christ this salvific meaning of suffering comes down to the level of man and becomes after a certain fashion his personal response.[12]

The Eucharist is the memorial. It is Christ who suffers and rises again in a permanent contemporary reality. The reality of the mystery of pain which in Christ is made positive, creative, redemptive, happiness and joyous, without ceasing to be the greatest pain, is the Eucharist. Taking part in the Eucharist is the concrete pathway by which to make our own afflictions enter the affliction of Christ. This is the Eucharistic Communion. Thus the Eucharist is our cross and our resurrection. It is the sole true remedy for pain. It is the medicine of immortality.

As was said above, to achieve our response to the full love of the cross a total 'yes' is required to the mysterious redemptive plan, a 'yes' that means the fullness of Love. This total 'yes' of Love is the Immaculate Conception of our Mother, Mary. Her 'yes' covered the whole of life, from the Annunciation to Calvary, until her glorious life.

By work of the Holy Spirit Mary conceived her divine Son and because of this love Mary joined herself on Calvary as Co-redeemer of the Saviour. Thanks to the highest maternal belonging to Christ, she received at the foot of the cross the maternity of the Mystical Body. Christ suffered on the cross all the pain that his Most Holy Mother suffered. And she suffered all our pain in Christ, she took it upon herself and knows how to pity

them with us. Our pain is also her pain. Thus internally, from the innermost part of his motherly heart, she also pities with us, she has compassion for the whole of humanity, she is maternally united to us in our pain and afflictions with all the tenderness that only she can have. And Our Lady spreads this tenderness over us according to the extent and intensity of our sufferings. [13]

In the Eucharist we find the very Body of Christ that Mary gives us. We find that Body which, as I have already observed, fills her with pain and bitterness, joy and happiness, at one and the same time. For this reason we acclaim her as our suffering Mother, the Mother of Holy Hope and Mother of Holy Happiness.

'Eucharistic' love for Mary means that our 'yes' is not closed up in a mere individuality but, rather, expands towards all pain and suffering. The suffering of Christ is directed towards annihilating sufferings. After that has been said about suffering, one could fall into the error of exalting suffering for its own sake. Suffering has value because the death of Christ inseparably involved his resurrection. In other words, suffering is valuable because it is directed towards destroying suffering. Then suffering itself understood from a Christian perspective leads us to combat suffering in this life as an anticipation of the resurrection.[14]

Thus the Eucharist, as participation in the suffering of Christ, pushes us to care for our sick brethren. It obliges us to become, as the Message of the Pope says, 'broken bread' for our brethren. This is the Christian logic of the 'Good Samaritan' and the final judgement, when whether we have found suffering Christ in every sick person, whether we have visited him, whether we have cared for him, will be subjected to judgement. Thus in Salvifici Doloris Pope John Paul II writes: 'Together with Mary, the Mother of Christ, who was at the foot of the cross, we stop beside all of the crosses of the men of today'.[15] This is a matter of sharing in the glory of the resurrection, now defeating death in its daily presentation in illness. Here we find the engine that urges us to fight against every infirmity in order to procure health for everyone. Here is born the obligation al-

ways to proceed in the field of medical art and science and go forward in its extraordinary contemporary advances.

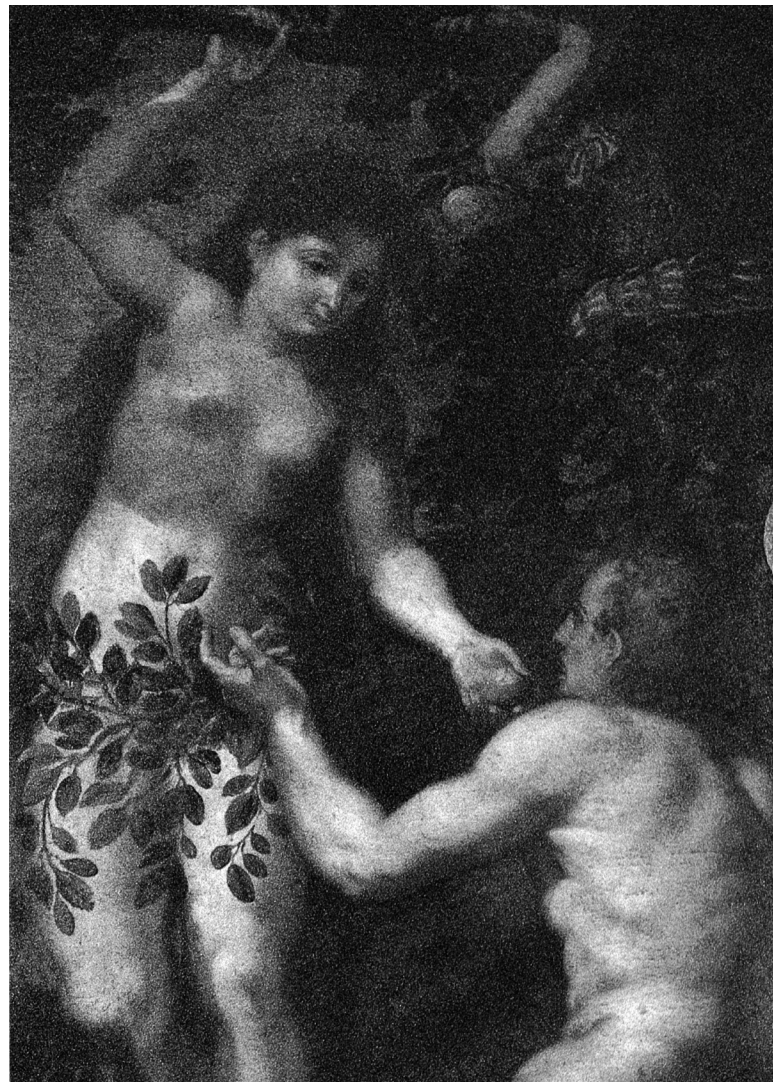
We will now impart the sacrament of the anointing of the sick as an effective preparation for experiencing the mystery of the healing suffering of Christ. This anointing, which comes from the Eucharist and is also a preparation for it at the same time, is the strength to find health in illness itself. As anointing it is the 'Christification' of the sick person, the strength to find health in infirmity itself. Through participation in this sacrament we tend towards the harmony of Christ, which is health, and which we receive fully in the Eucharistic communion.

We invoke the maternal care of the Most Holy Mary over all the sick people of the world and we hope that on this hundred and fiftieth anniversary of her apparitions at Lourdes the Virgin will make us all meek in relation to the action of the Holy spirit so as to be able to suffer our own sufferings in Christ. Thus, in entering the open heart of Mary in the total 'yes' of her Immaculate Conception, we place ourselves under her protective cloak and acclaim her as our health, as 'Mary, health of the infirm'.

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

Notes

[1] BENEDICT XVI, 'Message on the Occasion of the XVI Day of the Sick', Vatican City, 11 February 2008.
[2] JOHN PAUL II, Apostolic Letter *Salvifici Doloris,* n. 24.
[3] Ibid, 20.
[4] II Tim. 3:12.
[5] Jn. 2:4; 5:25-28; 7:8.30; 8:20; 12:23-27: 13:1.
[6] Cf. JOHN PAUL II, Apostolic Letter *Novo Millennio Ineunte,* January 2006, n. 27; Apostolic Letter *Salvifici Doloris,* n. 31.
[7] Apostolic Letter *Salvifici Doloris,* n. 26.
[8] Is. 53:2-6.
[9] Apostolic Letter *Salvifici Doloris,* nn. 20, 26.
[10] Jn.17:11.19:21-22; 19:25; II Tim. 3:12
[11] Col. 1:24
[12] Apostolic Letter *Salvifici Doloris,* n. 26.
[13] Apostolic Letter *Salvifici Doloris,* nn. 25-26.
[14] Jn 3:16.
[15] Apostolic Letter *Salvifici Doloris* n. 31.



Topics

Pain, the Placebo and Prayer: Clinical, Therapeutic and Ethical Aspects

'Comfort ye, Comfort ye my People': Sanctuaries, the Sacrament of Comfort

The Role and Importance of Pastoral Care for Disabled People in the Ministry of the Church

Does Suffering have Meaning?

The Humanization of Medicine – a Religious Viewpoint

The Right to Die: a Neglected Document

Pain, The Placebo And Prayer: Clinical, Therapeutic And Ethical Aspects

Preface

It is with real pleasure that I accepted the invitation to write a preface to this original scholarly work 'Pain, the Placebo and Prayer', which is unique of its kind in the literature in the field, of the prestigious review *Dolentium Hominum*, the official organ of the Pontifical Council for Health Care Workers of the Vatican, whose President is His Eminence Cardinal Javier Lozano Barragán.

I would like to congratulate the authors of this article on the elegance and the rigour of the aspects addressed, including the historical ones; on the choice of these sensitive subjects which are examined with great care and prudence; and on the cultural weight that emerges – these are elements that enrich the reader and make this edition of this review more valuable.

I am very happy to observe that my co-worker Pierluigi Zucchi and my dear colleague Maria Rosa Voegelin, who are valuable and impassioned researchers at the Faculty of Medicine and Surgery at the University of Florence, have continued their research, which began over a decade ago with very important studies for the medical and theological fields, with the distinguished and very dear Professor Bonifacio Honings OCD, a distinguished moral theologian, a lecturer at the Pontifical Lateran University and the Pontifical Urbanian University and a close consultant of the Congregation for the Doctrine of the Faith of the then Cardinal Joseph Ratzinger, today His Holiness Benedict XVI.

This work brings to the scientific-theological cultural field very relevant facts on the important function of the placebo and prayer in patients afflicted with painful pathologies and this invites first and foremost scholars in the clinical sphere to rethink a number of their therapeutic approaches.

I would like to emphasise that amongst the definitions of pain that appear in the literature in the field that formulated by the Florentine Algological School seems to be truly compelling for the work under consideration. The vision of pain in this definition is not confined, in fact, to describing the organic damage of illness but invites us to also take into consideration the philosophical and psychological aspects as assumptions for an internalisation of a theological kind. As, indeed, Pope Benedict XVI stated in a fragment of the allocution that he was to have pronounced on Thursday 17 January 2008 at the La Sapienza University of Rome: 'theology and philosophy form a special pair of twins in which neither can be totally detached from the other; however, each one must maintain its own task and its own identity'.

As regards the placebo and the placebo effect, the authors have rightly wanted to refer to the semantic character of this oxymoron, that is to say the drawing near of two words with opposing meanings.

With respect to prayer, I would like to quote the last part of the definition taken from the *Dizionario Enciclopedico di Spiritualità* which states that prayer 'is found in all the atheistic religions as the fundamental act of religious life, even where faith in a personal God (or in personal gods) is defined only vaguely or is muddied by false portrayals. This is a sign that non-degenerate man cannot live without prayer'.

In this work, of interest are the data on experimentation of a truly Galileo style, that is to say they can be reproduced, even though carried out with small numbers, on benign and malign pain treated with a placebo and prayer. Pain, for that matter, is an inevitable reality which involves the whole man at a physical level (*algos*), at a mental level (*pathos*) and at a social level (*ethos*) and on which bear not only immanent factors (pharmaceuticals, placebos, medical doctors) but also transcendent parameters (faith, prayer, priests), as indeed clearly emerges from this research.

As regards malign pain, there emerges the salient fact that man, when he has reached the final stages of his life, even though he may be distant from official religious positions should nonetheless entrust himself through personal prayer to a Transcendent Being. This condition seems to improve not only the spiritual relationship between the Creator and His creature but also the clinical state of pain. The realities of this condition are explained in a very clear way in figure 10.

From the data of the study one can also see that an improvement in the pain condition is achieved not only in the believer but also in the agnostic because he, too, is a creature made in the image and likeness of God.

From this work one clearly deduces that science must be above all else Science of Life and thus within the context of the *bios* the medical doctor and the health-care worker cannot but also take into account anthropological and ethical thought.

I would therefore like to congratulate the authors of this study for having addressed in such a clear and incisive way a subject that is both difficult and important for medicine and theology, pointing to the fact that science is a single thing with different features, and for having created a clinical-theological scientific bridge with a methodological approach that is truly original.

Prof. GIAN FRANCO GENSINI
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Introduction

In this study the placebo, a substance defined as being inactive or inert, and the placebo effect, defined as effective inertia or active inactivity, are subjected to examination. These two terms, the placebo effect and the placebo, create a semantic condition for an oxymoron where two words draw near that have opposite meanings, with the result that the placebo moves from the uncertainty of *doxa* to the concreteness of epistemology.

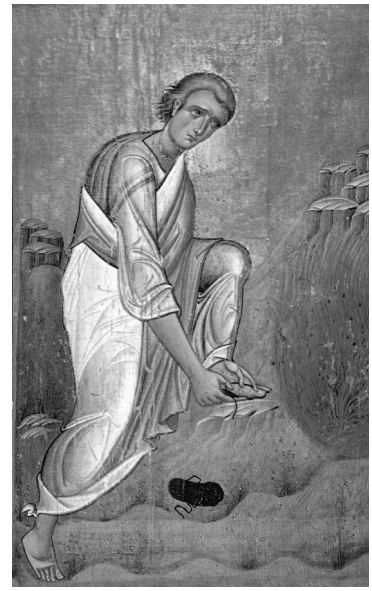
The researcher tests the placebo as an inert substance, although verifying a effect, above all in controlled clinical studies with the pharmaceutical to be experimented with and in this case the placebo has a fundamental scientific necessity because it points to a measurable parameter of difference between the effects of the pharmaceutical and the effects of the placebo itself. In clinical research carried out with a placebo, of fundamental importance also is the enrolling of patients on a random criterion (the casual placing of patients in the study group and the control group) and in conditions of blindness (see below), obtaining an assessment of the placebo effect and preventing or reducing possible bias.

From a theoretical approach of this kind it is obvious that not only clinical and therapeutic assessments but also ethical assessments are taken into consideration. From an ethical point of view it is also right to point out to begin with that studies in which the placebo is used for its action must have an assessment that is different from that in the case of studies that use the placebo for its inertia.

In addition, the authors also wanted to examine how the two parameters – the immanent (placebo) and the transcendent (prayer) – may have influenced pain.

The Definition of Pain

The Committee for Taxonomy of the International Association for the Study of Pain (IASP) defines 'pain as an unpleasant sensorial and emotional experience associated with a real or potential damage to a tissue or described in terms that refer to that damage' (IASP, 1979). The Florentine Algologia School defines 'pain as a psycho-physical entity with universal valences in the perception of which participate various individual, cultural and religious factors and in the contextualisation of which take part 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 Prayer

Evagrius Ponticus (346-399) defined prayer as a 'dialogue of the mind with God' and St. John Damascene (675-749) defined it as the 'raising of the mind to God'. The term 'mind' in these definitions should not be interpreted solely in a rational way but rather in a spiritual way because prayer totally involves the feelings and the freedom of the praying man. The *Enciclopedia Cattolica* (vol. IX, Vatican City, 1952) defines prayer as the 'language of praise, or of invocation, or a request directed by man to God'. The *Dizionario Enciclopedico di Spiritualità* (vol. 3, Città Nuova, 1990) defines prayer as 'a primary phenomenon of religious life, it is its heart and its central gesture, and to such a point that it distinguishes religious man from non-religious man. Like religion it is a universal fact which is to be found in the popular piety of all peoples and all cultures. It pre-supposes faith in a personal and present God. God is in the consciousness of a praying man not as a philosophical or theological idea but as a reality, a present person. The relationship with God is experienced as distance and also as contact. The believer has no doubts about the possibility of communicating with God, even though he does not see Him. He also knows that he is obliged, in the strictest sense, to engage in prayer. For this reason, prayer is found in all the atheistic religions as the fundamental act of religious life, even where faith in a personal God (or in personal gods) is defined only vaguely or is muddied by false portrayals. This is a sign that non-degenerate man cannot live without prayer'.

Historical Aspects of the Relationship between Pain and Prayer

The condition of pain present in illness leads the individual who is faced with uncertainty about the future to look for answers solely in prayer to the Lord, even though 'to invoke God as healer, as He who can do things that human invention cannot perform, seems ill-advised and superstitious to a man who by now seems himself as the sole arbiter of his own destiny' (CEI, *Evangelizzazione e sacramenti della penitenza e dell'unzione degli infermi*, n. 123). However, above all in the condition of illness, although he trusts in the healing power of medicine, recourse to prayer seems to be a fundamental requirement of each individual.

We believe, together with other researchers (Duquoc and Floristan, 1990; Dossey, 1996; Zucchi, Honings, 1996; Zucchi, Honings, Voegelin, 2001, 2003, 2005), that prayer is the fundamental core of the reli-

gious experience in the sense that without prayer there is no religion and without religion prayer does not exist, above all in Christian life.

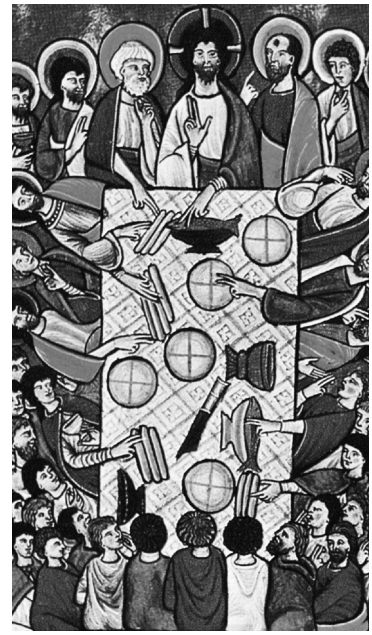
The research that has appeared in the literature in the field on the relationship between *illness and prayer* bear witness to the fact that medical science previously had to take into account the psychological dimension and now has to take into account the ethical and spiritual dimension in dealing with the various pathologies that exist.

We would like, however, to stress the fundamental concept that although prayer does not need to be approved by science, it has demonstrated that it has a significant effect when it is applied scientifically. The principal aim of prayer is not to obtain solely the health of the praying person but also to create a dialogue between the praying person and God in an act of 'self-devotion rather searching for oneself' (Finney and Malony, 1985 b). Biblical theology on suffering suggests that the healing activity of God should also be seen in prayer. Christ himself, in fact, said, 'come to me all of you who are heavily laden and I will give you rest' (Mt 11:28).

For some authors the term 'prayer' derives from the Latin *precarius* which means obtained through alms (Dossey, 1996) and for others (Petrini and Caretta, 1997) it derives from *precare*, which means to implore, to beseech.

The Correlation between Prayer and State of Health

It should be stated that there are at least three reasons in the literature in the field which explain the low number of studies on the correlation between prayer and pain. The first is the fact that many researchers do not believe in the healing power of prayer. The second is the scepticism of certain theologians about the advisability of engaging in such research given that God does not need demonstrations. The third is the low number of studies that utilise a quantitative model in the description of the effects of prayer on state of health, as argued by McCullough (1995), and as demonstrated, on the other hand, by the studies of Zucchi, Honings, Voegelin (1996, 2001, 2003, 2005).



Prayer and Psycho-physical Modifications

Prayer can induce electrophysiological, psycho-neuro-endocrino-immunological, cardiovascular, cerebral and neuro-muscular modifications (Finney and Malony, 1985; Martin and Carlson, 1988; Zucchi and Honings, 2003). Prayer can also activate psychological mechanisms that can foster a mental and physical state of health (Maton and Pargament, 1987; Patene *et al*., 1991; Wilson, Nelson and Bishop, 1992; Zucchi and Honings, 2005).

Thoughtful reading of the gospels and the Bible, together with prayer, give rise to greater wellbeing (Koenig, Kvale, Ferrel, 1988; Ellison, 1991), greater life satisfaction (Markides,1983; Koenig, Gorge, Meador, Blazer, Ford, 1944), a qualitatively better and more motivated style of life (Benson, 1984; Kiesling and Harris, 1989), and an authentic recovery (Ratzinger, Bertone, 2000).

The physiological and psychological effects of prayer are proportional to the ethical-religious maturity of the person involved. A spiritually mature Christian thus possesses a pain threshold that is much higher (that is to say he feels less physical and mental pain) compared to a Christian with a lower level of spirituality or an agnostic person (Zucchi, Honings, 1996; Zucchi, Honings, Voegelin, 2001, 2003, 2005).

Prayer and the Level of Spirituality of an Individual

Spirituality is defined by Soravito (1984) as 'the set of aspirations and beliefs that organise the life of a man in a unitary project, on the one hand, and, on the other, the set of personal reactions and expressions in which that project of life is implemented'. The level of spirituality of an individual can be assessed, in our view, on the basis of the weight that he attributes to gratification of a transcendent kind, compared to gratification linked to the purely sense sphere. According to Brusco (1996), spirituality can be defined as being religious when the aspirations and beliefs that are the basis of a project of life enter into a dialogic relationship with God. The level of religious spirituality of each individual bears upon his modality of prayer, its length and frequency, as has been demonstrated by the studies by Poloma and Gallupp in 1991 and by Petrini and Carettain 1997. Indeed, an increasing level of spirituality increases the frequency of prayer in connection with God compared to prayer involving requests. The intensity of prayer, as is argued by Torrey (1983) as well, depends on the beliefs of the person who prays, and a feeling of sin, conflict situations, the fear of not being forgiven, awareness of the will of God and obedience to His word all bear upon this intensity.

The Effectiveness of Prayer

In the Old and New Testaments there are many examples of the effectiveness of prayer. In the Old Testament

we observe that Abraham prays with success for Abimelech and his family (Gn 20:18). We also observe that sterility is eliminated through the gift of children to Sarah (Gn 18:10-14), to the wife of Manoah, the mother of Samson (Judges 13:5-24), to Anna, the mother of Samuel (1 *Sam* 1:19-20) and to the Samaritan woman (2 Kings 4: 6-17). Elijah and Elisha address their prayer to the Lord and obtain the healing of a child (1 Kings 17: 17-23; 2 Kings 4: 18-37). There are many psalms (Ps 41, 46, 62, 74, 116, 121, 147) which invite us to have trust in God as the only Healer of minds and bodies. Together with these Biblical citations, which demonstrate the healing action of prayer addressed to God, we can read in the words of Judith trust in the answer of God to prayers: 'Therefore, while we wait for his deliverance, let us call upon him to help us, and he will hear our voice, if it pleases him (Jud 8:17). The efficacy of prayer is demonstrated with incisive force by Jesus: 'Ask, and it will be given you' (Mt 7:7-11; Lk 18:1-8). It should be observed that almost all of the sentences on prayer to be found in the synoptic gospels relate to prayers that ask for something so that 'to pray' (*proseuchesthai*) in the gospels is synonymous with 'to ask' (*aitein*, *deisthai*, *erotan*, *parakalèin*).

The effectiveness of prayer that has a request is accentuated by insistent perseverance in prayer (Lk 18:1-8), by trusting awareness that one's own request has already been heard (Mk 11:24) and by the choral participation of the community (Mt 18:19). Jesus prayed in public and in private (Mk 1:35; 6:46; 14:12:26; 35-42) and taught his disciples to pray (Mt 6:9-13; 7:7-11; Lk 11:1-4). The teaching on prayer with a request raises the question of apparently unheard prayers, of which the prayer at Gethsemane is a dramatic example. The teaching of Jesus about prayer that has a request should be interpreted, as Soares-Prabhu (1990) argues, in the light of the Our Father, according to the approach of which all prayers with a request obtain an answer not because of our will but because of the will of God.

God answers human prayer, as McCullough (1995) argues, because of His sovereignty and will and not on the basis of the typology of the subject who prays or the typology of prayer. This statement is supported by many examples offered by daily life to each one of us. Indeed, there are simple and humble people, at times *distant*, but fundamentally true to themselves and other people, whose prayers seem to be immediately heard, provoking the amazement of their *neighbours*, who are often *giants* and *defenders of the faith*, whose prayers, at times, however, seem to be unanswered. It appears that God listens more to a man whose faith is experienced with the simplicity of a trusting and not rationalised abandonment to His will.

The Definition of a Placebo

The *Dizionario dei termini tecnici di Medicina* (Garnier and Delamare) defines 'placebo (from the Latin 'I will please') as the idiom that Anglo-Saxon authors confer on pharmaceutical preparations (pills, cachets, potions) without active principles and containing only inert substances. They are prescribed for psychotherapeutic purposes or to judge, by comparison and eliminating the psychological factor, the real action of medicaments presented in the same form, with which they are alternated without the patient being aware of the fact (blind tests)'. More specifically, 'the blind test takes places when it is only the patient who does not know the substance that he is receiving is without pharmacological effects; the double-blind test, on the other hand, involves the administration of the medicament to the individual, alternating it with the placebo where the patient and the medical doctor is unaware of this fact and where only a third party is aware of the real contents of the product that is administered at the moment of the test' (M. Garnier and V. Delamare., 1982).

Placebos can be pure or impure (pseudo-placebos). A *pure placebo* is an inert substance adopted because of its non-specific effects in order to quantify in a more effective fashion the level of the efficacy of the treatment that is being experimented with. An impure placebo or pseudo-placebo is every measure without intrinsic activity and which does not have documented effects as regards the clinical condition for which it is used.

A placebo can modify a series of objective parameters (for example arterial pressure, motility and gastrointestinal secretions, glycaemia, body temperature and anti-body reactions) and have favourable effects on both mental pain (anxiety, depression) and physical pain (osteo-arthrosis and rheumatic illnesses).

Historical Aspects of the Definition of a Placebo

Taber's Cyclopedic Medical Dictionary (Clayton, L. T., 1985, p. 1307) defines a placebo as any inactive substance that is given to the meet the request for medicines on the part of the patient. *La Nuova Enciclopedia Medica Garzanti* (Rothenberg, R. E., 1987, p. 1213) defines a placebo as any preparation that is completely without any active substances used for purposes of suggestion or in clinical experimentation so as to make a comparison with real medicines. *Stedman's Medical Dictionary* (Hensyl, W. R., 1990, p. 1205) defines a placebo as an inert substance given as a medicine for its effects of suggestion and in comparatives studies in the same shape and form as that of the active pharmaceutical. *Churchill's Medical Dictionary* (Koenigsberg, R., 1994, p. 1464) defines a placebo as an inactive substance of an identical aspect to that of the pharmaceutical that is tested and administered to subjects or patients in similar con-

ditions. *Il Dizionario Enciclopedico di Scienze Biologiche e Mediche* (Zanichelli, 1995, p. 966) defines a placebo as a pharmaceutical preparation without therapeutic substances made up only of inert principles and which is identical in appearance to a pharmaceutical. *Il Vocabolario della Lingua Italiana* (Treccani, 1998, p. 1201) defines a placebo as a pharmacologically inert substance which is administered above all for the psychological effects that it can have on a patient or to carry out comparisons with effective medicaments in a series of clinical tests. *Il Vocabolario della Lingua Italiana* (Zanichelli, 1999, p. 1348) defines a placebo as any preparation without active substances that is administered to a patient with non-physical disturbances for the purposes of suggestion, making the patient believe that it is a real treatment, or which is used in the place of a pharmaceutical in order to measure its pharmacological action. *The Merck Manual* (Merck, 1999, p. 2585) defines a placebo as a presumably inert substance that is used in control studies to establish comparisons with presumably active pharmaceuticals or prescribed to treat symptoms orto meet the desire for medicines on the part of a patient.

In his definitions of a placebo made between 1964 and 1971, Shapiro offers a synthesis of all these definitions that appeared previously in the literature in the field. Indeed, he defines a placebo as any deliberately implemented procedure designed to produce an effect or which, without this being known by the patient, acts upon the patient or on a symptom or on an illness, but which is objectively without any specific action as regards the condition that is being treated. This procedure can be actuated with or without the knowledge that a placebo is involved. This procedure thus includes all medical directives, independently of whether they are oral or injected pharmaceuticals, locally applied treatments, substances that are inhaled, or mechanical, surgical or psychotherapeutic procedures. Placebos are also used to create a suitable control reference in clinical research.

In all these definitions, as Giorgio Dobrilla rightly points out in his originally entitled book, *Placebo e dintorni* ('The Placebo and its Context', with a preface by Silvio Garattini, a placebo is 'described as an inert substance or inactive composite, whereas in fact the existence of the placebo effect, which is of not unusual significance, demonstrates specifically the opposite, that is that it is very far from being inert or inactive'.

The Definition of the Placebo Effect

Pepper defines the *placebo effect* as the therapeutic effect produced by an inert biomedical substance. Wolf defines the *placebo effect* as a therapeutic effect or a side effect attributable to treatment but not to its pharmacological properties. Shapiro defines the *placebo effect* as the non-specific effect of a therapy than can have or not have an additional specific effect. Modell defines the *placebo effect* as what all forms of treatment have in common. Brody defines the *placebo effect* as the variation in the condition of the patient attributable to the symbolic meaning of the action of healing rather than the pharmacological effects of the action itself. Fisher defines the *placebo effect* as the quota of the behavioural variation that can be attributed to the symbolic transaction of care that is received in contrast with the behavioural variation due to the mere passing of time, to repeated tests or to other spontaneous influences present during the placebo therapy. The placebo effect, which within the sphere of pain is identified with the state of analgesia, like the nocebo effect, which in the algological sphere is identified with a state of hyper-algesia, is present in children and even animals, being installed with mechanisms analogous to those in man.

Historical Aspects of the Placebo Effect

The history of treatment is to a large extent the history of the placebo effect and here one should emphasise that for millennia medical science used and prescribed placebos almost exclusively. In ancient Egypt the Ebers papyrus, which goes back to the sixteenth century BC, and even before that in Mesopotamia the Hammurabi Codex (eighteenth century BC), have unending lists of hundreds of substances used in the most varied of pathologies which clearly have a placebo effect in the view of contemporary researchers.

The word 'placebo' derives from the Latin version of Psalm 116:9 '*placebo Domino in regione vivorum*', which is usually translated as 'I walk before the Lord in the land of the living', even though the literal translation of 'placebo' is 'I will please'. It appears that tradition does not reflect the original Hebrew because the word that corresponds to 'placebo' in Hebrew is '*eth-hal-lech*', which means 'I will walk'. When this psalm was translated into Greek in about the second century BC, the scribe erroneously wrote *euarestaso* ('I will please') rather than 'I will walk'. Five centuries later St. Gerolome translated the Bible from Greek into Latin and thus translated the verb '*euarestaso*' in this psalm with *'placebo*'.

In English the term 'placebo' appeared in the fourteenth century to refer to the vespers sung for the dead by professional mourners paid for this purpose. Subsequently, the word 'placebo' took on the figurative meaning of 'adulator'. Today to weep and sing the praises and virtues of the lives of dead people is a practice that survives in some neo-Latin countries and in some of the regions of the South of Italy. Even Giovan Battista Morgagni (Forlì 1682-Padua 1771), a medical doctor and anatomist , who introduced the experimental method into medical science and established for the first time the relationship between clinical

symptoms and the anatomical-pathological condition of a patient, prescribed pieces of viper in a broth for a girl affected by diarrhoea. For that matter, until the middle of the nineteenth century in the pharmacy of the Hospital of Santa Maria Nuova in Florence live vipers were kept, ready to be used to treat tetanus and rabies.

1785 marked the beginning of a new era in scientific therapies with the use of extract of digital leaves for the treatment of cardiac insufficiency. Before that date the history of medical science was made up of 'treatments' without any scientific basis at the level of specificity and may be seen as belonging to the history of the placebo effect. The literal translation 'I will please' goes back to 1811 and *Hooper's Medical Dictionary* which at the time defined a placebo as a 'medicament given more to please the patient that to provide him with a benefit'. *The Oxford Dictionary of Medicine* defined the placebo 'as a medicament without efficacy but one which can help to alleviate a disturbance because the patient trusts in its properties. In the course of pharmacological tests a placebo and the new pharmaceuticals are administered: the effect of the medicine is compared with the placebo response that is expressed even in the absence of an active pharmacological substance'. In 1890 in an anonymous editorial of the review *Medical Press* reference was made to the term 'placebo' when discussing a legal case brought by a patient against his doctor who, after administering a saline solution, was paid as if he had administered morphine. In 1955 Henry K. Beecher, in his famous publication *The Powerful Placebo*, was the first to examine the placebo as the subject of a scientific study, quantifying at 35% the positive effects of placebos on the symptoms of an illness. In 1956 in the *New Gould Medical Dictionary* the placebo was defined as 'a medicine without pharmacological effects but one that is given to please and support the patient'.

Factors that Influence the Placebo Effect

These are: a) injections are more effective than pills where there is parity of dosage and large pills are more effective than small ones; b) the trust of the patient in the medical doctor (an optimal doctor-patient relationship) increases the effect of the placebo, as do the certificates hung on the walls of the surgery of the medical doctor and the qualifications that appear on the prescription (iatroplacebogenesis); c) the placebo effect increases if the patient is told about the way in which the pharmaceutical works; d) the placebo effect is greater in anxious patients than in patients with a low critical capacity; e) an inverse relationship exits between the effectiveness of the placebo and the intensity of pain (very intense pain responds less to the placebo).

As is also stressed by Manfredi, a medical doctor who intends to exercise a placebo effect which goes beyond his person, he has already invested himself with a role of this kind, must be convinced of the utility and advisability of what he prescribes as long as the concept of deception remains separated from that of a placebo.

If the results of the placebo effect are negative one speaks in this case of a *nocebo effect*. Vinar emphasises cases of idiosyncrasy as regards the placebo and cases of dependency that are comparable to that obtained with various pharmacological substances, whereas Jospe describes an authentic syndrome of abstinence in response to the suspending of placebo therapy.

The data of our study group emphasise, in line with those that have appeared in the literature in the field (Beecher, Dobrilla), that in the sample of patients subjected to examination there is an improvement in symptoms (in our sample the improvement amounted to a decrease in intensity of pain: VAS from 10 to 6-5 and at times as low as 4-3) of 20% to 40% after the taking of the placebo, with benefits that were not only subjective but also objective in character. One can rightly deduce from this that the efficacy of a pharmaceutical is also provided by its placebo effect. A pharmacologically active substance can create, according to our study group, pain relief that goes from 40% to 100% (fig. 1).

The duration of the placebo effect varies in patients according to the pathologies they are afflicted but also in a homogenous sample of patients with the same pathology. In functional (psychological) pathologies the beginning of the placebo effect is much quicker than is the case with physical pathologies

Fig. 1. Diagram that indicates pain relief (from 40% to 100%) in patients treated with a pharmaceutical and pain relief (from 20% to 40%) in patients treated with a placebo.

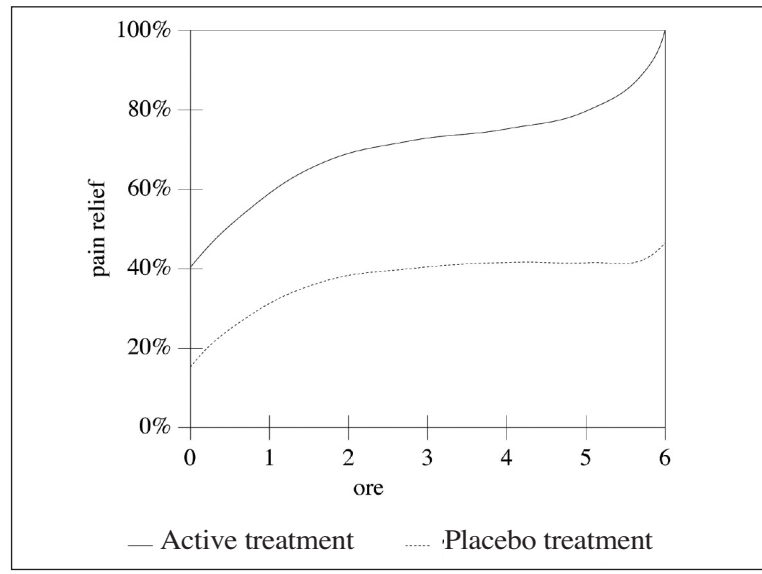


Fig. 2. The algic system (or pain pathway) is made up of three characteristic neurons. The first neuron (the primary sense neuron or pain receiver=area of reception) goes from the periphery of the posterior horn to the grey substance of the spinal cord; the second neuron begins from the spinal cord (the area of transmission and modulation of transmission) which reaches the thalamus through the (anterior and lateral) spinal-thalamic band; the third neuron rises from the thalamus to the soma-sensorial cortex (the area of perception and integration).

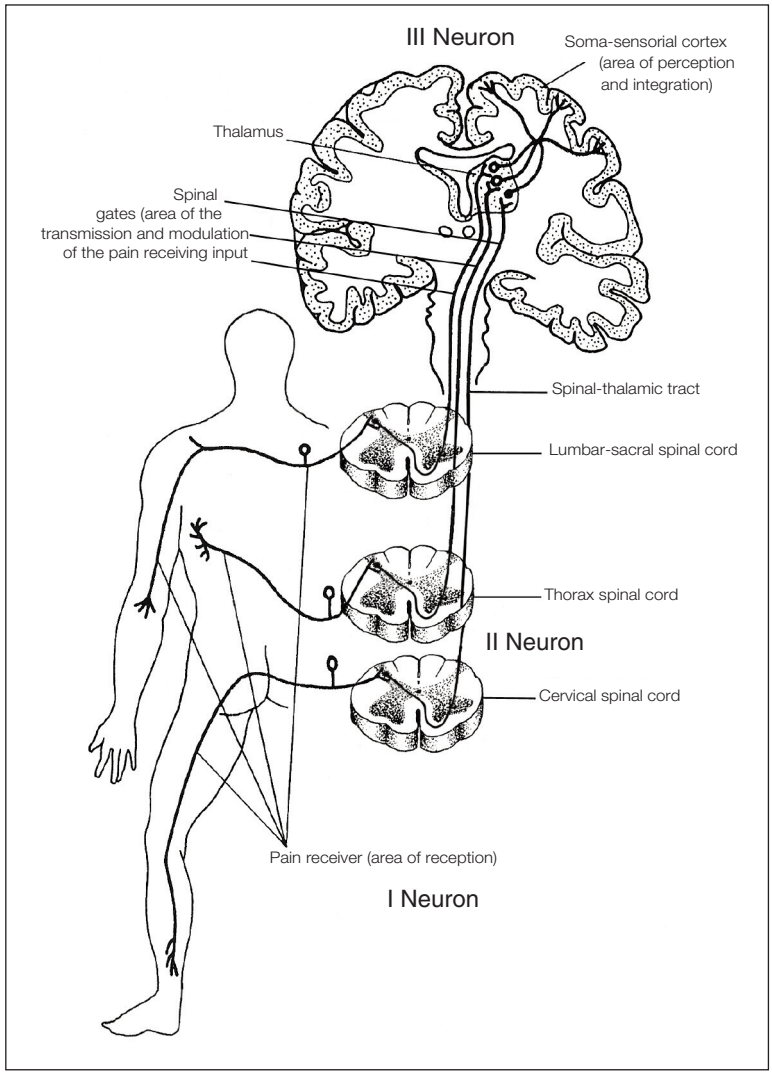
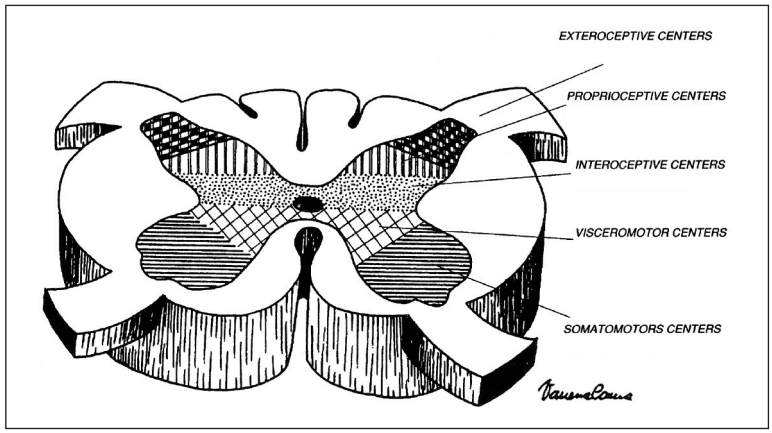


Fig. 3. Schematic depiction of the sense centres (exteroceptive in the head, proprioceptive in the neck, interoceptive at the base) of the posterior horn and the motor centres (viscermotor centres at the base, somatomotor centres at the top) of the anterior horn of the grey substance of the spinal cord.



The Anatomical and Physiological Aspects of the Relationship between Pain and the Placebo Effect

It is of fundamental importance in a correct interpretation of the physiopathology and the treatment of acute and chronic painful pathologies to have a knowledge about the *algic system*, that is to say that part of the central and peripheral nervous system that is involved in pain and its control.

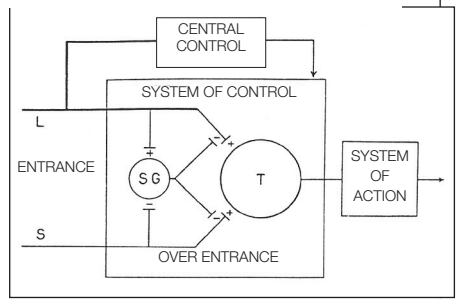
The *algic system* can be divided into four anatomical-functional areas: 1) the area of reception which is made up of the pain receiver (a term created by the neurophysiologist Sherringtom, 1947); 2) the area of transmission from the pain receiver to the thalamus and the cortex; 3) the area of control or of the modulation of the transmission (spine gates); and 4) the area of perception and integration (soma-sensorial cortex or sensorial, cognitive and emotional brain), figs.2 and 3.

From these premises one can understand why of all the theories that now exist in relation to pain that, which best explains most of the acute and chronic painful syndromes is the gate theory of Melzack and Wall (fig. 4).

The gate control theory of Melzack and Wall explains how Roland's gelatinous substance (GS) has the task of modulating the peripheral input to the thalamus (T). The entire system is under the control of the cerebral cortex with the fundamental mediation of the mesencephalic reticular substance.

The A-delta myelinic and

Fig. 4. Schematic depiction of the 'gate control theory' according to Melzack and Wall (1965).



amyelinic C nerve fibres of a small diameter (S) carry the pain receiving input whereas the fibres of a large diameter (L) above all carry sense information. The fibres of a large and small diameter (L) have a stimulating effect on the T cells but have a different influence on the cells of the gelatinous substance. Indeed, the fibres of a large diameter have a facilitating effect on them whereas the fibres of a small diameter are inhibitory in their effect.

It should be borne in mind that the cells of the gelatinous substance always have an inhibitory effect on the T cells. Thus a stimulating effect on the part of fibres of a large diameter in the cells of the gelatinous substance will determine an accentuation of the inhibition which will tend to close the gate of the pain receiving information which reaches the T cells.

The pain receiving input which flows through the fibres of a small diameter inhibit the cells of the gelatinous substance, producing a process involving the removal of inhibition, thus fostering the opening of the gate, thereby giving rise to the perception of pain.

The information transmitted from the T cells to the cortex depends on the relative activity of these two kinds of fibres.

This fascinating theory finds confirmation in clinical practice. For example if involuntarily we hit a finger on our hands with a contusing body the fibres of a small diameter are activated and open the neuronal gates, thereby allowing the pain receiving inputs to reach the cortex and permitting the perception pain. However, if we put ice on this painful finger there is an activation of the fibres of a large diameter which close the gate to pain receiving inputs, thereby blocking the pain.

Henry Beecher, one of the most famous students of the placebo effect, noted during the Second World War that soldiers with serious wounds rarely suffered a great deal because they were grateful that they were still alive. However, they protested when they were given an intra-muscular injection.

In addition to the gate control neurophysiological mechanisms, there is an analgesia of endogenous opiates (endorphins), neurotransmitters, whose cerebral effects are very similar to those of morphine.

There are two principal kinds of analgesics or pain killers. Firstly there are those that act at a central level, which have an influence on the pain of the whole organism. Usually these are opiates – morphine, codeine and similar substances. These substances mimic the action of the endogenous opiates.

The other form of central (or peripheral) analgesia is non-steroid anti-inflammatory pharmaceuticals (FANS), such as aspirin, ibuprofen, naproxen and other similar compounds. Prostaglandins, lipid molecules of fatty acids with a fundamental role in inflammation and important in the production of the protective layer of mucous, above all in the stomach, are involved in the mechanism of action of these pharmaceuticals. The FANS, by reducing the production of prostaglandin, reduce inflammation, pain, and fever but also the protective layer of mucous in the stomach, giving rise to gastric pyrosis. Both in the case of FANS and in that of opiates the effect of the pharmaceutical is generalised to the whole of the organism.

Theories of the Placebo Effect Physiopathological Aspects of the Pain/Placebo Effect Mechanism

The theories that seek to explain the physiopathological mechanisms of the placebo effect are:

a) the chemical theories: demonstration of an increase in circulating endorphins after the administration of a placebo (Levine, Gordon, Fields, 1978; 1979; Ter Riet, De Craen, De Boer, Kessels, 1998; Amanzio, Benedetti, 1999; Benedetti, Arduino, Amanzio, 1999); production of dopamine, the cerebral receiver of good mood, produced in an area of the brain known as the *nucleus accumbens* which is normally involved in the processes involving conditions of reward. This area of the pre-frontal cortex, which has a fundamental role in the perception of pleasure and pain, is identified thanks to the technique of spectroscopy with the emission of positrons and the technique of functional magnetic resonance. These important scientific advances were published by Zubieta *et al*. of the University of Michigan in the review *Neuron* in July 2007.

b) The mentalistic (or psychological) theories which refer to the subject states of consciousness of a patient. In pain, the placebo creates a decrease in anxiety which in turn provokes a decrease in pain (Evans, 1974; Sternbach, 1968). The mentalistic or cognitive theory is a theory that refers to the expectations of the patient. As indeed is argued by Schachter and Singer, the expectation of a change in symptoms is said to lead to a behavioural change through a cognitive re-adaptation. Here Jon Kar Zubieta (*Neuron*, 2007) has shown that the activity of dopomine in response to a placebo is directly proportional to the benefits that a patient expects to receive. This famous researcher argues that 'the more we believe that a pill will have an effect, the more it will have an effect'. He also adds that 'the acquisition today of this scientific evidence could be of great help in identifying new therapies for individuals who are especially sensitive to the active principles of the pharmaceutical that they have to take' (Cf. Gensini, preface).

c) The theories of conditioning. Conditioning demonstrates the causal nexus between stimulus and response without referring to the mental states of the individual:

Pavlov's dogs begin salivating when a bell is rung.

d) The mixed theories, which argue for an inter-relationship between the mediation mechanisms of the endogenous opiates, those of classical conditioning and those of expectations as regards the analgesic

response to the placebo (Amanzio, Benedetti, 1999).

However our study group wishes to emphasise that in the relationship between pain and the placebo effect, in addition to the activation of the endogenous pain killing system, as argued for by Petrovic (Science, 2002), the neuroendocrinal system (ipothalamus, ipophysis, surrene) and the immunity system demonstrate that a positive belief in a pharmaceutical or in specific situation even increases the immunity defences in addition to combating pain.

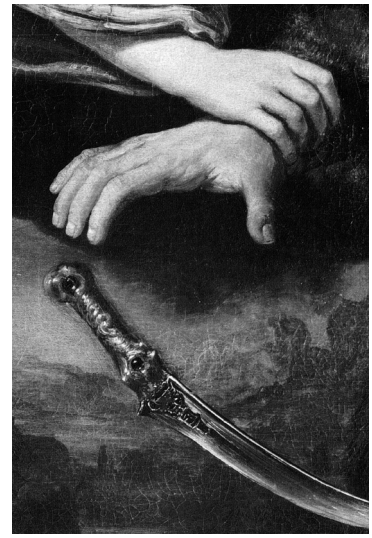
Clinical Conditions and the Placebo

The effectiveness of the placebo is demonstrated in all those clinical conditions (hypertension, depression, algic syndromes) in which the psychological component has a preponderant role. In these pathologies there are positive responses to the placebo that can reach 40% to 50%.

Levine, Gordon, Fields (1978) and Benedetti and Arduino (1999) are the most important researchers to have demonstrated that in painful pathologies the analgesic action of the placebo is directly proportionate to the response to endorphin (the name 'endorphin' is an abbreviation of 'endogenous morphine', that is to say morphine produced by the organism.

John Levine, Newton Gordon and Howard Fields, researchers at the University of San Francisco in California, in 1978 published in the prestigious review *The Lancet* results that are truly fascinating. These researchers injected a saline solution into patients who had had a tooth removed, telling them that they had been given a powerful pain-killing pharmaceutical. In many of these patients the pain diminished or completely disappeared (the placebo effect). However, if naloxone was added to the saline solution the placebo effect was blocked and the pain reappeared (naloxone is a molecule that blocks the effect of (narcotic) pain-killing substances such as morphine, and to such an extent that it is used to save the lives of drug addicts who fall victims of overdose). The suggestion of, and the belief in, the expectation of the disappearance of pain induces the placebo effect with the freeing into our brains of endorphins (endogenous morphine). With the administration of naxolone we block the endorphins and thus the placebo effect as well.

In their study Benedetti and



Arduino (1999) divided their voluntary patients into two groups. The first group was treated with morphine and the second was treated with a placebo (a saline solution). The second group responded with a net improvement in their painful symptoms as though they had taken morphine. In addition, naxolone, a substance capable of blocking the receptors of the endogenous pain killers, was administered to the two groups. In this way the algic symptoms reappeared in both groups, thereby confirming a direct relationship between endorphin and the response to the placebo.

In pain treatment, the studies (Benedetti *et al*.) that appear in the literature demonstrate that one can decrease (< 30; 40%) the taking of morphine by alternately administering the pharmaceutical and a placebo to patients.

As regards side effects during therapy with a placebo, Green believes that these manifestations represent nothing more than pre-existent disturbances to which the patient pays greater attention after the administration of the placebo. Our study group believes, instead, that in the administration of a placebo side effects can really take place, as occurs with the administration of any other pharmaceutical.

Another interesting research study carried out by Wager *et al*. (Science, 2004) with a study of functional magnetic resonance demonstrated that when the subjects were subjected to small electric shocks they were convinced that a cream which had analgesis properties had been spread on their arms and the centres in their brains entrusted with pain (the thalamus, the island of Reil, the cortex of the anterior cingulum) were less active than was the case with the sample of subjects to whom the properties of the cream had not been specified. At the level of psychic pain, instead, a correlation was observed between the perception of pain and the cerebral activity of the prefrontal dorsolateral cortex and the orbitofrontal cortex, that is to say a greater activity of these areas was connected with a lesser perception of pain.

A placebo, in addition to subjective symptoms, can also modify objectively quantifiable parameters such as a lowering of gycemia in diabetics (Singer, 1967).

Another example is demonstrated by a significant improvement in strength tests compared with the non-placebo group in patients with moderate to severe cardiac deficiency (Archer and Leier, 1992). In a study that demonstrated the efficacy of chlofibrate, those with heart disease who took less than 80% of the pills with a placebo base had a mortality rate that was 28.3% higher after five years compared to the 15.1% of patients who regularly took the placebo (The Coronary Drug Project Research Group, 1989).

A placebo produces a remission of symptoms in 30% of patients with ulcer colitis (Ilnyckyj, 1997) and a reduction of the frequency of a re-opening up of the ulcer with less

disability compared to the clinical conditions of pre-enrolment in multiple sclerosis (La Mantia *et al*., 1996). It is effective in acute pain such as that experienced in labour (Liberman, 1964) and in post-surgical situations (Gracely, 1983), as well as in chronic cancer pain (Boureau, 1988) and low back pain (Deyo, 1990). In patients with Parkinson's disease the administration of a placebo induces the release of dopamine in the striatal body (de la Fuente – Fernandez *et al*., Science, 2001) and in patients suffering from depression it has been demonstrated that serotonin is involved in the placebo response (Mayberg *et al*., *Am. J. Psychiat*., 2002).

The placebo effect also takes place in surgery where it constitutes a powerful symbol of healing, as is also argued by Johnson (*The Lancet*, 1994). Indeed, we know about the clinical improvement of symptoms in patients with operations on their colons or appendixes who have been found to be unharmed both from a surgical point of view and an anatomical point of view.

It is believed that the placebo effect in physical illnesses is slower to become established than is the case with functional illnesses and that the duration of the placebo effect can vary not only in individuals with various illnesses but also in patients with the same pathology. There can be no doubt about the influence of the medical doctor in the placebo effect and of fundamental importance here is the establishment of a good relationship between the medical doctor and the patient. This aspect, obviously enough, must also be extended to the paramedical staff and to the surroundings, which should be pleasant.

In healthy individuals as well the placebo effect varies according to the character of the individual, with the creation of an authentic ubiquitous condition. In a newly-born child the placebo effect is present even though it depends more on the character (whether anxious or calm) of the parents than on that of the baby. In children it is even more demonstrable than in adults and in this age band as well the placebo effect varies according to the character of the parents or the nearest relatives with whom the children live. In a culturally more emotional environment the placebo effect has a decidedly greater dimension compared with a culturally more rational environment, where, obviously enough, the pathology is the same.

In animals the placebo effect has been studied above all in certain kinds of animals – dogs, cat and mice. The studies on the conditioned reflexes of Pavlov, in which the placebo effect is explained with reference to a mechanism of conditioning, are famous. The sense of security that an animal feels as regards who looks after it is also important. Animals have also been a valuable instrument in studies on the analgesia of placebos, supported, as in the case of man, by the freeing of endorphins and blocking by naloxone.

Complementary alterative medicines (homeopathy, phytotherapy, Ayurvedic medicine, traditional Chinese medicine, plantar reflex therapy, digiopressure) or CAM, to use the English acronym, often have beneficial effects on the symptoms of pathologies referred to by patients, even though in large measure there are no demonstrable evidence of their efficacy and security. Given that the placebo effect is therapeutic it would not be correct to be hypercritical towards therapies whose physiopathological mechanisms are not known, even though distinguished clinicians, for example Antiseri, Federspill and Scandellari, believe in categorical fashion that 'alternative medicines do not pursue the fundamental goal of science, they do not, that is to say, aspire to construct consensual knowledge based upon public empirical experience and rational discussion. They constitute, therefore, a set of assertions and pseudo-scientific practices'.

From what has been said hitherto in this article it clearly emerges that the placebo effect has an influence on a (painful) illness in all its (physical, psychic and social) aspects, an idea expressed very well in English but not, unfortunately, in Italian. More specifically in English the word 'disease' refers to the physical component of the painful illness, *algos*, usually acute pain; 'illness' refers to the psychic and moral component of painful illness, *pathos*, usually chronic pain, experienced by the patient and his family relatives; and 'sickness' refers to a painful illness as a social perception, *ethos*.

As regards the relationship between the placebo effect and the effect of prayer, the interpretation of a favourable result varies, obviously enough, according to whether the patient is a believer or an agnostic.

In the believing patient, of fundamental importance is the role of religious faith as an instrument for the acquisition of grace and thus of healing, whereas the agnostic patient reduces the favourably result solely to a freeing of chemical substances (for example endorphin) in the organism without any transcendent intercession. Our research group (Zucchi, Honings, 1996; Zucchi, Honings, Voegelin, 2001, 2003, 2005) has explored in very rigorous studies (the choosing of patients according to random criteria and along double blind lines) that have been published in international reviews the physiopathological and theological interpretation of the relationship between (painful) illness, faith and prayer.

The Components of the Placebo Effect

Amanzio and Benedetti believe that in the placebo effect in fundamental terms three components can be identified: deception, expectation and the effect (M. Amanzio and F. Benedetti, *Meccanismi neurofisiologici e neurochimici della risposta placebo*, 1995). *Deception* is represented by the administering of a placebo to a patient with a set of

painful symptoms telling him that it is a powerful pain killer. *Expectation* is that state of mind that is created in the patient who trusts that

there will be a strong reduction in his pain. The *effect* is given by the clinical condition in which the individual refers to a strong reduction in the pain that he perceives.

Giancarlo Carli, a very rigorous neurophysiologist, stresses that in studies on the placebo it is necessary to observe precise rules of experimental protocol. For example, if it is used as a pharmaceutical in comparison with morphine one should bear in mind that this powerful analgesic does not act on its own in 20% of cases.

Mario Tiengo, a distinguished mentor who created the first teaching chair of 'the physiopathology and treatment of pain' in Italy, demonstrated that in a high number of patients with painful pathologies the placebo functions in different ways in different pathologies and that there is no difference between the two sexes. A similar observation about the pain threshold in the two sexes was made by Zucchi and Honings (2006).

The results obtained from the administration of the placebo are fascinating not only for scientific research *sensu strictiore* but also for the philosophical domain. This is because it has stimulated and continues to stimulate physiological studies that examine the close relationship between *the brain and the mind*.

The Brain-Mind Relationship
The Dualistic Conception of the Brain and the Mind of Popper and Eccles

The neurophilosopher Karl Popper and the neurophysiologist Jon Eccles proposed theories on the interaction between the brain and the mind which are different in only small ways from that of Descartes, according to whom 'it is the soul that pulls the strings that make the brain act', agreeing, therefore, with him that 'if there is mental activity, the brain must be open to non-physical influences'.

Popper was responsible for the famous 'theory of the diagram of three worlds' which constitutes the dualistic conception (the brain and the mind are different systems) that is opposed to the supporters of the unicistic conception (the brain and the mind are the same thing). 'By world 1', wrote Popper', 'I want to refer to the universe of physical things, including the organisms and the forces that act with them. By world 2 I wish to refer in a particular way to conscious experiences such as pleasure and pain, hopes, fear and expectations, the perceptions of things and events, and the memories of events in the past, the experience of grasping an argument or understanding a theory; and in addition, if they exist, unconscious experiences. By world 3 I wish to refer to the products of the human mind such as a tale, a painting, a poem, a symphony, a scientific theory, or an invention'. In such a way pain reception, as Tiengo also argues, is included in world 1 (or the world of physical states) whereas pain, a sensorial, cognitive and affective complex phenomenon, in agreement with Melzack, is included in world 2 (or the world of states of consciousness: perception, thought, emotions or dreams). The mind belongs to this. World 3 (the world of knowledge) is the cultural patrimony produced by man: philosophy, psychology, theology and science.

How the placebo effect (a mental event) can block the pain receiving input to the brain was explained by the Nobel Prize winner John Eccles, who on the basis of the brain-mind diagram of Karl Popper (the model of the interaction between world 1 and world 2) proposed the theory of 'psychons'. Eccles posited the existence of psychons (world 2) as immaterial entities that envelop dendrons (world 1), which are themselves made up of pyramid cells.

However, how is the language of a physical object (the Dendron) and a non-physical object (the psychon) actuated? In the view of Eccles communication between dendrons and psychons is actuated through fields of quantistic probability in which waves modulate the release of neurotransmitters in the inter-synaptic space between dendrons (the brain) and psychons (the mind). However, this fascinating theory has never been experimentally verified and has had notable opponents, amongst whom eminent physiologists such as Changeux and Edelman. Today, the theory of the diagram of the three worlds of Karl Popper has acquired a purely historical value.

The Unicistic Conception of the Brain and the Mind of Edelman and Damasio

The dualistic conception of Popper (a neurophilospher) and Eccles (a neurophysiologist), which goes back to the Cartesian conception of *res cogitans* (consciousness) and *res extensa* (th body), is opposed by the unicistic conception of the Nobel Prize winner Gerald Edelman who argues that 'to study the problems of the mind involves methods that are not suited to them so as to engage in a science of the brain.' The neuophilosophical position of Edelman as regards the mind can be extrapolated from the following words: 'the attribution of the mind to the body and the apparent mysteries of consciousness raise a dilemma that can be resolved by seeing the mind and consciousness as direct properties of matter'. He goes on to say: 'Cartesian dualism will dissolve only when the relationship between consciousness and physics is understood'. However the aim of Edelman is 'to demonstrate that it is scientifically possible to understand the mind'.

Antonio Damasio in his essay entitled '*L'errore di Cartesio*' '(The Error of Descartes') also engages in a very critical analysis of Cartesian dualism. He writes: 'The brain and the body are undoubtedly integrated by nerve and biochemical circuits which point to each

other'. The most famous pronouncement of the whole of Cartesian philosophy appears in this philosopher's work *Discours de la Méthode* (1637), and it is '*cogito, ergo sum*', which precedes the net separation of the brain (*res extensa*) and the mind (*res cogitans)*. *Damasio* is convinced that the mind appeared during the evolution of living creatures because the cerebral structures reached a sufficient complexity. It is suggestive to think, Damasio goes on, that Descartes helped to modify the development of medicine and to ensure that it deviated from the organic direction, or better the organicistic direction (the mind is in the body), which had prevailed down the centuries from the time of Hippocrates to the Renaissance. This would have irritated Aristotle if he had encountered it.

The neurophysiologist Strata when summarising the question writes: 'according to the unicistic conception the complex cerebral problems that follow a sensorial stimulation are to be identified with subjective sensations: the two phenomena are simply dimensions or different ways of seeing the same phenomenon, the working of the brain. According to the dualistic conception, the brain is the complicated instrument of an independent mind or soul. For dualists, the processes of the brain act upon the mind and vice versa'.

All the studies that have been carried out in the neurophilosophical, neurophysiological and neuropharmacological spheres on the brain and the mind are of fundamental importance in achieving a better understanding of the placebo effect.

Reflex Conditioning and the Placebo

Pavlov (Ivan Petrovic, 1849-1936, a Russian physiologist and medical doctor and Nobel Prize winner for medicine, 1904) in his fundamental studies on the conditioned reflex also established the bases for an interpretation of the placebo effect. Indeed, both in the brain of animals and in the brain of humans when a special expectation is established an involuntary conditioned reflex is created which constitutes an authentic placebo effect. In animals, the famous Pavlovian experiment, abundant salivation is created when a bell sounds, while in humans affected by physical pain there is authentic pain relief following the taking of an inert preparation (placebo) as though this was a real pharmaceutical.

The Contemporary Situation as Regards the Placebo

From the definition of the placebo one deduces that this pharmaceutical preparation is a useful instrument in therapy and indispensable in scientific research, above all in physiopathological studies on pain. However in recent years lively disputes have taken place about the ethics of the use of the placebo which have forced scientific institutions to review their previous positions. One of the most important of these institutions is the World Medical Association (WMA) which deals with the updating which is periodically required of the Helsinki Declaration. In one of the latest versions of the Helsinki Declaration the WHA emphasised the non-use of the placebo where a treatment exists that is of proven efficacy, as reported in n. 5 and n. 29 of the Declaration itself, where one reads that the interests of the patient must not be subordinated to the interests of science. More specifically one reads in section 29 of this Declaration: 'The benefits, risks, burdens and effectiveness of a new method should be tested against those of the best current prophylactic, diagnostic, and therapeutic methods. This does not exclude the use of placebo, or no treatment, in studies where no proven prophylactic, diagnostic or therapeutic method exists'. However this correct and ethical position has been criticised by many researchers and institutions, and to such an extent that the new indications envisage the use of the placebo even in the presence of an effective treatment when innovative scientific research must be engaged in or when the suspending of a treatment does not cause serious and irreversible damage.

At this point we would like to emphasise that in agreement with other moralists (Ciccone, Sgreccia, Tettamanzi), from an ethical point of view the correct use of the placebo in clinical conditions must take place only when in is added to the administration of the best current therapies and in the case of pathologies where effective therapies do not yet exist.

Deontological and Ethical Aspects The Medical Code of Ethics, the Medical Act and the Placebo

The Code of Medical Deontology (1989) definitively sanctioned in articles 39, 40 and 41 how the duty to inform the patient and the relative obtaining of consent to the medical act are fundamental cardinal points in a new relationship between the medical doctor and the patient based upon the principal of equal dignity and self-determination.

More specifically, when a health-care worker has to address questions and issues connected with clinical experimentation, or so the National Committee for Bioethics emphasises, 'the question becomes even more difficult in the case of comparison of the placebo which for that matter is seen as being of crucial importance for an assessment of the pharmacological effect. It is believed that this difficulty can be overcome by explaining to the patient the modalities of the inquiry and thus making him aware that the possibility exists that he will be treated with a mere placebo'. However a list of indications was drawn up: a) the use of a placebo is not acceptable if the patient runs the risk of a grave worsening of his conditions; b) it is not acceptable to interrupt a treatment that is stabilising his condition in order

to make the patient take part in research where the possibility exists that a placebo will be administered to him; c) researchers should be able to justify the failure or the interruption of a treatment where they subject a patient being treated to a placebo; relief pharmaceuticals, if they exist, must always be available on request, even though this means that the patient in wishing to take them will no longer be able to belong to the research sample; e) if the possibility does not exist of administering a pharmaceutical in order to alleviate the situation of the patient, he must be considered as being outside the research sample if the pain and other symptoms become unacceptable; f) patients should be able to make telephone calls throughout the twenty-four hours of the day so as to obtain information on their state of health; g) patients receiving therapy with a placebo should be frequently monitored so as to prevent a worsening of their condition; h) if the conditions of a patient worsen it should be possible to identify his code immediately and in the case of therapy with a placebo a specific therapy should be begun immediately; i) potential participants in a research sample should be informed 1) that they will be placed in a group that will not receive a specific therapy; 2) or in a group that will have a placebo or a special therapy; 3) or in a group that will receive a placebo before beginning a specific treatment; j) the possibility that a placebo will be administered must be specified; k) if a specific treatment has be interrupted for a person to be admitted to a research sample and this can involve added suffering the patient must be clearly informed about the length of the suspension of his specific therapy and the possible side effects; l) the use of a placebo cannot be ethically acceptable in more vulnerable patients such as cancer patients who are in the final stage of their illness; m) in order to ensure that the placebo is scientifically valid it must as regards it weight, size, colour, structure taste, smell be similar to that of a specific pharmaceutical so that it cannot be identified by the patient or the researcher; and n) invasive placebos such as injections with inactive substances have to have minimal risks and their nature must be clearly explained to the patients who take part in the research.

However, we would like to emphasise what is written in a classical tract of medical science, where one reads: 'a placebo is an indispensable element in certain controlled clinical trials. In contrary fashion it has only a limited role in the common practice of medicine. An attentive relationship between the medical doctor and the patient is generally preferable to a placebo in promoting a therapeutic effect'. (Goodman & Gilman's, *The Pharmacological basis of Therapeutics*, 9th ed. Mc Graw Hill, 1996, p. 53).

The Placebo and the Pharmaceutical Industry

It is important to emphasise that in experimenting with a substance employing a placebo as a comparison that there exists the phenomenon of publication bias where the pharmaceutical company sponsoring the trial encourages the publication only of those results that are favourable and not those that are unfavourable to the product in question. This very important aspect of scientific research has been the subject of special attention on the part of the editors of two authoritative international journals, namely *The Lancet* and *The British Medical Journal*, who specified that all randomised controlled studies must be registered before the beginning of trials, with the publication of all the results, including those that are unfavourable.

Another ethical subject that should be borne in mind is the controlled placebo studies sponsored by the pharmaceutical industry in the under-developed countries of the third world. Here the Council of International Organizations of Medical Sciences, together with the World Health Organisation, proposed ethical guidelines for multinationals that carry out research in the third world (see the bibliography below). These guidelines are: a) the objectives of the research must correspond to the health-care needs and the priorities of the country where the research is carried out; b) every pharmaceutical produced as result of a study carried out in economically depressed areas must be reasonably available to the inhabitants of these areas as well; c) one should no longer plan phase 1 studies (those carried out at a preliminary level on so-termed healthy volunteers) in third world countries only because they cost less and the trials are regulated in an aleatory way.

From the legal medical point of view it is advisable to make a distinction between the use of a placebo in clinical practice where it is taken for granted that there are effective pharmaceuticals beyond the placebo, on the one hand, and trials where it is necessary to inform the patient and administer the effective therapy to him where this is present, on the other Were a health worker to administer a placebo to the control group in alternative to an existing effective pharmaceutical, difficulties could arise for that health worker at a civil and penal level.

Ethical-Theological Aspects. The Relationship between Pain, the Placebo and Prayer

The Influence of Immanent Parameters (the Medical Doctor, the Pharmaceutical, the Placebo) and Transcendent Parameters (the Priest, Faith, Prayer) on Pain.

The presence and the availability of a caring and attentive medical doctor has an influence on the pain threshold and constitutes a positive therapeutic moment of human and clinical relevance, in the same way as the administration of a placebo, that is to say an inert substance, as has already been amply observed in this paper, has an authentic pharmacological effect.

Fig. 5 VAS scale: L is a segment where the patient indicates the perceived level of pain. The part between the indicated pint and the corresponding point 'no pain' is in centimetres.

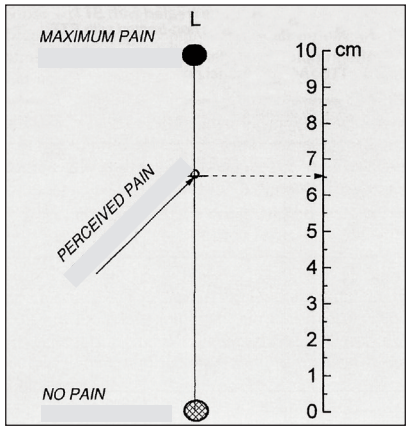


Fig. 6. Average levels of VAS over 24 hours in 4 measurements (every 6 hours after the base measurement) carried out on the first, fifth and tenth days in the first group made up of 8 believing patients and 8 agnostic patients with benign pain who were treated with a placebo.

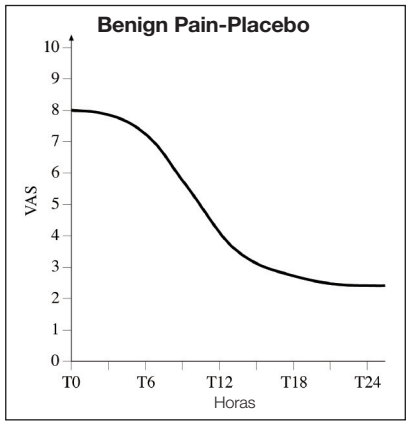
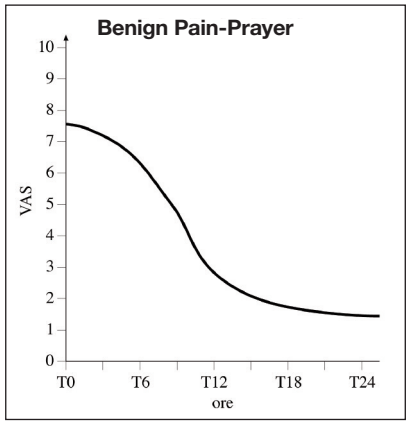


Fig. 7 Average levels of VAS over 24 hours in 4 measurements (every 6 hours after the base measurement) carried out on the first, fifth and tenth days in the second group made up of 8 believing patients and 8 agnostic patients with benign pain who were treated with prayer



A medical doctor who has prescribed a substance, even if it is an inert one, has an important and in terms of purpose therapeutic role because he has managed to establish a relationship of deep trust with his patient. It is specifically from this ontological physiognomy that the medical doctor acquires in relation to his patient a pharmacological profile as well.

From an ethical point of view, however, one should make an important distinction between how physical and mental pain is seen by a believer and how it is seen by an agnostic person. Very rigorous studies on the relationship between painful illness, faith and prayer (Zucchi, P.L., Honings, B., 1996; Ratzinger, J., Bertone, T., 2000; Zucchi, P. L., Honings, B., Voegelin, M.R., 2001, 2003) have demonstrated that faith, by raising the pain threshold, creates in an individual the condition of perceiving less pain. The improvement in the painful set of symptoms takes on a different significance if the (consentient) patient has used a placebo and prayer.

In our *open* study an assessment was made of 64 patients (believers and agnostics, volunteers and consenting participants) with stabilised benign and malign painful pathologies, sub-divided into 4 groups each with 16 patients. The first group was composed of 8 believing patents and 8 agnostic patients with benign pain who were treated with a placebo; the second group was composed of 8 believing patients and 8 agnostic patients with benign pain who were treated with prayer; the third group was composed of 8 believing patients and 8 agnostic patients with malign pain who were treated with a placebo; and the fourth group was composed of 8 believing patients and 8 agnostic patients with malign pain who were treated with prayer. Obviously the patients could leave the study group at any moment if they so wished.

The assessment of the intensity of pain was done using the visual analogical scale (VAS) of Scott Huskisson (fig. 5) every six hours on the first, fifth and tenth days. Below, these data are employed to produce an average of the four measurements, after the base measurement, made on these above-mentioned three days during the ten days of treatment (cf. figs.6, 7, 8, 9).

This approach uses a pattern with a vertical line 10 centimetres in length and delimited with two points at the end in which the low point refers to the condition of absence of pain (pain = 0) and the high point refers to the condition of maximal pain (pain = 10). This scale is given to the patient who has to indicate the intensity of his pain. Subsequently, thanks to the measurement in

Fig.8. Average levels of VAS over 24 hours in 4 measurements (every 6 hours after the base measurement) carried out on the first, fifth and tenth days in the third group made up of 8 believing patients and 8 agnostic patients with malign pain who were treated with a placebo.

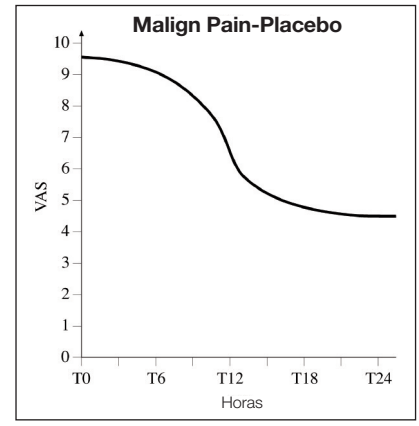
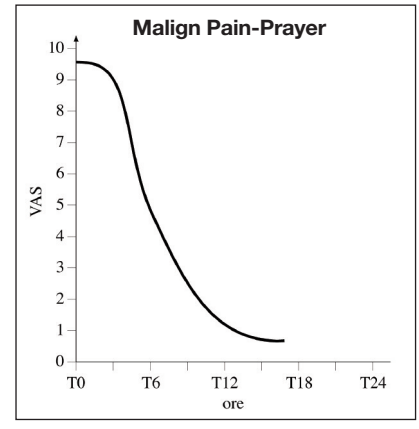


Fig. 9 Average levels of VAS over 24 hours in 4 measurements (every 6 hours after the base measurement) carried out on the first, fifth and tenth days in the fourth group made up of 8 believing patients and 8 agnostic patients with malign pain who were treated with prayer.



millimetres of the segment between the end of the scale that corresponds to the absence of pain and the indicated point (cf. fig. 5), one obtains the conversion of the pain intensity in a numerical datum that can be subjected to statistical computation. At the present time the VAS scale is the most sensitive method we have for the assessment of (acute) pain in clinical conditions. The results obtained on the assessment of intensity of pain in the four groups that were examined demonstrated an improvement in pain relief in the sample of patients (believers and agnostics) affected by neoplastic pain who had agreed to engage in a mediated reading from the gospels compared to the equivalent sample with the placebo. However, in the group of patients with benign pain as well the results tended to be more favourable in the group which had engaged in a mediated reading of the gospels compared to the equivalent group with the placebo. In examining each of the two groups, with benign pain and with malign pain, who had agreed to engage in a mediated reading from the gospels, more favourable results were obtained in the group of neo-plastic patients than in the group of patients with benign pain, a fact that had already been demonstrated in previous studies.(Zucchi, Honings, Voegelin, 2001).

This clinical result could be explained by the fact that in very precarious psycho-physical conditions, for example where there is neo-plastic pain, it is obvious that the mechanisms involving the inhibition of pain are strongly activated and thus less receptive to other stimuli such as the placebo.

From a theological point of view pain, and especially neoplastic pain, constitutes a privileged moment to enter into perfect harmony with the Lord, who feels especially for the smallest amongst us and the most suffering.

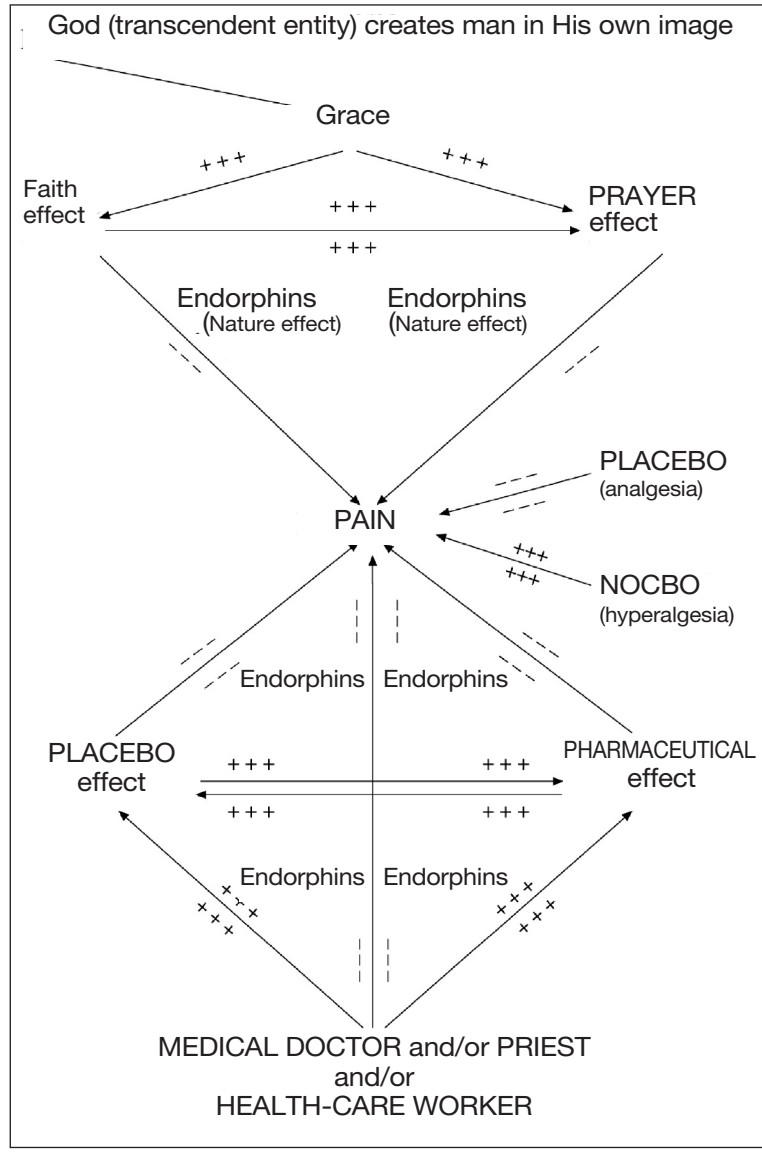
Those who entrusted themselves to the Lord with the very strong instrument of prayer not only improved their state of psycho-physical well-being, obtaining relief from their set of painful symptoms, they also obtained a close alliance with God, the Father of everyone and an authentic medicine for everyone.

A believer, in fact, tries to live out his illness and his pain in a trusting relationship with God, certain that God is the true Healer. He experiences this above all else when he turns to a priest for the administration of the sacrament of the anointing of the sick.

The immanent influence (the placebo), on the one hand, and the transcendent influence (prayer), on the other, in the sphere of pain, find a profound support in theological thought about the relationship between the Creator and His creatures.

God created all things with great ease and swiftness and left in them some traces of His being, drawing them from nothing into existence, and doing all of this through His wisdom, which is the Word, his only-begotten Son. Thus all creatures bear witness to the greatness and perfection of God, but this is especially true of man, who was created in His image and redeemed by Christ in his likeness. It should therefore be observed that

Fig. 10. Schematic depiction of the influence of transcendent parameters (faith, prayer, the priest) and immanent parameters (the medical doctor, the health-care worker, the pharmaceutical, the placebo) on the clinical-theological interpretation of *pain-the placebo-prayer*.
+++: facilitating activity (increase, augmentation)
- - - : inhibiting activity (decrease, diminution)



God, with the sole image of His Son, looked at all things and gave them their natural being. Seeing, therefore, that all the things that He had created were very good, He saw them in the Word, His Son. In looking at them, as St. John of the Cross makes clear, He not only communicated to them their being and natural graces but with this image of His Son He had them clothed in beauty,

communicating to them their supernatural being. This happened when He became man, raising man to the beauty of God and as a consequence in man all creatures as well because in making Himself man He joined Himself to the nature of all creatures. With respect to man, the *Catechism of the Catholic Church* teaches: 'It is in Christ, Redeemer and Saviour, that the divine image, disfigured in man by the first sin, has been restored to its original beauty and ennobled by the grace of God' (n. 1701). This image of God is present in every man and thus also in an agnostic. Thus the immanent parameters (the medical doctor, the pharmaceutical, and the placebo) and the transcendent parameters (the priest, faith and prayer) influence both believers and agnostics. This is explained by the fact that the immanent parameters influence the psyche and thus the feelings as well and thus the soma as well. But, and this is a very interesting point, because of his spiritual soul and corresponding spiritual powers of intelligence and will, man (both believer and agnostic) is also and above all open to the influence of the transcendent parameters (the priest, faith and prayer). This openness of his to the transcendent, which is characteristic of his pneumatic capacity, involves a special relationship, namely grace, with God, whereby man has his own influence on his psyche and through this on his soma.

In fig. 10 one can observe how God creates man in His image and likeness and through Grace strengthens Faith (the Faith effect) and the very effective instrument of Prayer (prayer effect), reducing pain (nature effect). The effect of the pharmaceutical and the placebo effect tend to strengthen each other, decreasing pain, and are positively influenced by the figure of the worker for physical health (medical doctor/health-care workers) and the worker for spiritual health (the priest).

To conclude, one may state that from the interpretation of this schematic depiction there follows an ethical-theological view not only of the incontestable value of Faith and Prayer and the appropriate use of a pharmaceutical and a placebo but also of the importance of the indispensable affectionate and not hurried participation of the medical doctor, the priest and other health-care workers, because they themselves are the bearers of authentic treatment.

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Bibliography/ References

AMANZIO, M., BENEDETTI, F., 'Neuropharmacological dissection of placebo analgesia: expectation – activated opioid systems versus conditioning - activated specific subsystems', *J. Neurosci*. 19 (1999), 484 – 494.

AMANZIO, M., POLLO, A., MAGGI, G., BENEDETTI, F., 'Response variability to analgesic: a role for non – specific activation of endogenous opioids', *Pain*, 90 (2001), 205-215.

Anonymous, *The Placebo in Medicine* (Medical Press, 1890).

ANTISERI, B., FEDERSPIL, G., SCANDELLARI, C., *Epistemologia, clinica medica e la questione delle medicine eretiche* (Rubettino Editore, 2003), pp. 129-188.

ARCHER, T. P., LEIER, C. V., 'Placebo treatment in congestive heart failure', *Cardiology*, 81 (1992), 125-133.

BEECHER, H. K., 'The powerful placebo', *JAMA*, 159 (1955), 1602-1606.

BEERS, M., BERKOW, R., *The Merck Manual* (Merck Research Lab., Whiterhouse Station, 1999), p. 2585.

BENEDETTI, F., ARDUINO, C., AMANZIO, M., 'Somatotopic activation of opioid systems by target – directed expectations of analgesia', *J. Neurosci*. 19 (1999), 3639 – 3648.

BENEDETTI, F., *La realtà incantata* (Zelig Editore, Milan, 2000).

BENEDETTI, F., MAYBERG, H. S., WA-

GER, T. D., 'Neurobiological mechanisms of the placebo effect', *Journal of Neuroscience*, 25 (2005) 10390 – 10402.

BENSON, H., *Beyond to Relaxation Response* (Times Books, New York, 1984).

BOUREAU, F., LEIZOROVICZ, A., CAULIN, F., 'The placebo effect in bone metastatic pain', *Presse Medicale*, 17 (1988), 1063-1066.

BRODY, H., 'The lie that heals: the ethics of giving placebos', *Ann. Intern. Med*., 97 (1982), 112 – 118.

BRUSCO, A., 'L'accompagnamento spirituale del morente', *Camillianum*, 13 (1996), 25-60.

CAGLI, V., 'L'utilità dell'inefficacia: il placebo', *Cuore e salute*, 12 (2002), 514-516.

CARETTA, F., 'Placebo', in: G. Russo (ed.), *Enciclopedia di Bioetica e Sessuologia* (Editrice Elledici, Turin, 2004), pp. 1375-1379.

CARLI, G. C., 'Analgesia da placebo: aspetti metodologici e meccanismo d'azione', in Pasqualucci, V. (ed.), *Atti del XVII Congresso Nazionale A.I.S.D.* (Perugia, 1994), pp. 32-33.

CICCONE, L., *Bioetica* (Edizioni Ares, Milan, 2003).

CLAYTON, L. T., *Taber's Cyclopedic Medical Dictionary* (Davis Company, Philadelphia, 1985), p. 1307.

Comitato Nazionale per la Bioetica, *La sperimentazione dei farmaci* (Presidenza del Consiglio dei Ministri – Dipartimento per l'Informazione e l'Editoria, Rome, 1992).

Council of International Organizations of Medical Sciences (CIOMS), *International Ethical Guidelines for Biomedical Research Involving Human Subjects* (Geneva, 1993).

DAMASIO, A., *L'errore di Cartesio* (Edizioni Adelphi, Milan, 1997).

DE LA FUENTE – FERNANDEZ, R., RUTH, T. J., SOSSI, V., SCHULZER, M., CAINE, D. B., STOESSI, A. J., 'Expectation and dopamine release: mechanism of the placebo effect in Parkinson disease', *Science*, 293 (2001), 1164 – 1166.

DELFINO, G., PANCIOTTI. E., LIGURI, G., STEFANI, M., 'Biologia e Medicina', *Dizionario Enciclopedico di Scienze Biologiche e Mediche* (Zanichelli, Bologna, 1995), p. 966.

DOBRILLA, G., BARBARA, L., BIANCHI PORRO, G., 'Ranitidina versus placebo nel trattamento a breve termine dell'ulcera duodenale: studio endoscopico multicentrico in doppio cieco' in Dobrilla, G., Barbara, L., Bianchi Porro, G. (eds.), *Ranitidina: il nuovo H2-antagonista* (Cortina Ed., Verona, 1983).

DOBRILLA, G., *Placebo e Dintorni* (Pensiero Scientifico Editore, Rome, 2004).

DOGLIOTTI, M., ROSIELLO, L., *Lo Zingarelli 1999*, Vocabolario della Lingua Italiana (Zanichelli, Bologna, 1999), p. 1348.

DOSSEY, L., *Guarire con la preghiera e la meditazione* (Rizzoli, Milan, 1996).

DUQUOC, C., FLORISTAN, C., 'Editoriale', *Concilium*, 3 (1990) 17-19.

ECCLES, J., *Come l'io controlla il suo cervello* (Rizzoli, Milan, 1994).

ELLISON, C.G., 'Religious involvement and subjective well-being', *Journal of Health and Social Behavior*, 32 (1991), 80-99.

EVANS, F. G., 'The power of a sugar pill', *Psychology Today*, 1 (1974), 55-61.

FEDERSPIL, G., 'Un antico problema metodologico riconsiderato: il placebo', *Ann. Ital. Med. Int*. 17 (2002), 209 – 212.

FINNEY, J.R., MALONY, H.N., 'An empirical study of contemplative prayer as an adjunct to psychotherapy', *Journal of Psychology and Theology*, 13 (1985 a) 284-290.

FINNEY, J.R., MALONY, H.N., 'Contemplative prayer and its use in psychotherapy: a theoretical model', *Journal of Psychology and Theology*, 13 (1985 b) 172-181.

FINNISS,D. G., BENEDETTI, F., '*Mechanisms of the placebo response and their impact on clinical trials and clinical practice'*, *Pain*, 114 (2005), 3-6.

FINNISS, D. G., BENEDETTI, F., 'Mechanisms of the placebo response and their impact on clinical trials and clinical practice', *Pain*, 14 (2005), 3-6.

FINNISS, D. G., BENEDETTI, F., 'Placebo Analgesia, Nocebo Hyperalgesia', Pain-Clinical Updates, XV (2007), 1-4.

FISHER, S., 'Non specific factors in response to drugs' in Di Mascio, G. C., Shader, H. J., (eds.), *Clinical handbook of clinical psychopharmacology* (Appleton, New York, 1970).

GAMBACCINI, P., GUAZZELLI, M., 'Il placebo: fantasma della medicina del corpo e risorsa della medicina della mente', *Toscana Medica*, 6 (2006), 19.22.

GARATTINI, S., 'Presentazione' *Placebo e dintorni* di G. Dobrilla, (Il Pensiero Scientifico Editore-Rome, 2004).

GARNIER, M., DELAMARE, V., *Dizionario dei termini tecnici di medicina* (Marrapese Editore, Rome, 1982).

GENSINI, G. F., 'Presentazione' *Dolore-Placebo-Preghiera* di P. L. Zucchi, B. Honings, M. R. Voegelin, *Dolentium Hominum*.

GRACELY, R. H., DUBNER, R., WOLSKEE, P. J., DEETER, W. R., 'Placebo and naloxone can alter postsurgical pain by separate mechanisms', *Nature*, 306 (1983), 264-265.

GREEN, D. M., 'Pre-existing conditions, placebo reactions, and side effects', *Ann. Intern. Med*., 60 (1964), 255-265.

HENSYL, W. R., *Stedman's Medical Dictionary* (Williams & Wilkins, 1990), p. 1205.

ILNYCKJ, A., SHANAHAN, F., ANTON, P. A., CHEANG, M., BERNSTEIN, C. N., 'Quantification of the placebo response in ulcerative colitis', *Gastroenterology*, 112 (1997), 1854-1858.

International Association for the Study of Pain (I. A. S. P.), 'Pain terms. A list with definitions and notes on usage, *Pain*, 6 (1979) 249; 14 (1982), 205.

JOHNSON, A.G., 'Surgery as a placebo', *Lancet*, 344 (1994), 1140-1143.

JOSPE, M., *The placebo effect in healing* (Lexington Books, Toronto, 1978).

KIESLING, S., HARRIS, G.T., 'The prayer war', *Psychology Today*, 23 (10) (1989), 65-66.

KOENIG, H.G., KVALE, J.N., FERREL, C., 'Religion and well-being', *The Gerontologist*, 28 (1988), 18-28.

KOENIG, H.G., GEORGE, L.K., MEADOR, K.G., BLAZER, D.G., FORD, S.M., 'Religious practices and alcoholism in a southern adult population', *Hospital and Community Psychiatry*, 45 (1994), 225-237.

KOENIGSBERG, R., *Churchill's Medical Dictionary* (Pensiero Scientifico Editore, Turin, 1994), p. 1464.

LA MANTIA, L., EOLI, M., 'Does placebo effect exist in clinical trias on multiple sclerosis? Review of the literature', *Ital. J. Neurol. Sci*. 17 (1996), 135-139.

LEONE, S., 'Placebo', in S. Leone and S. Privitera (eds.), *Dizionario di Bioetica* (EDB, Bologna, 1994), pp. 719-721.

LEVINE, J. D., GORDON, N. C., FIELDS, H. L., 'The mechanism of placebo analgesia', *The Lancet*, 2 (1978), 654-657.

LIBERMAN, R., 'An experimental study of the placebo response under three different situations of pain', *J. Psychiat. Res*., 2 (1964), 233 – 246.

MANFREDI, C., 'L'effetto placebo', *Toscana Medica*, 5 (2006), 30-31.

MARKIDES, K.S., 'Aging, religiosity and adjustment: a longitudinal analysis', *Journal of Gerontology*, 38 (1983), 621-625.

MARTIN, J.E., CARLSON, C. P., 'Spiritual dimensions of health psychology' 'n W. R. Miller and J. E. Martin (eds.), *Behavior therapy and religion* (Sage Newbury Park (CA), 1988).

MATON, K.I., PARGAMENT, K.I., 'The roles of religion in prevention and promotion', *Prevention in Human Services*, 5 (1987), 161-205.

MC CULLOUGH, E.M., 'Prayer and health: conceptual issues, research review, and research agenda', *Journal of Psychology and Theology*, 1 (1995), 15-29.

MAYBERG, H. S., SILVA, A. J., BRANNAN, S. K., TEKELL, J. L., MAHURIN, R. K., MC GINNIS, S., JERABEK, P. A., 'The functional neuroanatomy of the placebo effect', *Am. J. Psychiat*., 159 (2002), 728-737.

MODELL, W., *The relief of symptoms* (Saunders, Philadelphia, 1955).

MOERMANN, D. E., *Placebo. Medicina, Biologia, Significato* (Vita e Pensiero, Milan, 2004).

PAYNE, I.R., BERGIN, A.E., BIELEMA, K.A., JENKINS, P.H., 'Review of religion and mental health: prevention and the enhancement of psychological functioning', *Prevention in Human Services*, 9 (2) (1991), 11-40.

PEPPER, O., 'A note on the placebo', *Amer. J. Pharmacy*, 117 (1945), 409-412.

PETRINI, M., CARETTA, F., 'Preghiera cristiana e salute', *Camillianum*, 16 (1997), 1-44.

PETROVIC, P., KALSO, E., PETERSSON, K. M., INGVAR, M., 'Placebo and opioid analgesia – imaging a shared neuronal network', *Science*, 295 (2002), 1737-1740 .

POLOMA, M.M., GALLUPP, G.H.JR., *Varieties of prayer: a survey report* (Trinity Press International, Philadelphia, 1991).

POPPER, K., ECCLES, J., *L'io e il suo cervello* (Armando Editore, Rome, 1996).

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

ROTHENBERG, R. E., *La Nuova Enciclopedia Medica Garzanti* (Garzanti, Milan, 1987), p. 1213.

SACCÀ, L., 'Il placebo nella ricerca clinica: un compromesso continuo fra necessità etica e rigore scientifico', *Ann. Ital. Med. Int.* 17 (2002), 215-220.

SCACCHI, D., 'Mente e Cervello secondo John Eccles', Pathos, 3 (2007), 27-33.

SCHACHTER, S., SINGER, J. E., 'Cognitive, Social and physiological determinants of emotional states', *Psychol. Rev.*, 69 (1962), 379-399.

SCOTT, J., HUSKISSON, E. C., 'Graphic representation of pain', *Pain*, 2 (1976), 175-184.

SCOTT, D. J., STOHLER, C. S., EGNATUK, C. M., WANG, H., KOEPPE, R. A., ZUBIETA, J. K., 'Individual differences in reward responding explain placebo – induced expectations and effects', *Neuron*, 55 (2007), 325-336.

Sgreccia, E., *Bioetica* (Edizioni Vita e Pensiero, Milan, 1986).

SHAPIRO, A. K., 'Factors contributing to the placebo effect', *Amer. J. Psychiatry*, 18 (1964), 73-88.

SHAPIRO, A. K., 'The placebo response', in Howells, J. G. (ed.) *Modern perspectives in world psychiatry*, vol. 2 (Oliver and Budy, Edinburgh, 1971).

SHERRINGTON, W., *The integrative action of the nervous system*, 2nd ed. (Yale University Press, New Haven, 1947).

SINGER, D. L., HURWWITZ, D., 'Long term experience with sulfanylures and placebo', *N. Engl. J. Med.*, 277 (1967), 450-456.

SOARES-PRABHU, G., 'Parlaread Abbà. La preghiera come domanda e ringraziamento nell'insegnamento di Gesù', *Concilium*, 3 (1990), 55-69.

SORAVITO, L., 'Educare alla Spiritualità', *Credere Oggi*, 22 (1984), 91.

STRATA, P. G., 'Mente, fenomeno naturale: come si demolisce la differenza tra mentale e fisico', *La Stampa*, 23 November 1994.

TER RIET, G., DE CRAEN AJM, DE BOER, A., KESSELS, AGH, 'Is placebo analgesia mediated by endogenous opioids ? A systematic review', *Pain*, 76 (1998), 273-275.

TETTAMANZI, D., *Nuova Bioetica Cristiana* (Edizioni Piemme, Casale Monferrato (Al), 2000).

The Coronary Drug Project Research Group, 'Influence on adherence to treatment and response of cholesterol and mortality in the coronary drug project', *N. Engl. J. Med.*, 303 (1989), 1038-1041.

TIENGO, M., 'Il dolore nel dibattito cervello – mente' in Tiengo, M. and Benedetti, C. (eds.), *Fisiopatologia e Terapia del Dolore* (Masson, Milan, 1996), pp. 523-528.

TORREY, R.A., *How to prayer* (Whitaker, Springdale (PA), 1983).

Treccani, *Vocabolario della lingua italiana* (Treccani, Rome, 1998), p. 1201.

VINAR, O., 'Dependence on a placebo: a case report', *Brit. J. Psychiatry*, 115 (1969), 1189-1190.

WAGER, D., 'Expectations and anxiety as mediators of placebo effects in pain', *Pain*, 115 (2005) 225-226.

WAGER, D., RILLING, J. K., SMITH, E. E., KASEY, K. L., DAVIDSON, R. J., KOSSLYN, S. M., ROSE, R. M., COHEN, J. D., 'Placebo induced changes in MRI in the anticipation and experience of pain', *Science*, 303 (2004), 1162-1166.

WILSON, W., NELSON, A., BISHOP, L., *Utilization of spiritual interventions in psychotherapy. Paper presented at the Second International Congress on Christian Counseling* (Atlanta, Georgia, November 1992).

WOLF, S., 'The pharmacology of placebos', *Pharmacol. Review*, 11 (1959), 689-704.

World Medical Association Declaration of Helsinki: *Ethical principles for medical research involving human subjects* (Edinburgh, WMA, 2000).

ZUCCHI, P. L., VIVALDI FORTI, C., MILANESI, E., OBLETTER, G., 'Definizione del termine dolore' in 'Test di personalità proiettivi (Rorschach, T. A. T.) e non proiettivi (M. M. P. I.) nella cefalea psicogena e nella cefalea da tensione muscolare. Indirizzi terapeutici', *Algologia*, 1 (1983), 41-82.

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

ZUCCHI, P. L., HONINGS, B., 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., VOEGELIN, M. R., 'The effect of a thoughtful reading of the New Testament on the hyperalgesic area and on the perception of pain in patients with lumbar algic syndrome', *Dolentium Hominum*, 53 (2003), 44-51.

ZUCCHI, P.L., HONINGS, B., AGRÒ, F. E., PASQUETTI, P., INNOCENTI, M., TIRABASSI, A. F., 'Il dolore in Fisiatria', *Quaderni della Riabilitazione* (E. Biselli ed. in chief), Edizioni Fondazione Don Carlo Gnocchi, Milan, 5 (2006), 21-109.

‘Comfort ye, Comfort ye my People’: Sanctuaries, the Sacrament of Consolation

NINTH MEETING OF SPANISH SANCTUARIES
THE SANCTUARY OF OUR LADY OF MONTSERRAT,
26-28 SEPTEMBER 2006

A few years ago I read the book by Stefan Zweig *Momentos estelares de la humanidad* (‘Stellar Moments of Humanity’) in which Handel, given that he was no longer able to write music, was increasingly falling into a state of depression. One day he received a letter which made him take up writing music again. The page began with the words of Isaiah: ‘Comfort ye my people’. A ray of light lit up his soul and he began the composition of ‘Messiah’ which he then finished in a short time. Comforted internally, he was able to write a work that summed up life, joy… As an expression of his gratitude he gave the rights to this work to the centre where he had been treated.[1] He who has been comforted, is called to console. I will thus begin my paper with the n. 2 of Handel’s Messiah which we will now listen to.

I would like to thank the organisers of this meeting for their kind invitation to me and in particular I would like to thank Rev. Joseph Enric for the fine words with which he introduced me. In my paper I would like to show how much human beings need to be comforted and thus I would like to help to explore the subject of the mission of the sanctuary as a sacrament of God’s consolation and offer some key points to show that sanctuaries are truly sacraments of God’s comfort.

1. Human Beings: in Need of Consolation and Able to Consolation

Sooner of later we all need to be comforted. ‘We are so frail’, wrote Brother Roger in his unfinished letter, ‘that we need consolation. For all of us arrives the moment when we are shaken by a personal trial or by the suffering of other people. This could even lead to our faith being shaken or give rise to new hope. To rediscover our peace of mind at times we have to be patient with ourselves. There is a pain, however, that marks us in a particular way: the death of someone who is near to us and whom we need in order to walk upon the earth’.

There are many people who need consolation and who ask for comfort. I invite you to draw near to them with your minds and your hearts. Look at their faces, listen to what they have to say, hear their silences, and enter their lives. Discover and receive the appeal of those who are alone and are abandoned by their family relatives, the appeal of those who feel worn out by life, the appeal of the persecuted and the slandered, of the most unfortunate, the appeal of the excluded and the marginalised, the appeal of those who do not manage to give a meaning to their existence, the appeal of those who have not found peace of mind, and the appeal of those who suffer because of their own behaviour or because they feel guilty. Look at the incurably ill, the abandoned elderly, those who have lost a dear one, parents disorientated by the behaviour of their children, couples that are breaking up, those who live the experience of rejection, incomprehension or failure… believers who are submerged in a dark night etc. Think also of families and populations that are experiencing the horrors of war, acute poverty and hunger, the consequences of natural catastrophes etc.

However, stop as well to observe the multitude of so many anonymous people who are sensitive to the pain of other people and do everything to alleviate their suffering and end that suffering.

2. The Pathways by which to Bring Consolation

In the past, but this applies to today as well, all cultures, religions, schools of thought and humanitarian groups trusted to practical teachings to bring consolation to the afflicted and help those who suffer. The commonest proverbs and sayings, which condense popular wisdom, offer us a rich sample of pathways that bring consolation .

2.1 *It is natural to have afflictions and pain*

He who does not have an affliction will find it on his path. Affliction is lame, but it will arrive sooner or later.

2.2 *Consolation exists but you have to want it*

There is no pain without consolation. He who does not comfort himself does not want consolation. He who wants to find consolation will find it sooner or later. There is no ford without a river, nor is there pain without consolation. The lament of my neighbour does not alleviate my lament. Other people’s woes are a low consolation. Pain and misfortune belong to those who suffer them.

2.3 *There are different ways of experiencing affliction, pain and desolation*

Shutting yourself up in yourself: when pain reaches the soul it never leaves it.

Thinking, imagining, foreseeing: afflictions are worse in thoughts than in actual facts. The affliction that has passed hurts less than an affliction feared.

Not wanting to escape: there is no greater pain than pain that does want to be comforted.

2.4 *Pathways by which to find consolation*

Let off steam, communicate, breath, cry: pain that is transmitted; if it is not treated, it can be alleviated. Tears alleviate affliction. The sighs that rise from the heart lessen pain. To sigh alleviates pain. Pain that is communicated is already alleviated.

Exercise: to those who are not habituated to pain, a little pain seems a great deal. Tears alleviate afflictions, one's own tears, not the tears of other people.

See the positive side: there is no affliction that does not come for good. See the afflictions that you do not have as possessions. There is no pain that can resist for a hundred years. There is no going up without coming down. The calm comes after the storm.

Use the resources that you have: tears and bread soon dry up. Pain with bread becomes less.

O*pen up and see the pain of other people*: carry your cross in the street and you will see other, larger, crosses. Think of the homes of other people and you will keep your pain. Those who do not suffer, let them see my affliction and theirs will seem good.

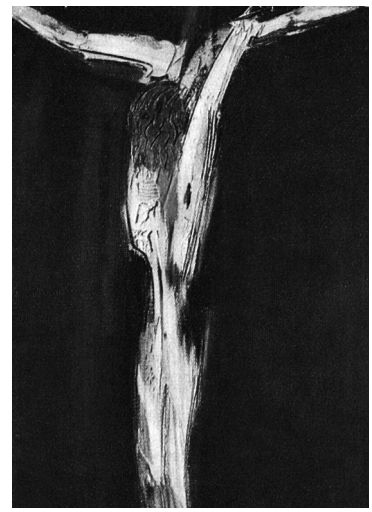
Receive help: not fine words for the sick but effective remedies. Consolation is worth little if it brings no remedy

3. God, the Source of all Consolation

'I am your comforter' (Is 51:12)

The Bible, without denying human consolation, demonstrates to us a deeper consolation, divine consolation, whose protagonist is God, who comes to us, is interested in our pain, listens to the cries of His people and sustains their hope then they are in desolation.

To comfort is the specific work of God and this we can see in a special way in the Psalms where we are often shown a God of love who always comforts man: 'Thy rod and thy staff comfort me' (Ps 23:4); 'Thou wilt increase my honour and comfort me again' (Ps 71:21); 'thou, Lord, hast helped me and comforted me' (Ps 86:17); 'When the cares of my heart are many, thy consolations cheer my soul' (Ps 94:19); 'This is my comfort in my affliction that thy promise gives me life' (Ps 119:50); 'When I think of thy ordinances from of old, I take comfort, O Lord' (Ps 119:52); 'Let thy steadfast love be ready to comfort me' (Ps 119:76).



For an Israelite afflicted by torments, God appeared as the great comforter who always feels compassion for His people and comforts it with the goodness of a shepherd, the love of a father and the tenderness of a mother: 'He will feed his flock like a shepherd, he will gather the lambs in his arms, he will carry them in his bosom, and gently lead those that are with young' (Is 40:11). 'Can a woman forget her sucking child, that she should have no compassion on the son of her womb? Even these may forget, yet I will not forget you' (Is 49:15). 'you shall suck, you shall be carried upon her hip, and dandled upon her knees. As one whom his mother comforts, so I will comfort you; you shall be comforted in Jerusalem' (Is 66:12-13); 'When I thought, "My foot slips", thy steadfast love, O Lord, held me up. When the cares of my heart are many, thy consolations cheer my soul' (Ps 93:18-19); 'This is my comfort in my affliction that thy promise gives me life… When I think of thy ordinances of old, I take comfort, O Lord… Let thy steadfast love be ready to comfort me according to thy promise to thy servant' (Ps 118:50,52,76).

God's consolation does not only come to men in a direct way; it also comes indirectly through various mediators and channels. The principal mediators of God's consolation are the *Prophets*.

Isaiah: 'Comfort, comfort my people, says your God. Speak tenderly to Jerusalem' (Is 40:1-2).

Jeremiah: 'I shall turn their mourning into joy, I will comfort them, and give them gladness for sorrow' (Jer 31:13).

Ezekiel: 'They will console you, when you see their ways and their doings, you will be consoled for the evil that I have brought upon Jerusalem' (Ez 14:23).

Baruch: 'Take courage, O Jerusalem, for he who names you will comfort you' (Bar 4:30).

Comforting is the finest work of the Prophets. Their mission was to create the environment, prepare the most adequate message, for the circumstances and know how to withdraw in time in order to foster true encounter with the God of all consolation. It was God who would truly speak to the heart of man.

The great comforter, however, is a mysterious envoy, the servant who will come to implement the work of comforting all those who weep (Is 61:2). The Jewish tradition would call him '*menahen*', the 'consolation of Israel'.

4. Christ, the Sacrament of the Consolation of God

The God who comforts comes to men in Jesus. He himself appeared as the expected servant, the envoy, to offer that comfort that only God can give, the only consolation that is able to alleviate afflictions. He is the Comforter of every man on earth.

In his person God the comforter came to men to announce that the afflicted would be comforted: 'Blessed are those who mourn, for they shall be comforted' (Mt 11:28) and offered rest to all those who suffer and feel the weight of their suffer-

ing: 'Come to me all who labour are heavy laden, and I will give you rest (Mt 11:28)

The whole of his work – under the impulse of the comforting Spirit – was an action that brought comfort. He healed the sick (Mt 14:14) and brought relief to the hungry (Mt 6:34; 8:2), to the afflicted (Mt 3:35-36) and to sinners (Mk 2:5).

Jesus consoled with his words but he also consoled through the example of his own life. He himself lived the experience of desolation: faced with the death of his friend Lazarus, he was deeply moved and in seeing the tears of Martha and others, he, too, wept. He wept when faced with the harsh position of the Pharisees and his rejection by Jerusalem; in the Garden of Olives he felt sadness and worry about the moments of his passion and death. He, too, needed to be comforted. He received comfort from the Father over his acceptance of death, comfort from the Cyrene in carrying his cross, and the comfort of his mother in being faithful until the end. And comforted, he became in his turn a comforter: 'In the days of his flesh, Jesus offered up prayers and supplications with loud cries and tears, to him who was able to save him from death, and he was heard for his godly fear. Although he was a Son, he learned obedience through what he suffered; and being made perfect he became the source of eternal salvation to all who obey him' (Heb 5:7-9).

Christ restores, treats and comforts from the cross all those who believe in him: 'As a Moses lifted up the serpent in the wilderness, so must the Son of Man be lifted up, that whoever believes in him may have eternal life' (Jn 3:14-15).

'By his wounds you have been healed' (1 Pt 2:24). Paul discovered that consolation springs from desolation when it is united to the suffering of Christ: 'Blessed be the God and Father of our Lord Jesus Christ, the Father of mercies and God of all comfort, who comforts us in all our affliction, so that we may be able to comfort those who are in any affliction, with the comfort with which are ourselves are comforted by God' (2 Cor 1:3-4.6)

Tonight, Christ of Calvary,
I have come to pray to you
about my sick flesh.
But seeing you, my eyes
come and go
From your body to mine,
with shame.

How can I complain about
my tired feet,
When I see that your feet are
broken?
How can I show you my
empty hands,
When yours are full of
wounds?

How can I explain to you my
loneliness,
When you are on the cross?
How can I explain to you
that I do not have love,
When your heart is pierced?

By now I no longer
remember anything,
All my pain has gone away.
The impetus of my
supplication,
Has remained suffocated in
my mouth.

I ask you only to not ask you
anything,
Only to stay here, near to
your image,
To learn that pain is only,
The holy key to your holy
door. Amen[2]

The Risen Christ continued his mission of consolation. He comforted the women who went to his tomb (Mt 28:8-10) and he comforted Mary Magdalene who wept over his death; and he comforted Peter with his gaze (Lk 22:61) and by placing trust in him (Jn 21:15ss). He restored hope and joy, which by then seemed to be lost, to his disciples at Emmaus who were disconsolate and overwhelmed (Lk 24:13-35). Everyone will be comforted and will receive the mission to comfort their brethren.

This consolation did not finish with Jesus' departure from this world to go to the Heavenly Father and he did not leave his disciples orphans because he sent them the Paraclyte, the comforting Spirit (Jn 16:16-26). Christians live in the consolation that they have received for ever from the Holy Spirit (Acts 9:31).

Lastly, God will comfort all human pain with his glorious presence amongst men: 'and I heard a great voice from the throne saying, "Behold, the dwelling of God is with men. He will dwell with them, and they shall be his people, and God himself will be with them; he will wipe away every tear from their eyes, and death shall be no more, neither shall there be mourning nor crying nor pain anymore, for the former things have passed away". And he who sat upon the throne said, "Behold, I make all things new". Also he said, "Write this, for these words are trustworthy and true"' (Ap 21:3-5).

5. The Church, a Sacrament of Consolation through the Spirit

God has wanted to be present in all epochs and be near to every heart. On the death of Christ, He did this through the Spirit whose action, in a special but not unique way, takes place through the historic mediation willed by the Lord: the Church, the sacrament of Christ, the earthly body of the glorious Christ, animated by the Spirit. The Church is the visible incarnation of Christ and his salvific and comforting action.

'The Church, "like a stranger in a foreign land, presses forward amid the persecutions of the world and the consolations of God", announcing the cross

and death of the Lord until He comes. (cf. 1 Cor 11:26) By the power of the risen Lord it is given strength that it might, in patience and in love, overcome its sorrows and its challenges, both within itself and from without, and that it might reveal to the world, faithfully though darkly, the mystery of its Lord until, in the end, it will be manifested in full light'.[3]

'The joys and the hopes, the griefs and the anxieties of the men of this age, especially those who are poor or in any way afflicted, these are the joys and hopes, the griefs and anxieties of the followers of Christ. Indeed, nothing genuinely human fails to raise an echo in their hearts. For theirs is a community composed of men. United in Christ, they are led by the Holy Spirit in their journey to the Kingdom of their Father and they have welcomed the news of salvation which is meant for every man. That is why this community realizes that it is truly linked with mankind and its history by the deepest of bonds'.[4]

'Wherever there are people…afflicted with serious distress or illness… there Christian charity should seek them out and find them, console them with great solicitude, and help them with appropriate relief'.[5]

'Thanks to an increase in cooperation between the different ecclesial bodies under the loving leadership of their pastors, the whole Church will be able to present to all a more beautiful and credible face, a clearer and more evident reflection of the Lord's own face, and will then be able to give new hope and comfort both to those who seek her and to those who, even though not seeking her, nonetheless need her'.[6]

'There will always be suffering which cries out for consolation and help. There will always be loneliness. There will always be situations of material need where help in the form of concrete love of neighbour is indispensable. The State… [is] incapable of guaranteeing the very thing which the suffering person – every person – needs: namely, loving personal concern'.[7]

Our Church is not always called to be the merciful and comforting face of God. Its sin removes from it that transparency required to being the men of today the consolation of the Lord. It follows from this that it must renew itself constantly. All of us who make up the Church are called by God to be like Him: welcoming and comforting. The saints were singular witnesses to God's consolation for suffering people: St. Vincent de Paul, St. John of God, St. Camillus de Lellis, the Blessed Teresa of Calcutta, and Mother María Rosa Molas, founder of the Sisters of Our Lady of Consolation. With their example and through their comfort we are stimulated to be like them.

Neither the Church nor Christians have a monopoly on the good work of comforting. The world is very large and we Christians are only a small part of it. It is a world in which a great deal of suffering, a great deal of frustration, disappointment, and powerlessness in the face of evil, exist. The Spirit of God, who is linked to nothing and nobody, everywhere inspires men and women who bring relief to the suffering of their brothers and sisters. We Christians know this and we thank God for this. The practice of good achieved by these men and these women for us is a reason for joy and must also be a stimulus.

6. Mary, the Comforter of the Afflicted

'Mary, comforter of the afflicted': thus is she invoked by popular piety. Many peoples venerate Our Lady of Consolation as the patron saint who intervenes for us. This popular invocation acquired greater doctrinal force when the Second Vatican Council stated that the mother of Jesus shines 'forth on earth, until the day of the Lord shall come, as a sign of sure hope and solace to the people of God during its sojourn on earth'.[8]

The Gospel emphasises that the sensitivity of the Mother of God is an expression of God's compassion and consolation towards men. Mary is placed in the heart of human frustration so as to bring her the comforting remedy which only her Son can give.

'Mary, who was present at the wedding feast of Canaan is located in the heart of human frustration so as to bring her the comforting remedy: the remedy that only her son can bring'.[9] But Mary, too, experienced desolation: 'a sword will pierce through your own soul also' (Lk 2:35). Desolation took possession of her heart but did not injure her faith. She lived to the depths the dark night. Her loneliness was the loneliness of faith. In the pain of the Son on the cross and then when she held him in her arms, Mary conserved the call of faith. And she deserved consolation. She thus became the Mother of mercy and consolation. She took part in a singular way in the consolation, the resurrection, of Christ, by whom God consoled the new messianic people afflicted by the death of the Saviour (cf. Lk 24:17). The joy of the resurrection makes her able to console her children in any affliction.

Mary has comforted and continues today to comfort her children, who go to her and cry out to her: 'turn to us your merciful eyes'. In the heart of the Church, which 'presses forward amid the persecutions of the world and the consolations of God', (*LG*, n. 8), she acts so that she is always filled with the comforting Spirit. And as 'our advocate' she exercises the function of interceding, which is equally a service of consolation.[10]

Let us now take a brief break in this paper to listen to the chorus of 'Messiah', n. 19, 'my yoke is bearable and my burden is light'.

7. Sanctuaries: Sacraments of Consolation

Sanctuaries have always been, and they remain today, privileged places for the encounter of human beings with 'mystery'. Many people go them on pilgrimages, bringing their lives, their questions, their desolation, their search for

meaning, their wounds, their pain and their loneliness, their tiredness and their afflictions, their disappointments and their hopes…In sanctuaries they find a space in which they can obtain release. The scene of Hannah in the temple of Shiloh is often repeated in our sanctuaries: 'After they had eaten and drunk in Shiloh, Hannah rose. Now Eli the priest was sitting on the seat beside the doorpost of the temple of the Lord, She was deeply distressed and prayed to the Lord, and wept bitterly…As she continued praying before the Lord, Eli observed her mouth, Hannah was speaking in her heart; only her lips moved, and her voice was not heard; therefore Eli took her to be a drunken woman. And Eli said to her, "How long will you be drunken? Put away your wine from you." But Hannah answered, "No, my lord, I am a woman sorely troubled; I have drunk neither wine nor strong drink, but I have been pouring out my soul before the Lord. Do not regard your maidservant as a base woman, for all along I have been speaking out of my anxiety and vexation." Then Eli answered, "Go in peace, and the God of Israel grant your petition which you have made to him." And she said, "Let your maidservant find favour in your eyes." Then the woman went her way and ate , and her countenance was no longer sad'. (1 Sam 1:9-10,12-18).

Paul VI called sanctuaries 'clinics of the spirit'. Dr. A. Mussi, of the University of Bologna, wrote a phrase that has been immortalised in the entrances to a number of hospitals: 'you come to be cured, and if not cured at the least cared for, and if not cared you, at least comforted'.

Are our sanctuaries, in fact, places where the sick, families who suffer, people who are alone and abandoned, those who find themselves submerged by an ocean of debts, find consolation?

Are they aware of the contribution that they can give and they are called to give today to meet the needs of so many people?

On what realities do our sanctuaries rely so that those who come to them or pass by way of them can receive the consolation and the peace that they are looking for?

How can sanctuaries, today, be 'sacraments of the consolation of God'?

These are some of the questions that I pose to myself and that I launch in your direction.

I do not have an answer because I do not have experience in the field or the facts. I would like to offer you, in rather concise form because of the lack of time, some practical suggestions. It falls to you to assess them and to put them into practice in those sanctuaries where you are present.

1. Attend with great care and attention to welcoming those who come to a sanctuary. In order to have a deeper idea of what this welcoming is I would like to refer you to the excellent paper given by Rev. José Enric Parellada to the III European Congress of Sanctuaries and Pilgrimages which was held in Montserrat in 2002. The title was 'I saw them pass by and I welcomed them. The ministry of welcome, a gift of the spirit'.

2. Create a climate of silence that relaxes and communicates serenity, which invites people to come together, to listening and to prayer. Music is without doubt very useful and indeed it is being increasingly used in some places.

Brother Roger quotes some words from the violinist Yehudi Menuhin: 'when words are sung they reach the deepest meanders of the soul. I am convinced that the young people of today who desert churches would go to Mass if they found there the mystery that should reign in them'.[11]

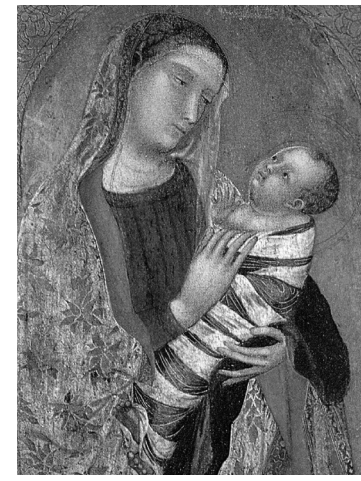
3. Create spaces that will allow those people who come or stay for a number of days to encounter themselves, mystery, release, and silent weeping.

4. Rely upon trained people who are ready to listen and to accompany visitors in a spiritual sense. In the last part of my paper I will dwell upon this subject at greater length.

5. Draw up special programmes and offer means that will allow people to express what they have inside themselves, their own worries and needs, their personal experiences…I am thinking of group encounters…of books or pamphlets in which people are invited to write…One of the pathways that leads to comfort is being with other people who are suffering.

6. Ensure that the celebrations of the Eucharist are lively, linked to the lives of the people who take part in them, and that the words evoke remembrance of God who is mercy and consolation, that God who loves us with the love of a mother.

7. Celebrate in the Sacrament of Reconciliation encounter with God, who is affectionate mercy, who comes to us and embraces us without asking anything of us, who redeems our lived with His freely-given forgiveness.



8. Celebrate the Anointing of the Sick, a sacrament of the tenderness and consolation of God, during pilgrimages in which groups of sick people take part.

9. The phrases that can be read at the feet of an image are very useful: fine texts, testimonies, poems and prayers. By way of example, I will now read you a valuable and profound text written by Rev. Moratiel, the founder of the School of Silence:

And God said:
If nobody loves you, it is my joy to love you.
If you cry, I want to comfort you.
If you are weak, I will give you my strength and my energy.
If nobody seems to need

you, I will search you out.
If you feel useless, I cannot do without you.
If you feel empty, my patience will fill you.
If you are afraid, I will carry you on my shoulders.
If you are tired, I will be your rest.
If you commit sin, I am your forgiveness.
If you ask me something, I will give unto you.
If you need me, I tell you: I am inside you.
If you are in darkness, I am a lamp to light up your steps.
If you are hungry, I am your bread of life.
If you have been unfaithful, I will always be faithful to you.
If you fall, I will treat your fractures.
If everybody forgets about you, my innards will shake remembering you.
If you think you have nobody, know that you have me.[12]

10. The novenae, the triduums, the pilgrimages etc. that are celebrated in a sanctuary…could be a good opportunity to speak about consolation and to pray for those who need consolation.

11. Sanctuaries can and must be promoters and spreaders of gospel culture and values which can be contrasted with those that are the source of many examples of desolation.

12. Sanctuaries must cooperate, to the extent that this is possible, to remedy the causes of people's desolation through their charitable and social initiatives. In other epochs, for example, they did this by building hospitals to care for sick pilgrims. Today they could do this with various works.

8. Those Who Offer Service in Sanctuaries, Sacraments of Consolation

Amongst the people who draw near to sanctuaries there are some who need 'somebody' who, in looking at them, goes beyond appearances, draws near and allows them to weep, who understands their feelings and receives their fears with respect, who has time to reflect together with them, somebody who smiles and lights a lamp on their journey, who perceives their loneliness and is moved with them with tenderness. This 'somebody' could be those who offer their service in sanctuaries, it could be you. God relies upon you to transmit His nearness to those who are suffering, to tell them that He loves them unconditionally, that He is the refuge where we can find a haven, the physician who heals our pain, the strong rock on which we can lean…This is a gift and a task that the Lord gives to us: comforting through you.

Thank you, Lord, for needing us.
In your silence that welcomes
You offer us your words,
Translated into a thousand different tongues,
Suited to every situation

In our history,
You stretch out your hands.

In your apparent paralysis,
You send us to travel down roads.
We are at your feet and we draw near to you,
To the most marginalised existences.

You ask us to be your ears,
So that your listening has a face,
Attention and feeling.
So that complaints about your absence,
Confessions about a past that gnaws,
Doubts that paralyse life,
And the love that shares its happiness,
Melt into air.

Thank you, Lord, for needing us.[13]

But it is not possible to do this from without. We must embody in our lives, bear witness to and proclaim the message of mercy and consolation revealed in Christ, and thus be bearers of God's consolation for our brethren. For this reason we must: cultivate the experience of God the comforter; fix our eyes on the Lord, the epiphany of God's tenderness and comfort, so as to make his approach, His words and his gestures our own; be aware that the Comforting Holy Spirit works in us and in other people; know how to be the envoys and instruments of the Comforting God who calls us to continue the work of Jesus, guided by the Spirit; be sensitive when faced with human pain, have compassionate hearts, experience the need for help, consolation, compassion, encouragement…and feel the joy of being comforted.

How can a person who has never needed a friendly shoulder
Provide help?
How can he console
If inside himself, he has never trembled because of pain?
How can he cure,
If he has never felt wounded?
How can he be compassionate
If he has never felt downcast?

How can he under stand,
If in his life he has never had a broken heart?
How can he be merciful,
If he has never been in need?

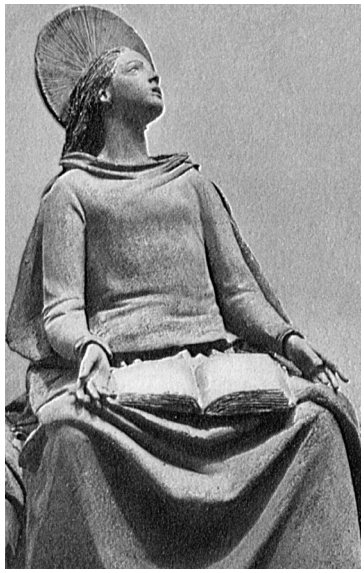
How can he encourage,
If he has never felt bitterness?
How can he re-invigorate other people,
If he has never fallen?

How can he restore joy
If he has never drawn near to the black wells of life.
And how can he accompany other people
If his life has been a solitary journey?[14]

9. The Keys by which to Live and Perform the Ministry of Consolation

This point is essential and of primary importance. On the basis of my experience and the experience of many other people with whom I have shared the task of accompanying those who suffer, an experience enriched by the study and the contemplation of the life of Jesus

of Nazareth, I would like to present you with certain *practical keys* with the sole hope that they will be of help to you in living and performing the ministry of consolation wherever you find yourselves.



1. *Welcoming and being near to people*
   'The Lord is near to the broken-hearted' (Ps 33:18).
   'But standing by the cross of Jesus was his mother' (Jn 19:25).
   'You… received me… as Jesus Christ' (Gal 4:14).

A person who is afflicted needs people near to him who temper his affliction with human warmth, who comfort his sadness with words. One cannot help those who suffer from far off. One must draw near to them and enter what a person is suffering, moved by compassion and by the desire to comfort, to encourage and to be a support. In addition, one must do this without hurry and without paternalism, doing things so that the person who is need of consolation is then a protagonist. Solidarity-inspired nearness has a curative power: it activates and makes present for the person who is suffering God's love and the love of his brethren.

H. Nouwen writes: 'More important than any concrete action or an instructive word is the simple presence of someone who is concerned about us. When we are in a crisis we are told: 'I do not know what to say to you but I want you to know that I am with you, that I will not abandon you'; we rely upon a friend through whom we can find consolation and relief. In an epoch such as ours, which is so saturated with methods and techniques conceived to change people, to influence their behaviour, to ensure that others do new things and think new ideas, we have forgotten about the simple but difficult gift of being present in relation to one another. We have lost this gift because we have been made to believe that presence must be useful'.[15]

2. *With delicacy and humility*
   'Take your sandals off your feet for where you are standing is holy ground!' (Ez 3:5).

One does not enter the world of those who suffer desolation by subordinating others, but, rather, one does this with delicacy. We must offer our presence to the person who is suffering but we must not impose our presence. And we must do this with humility, that is to say following the example of the sandals of the wise man. Humility is based upon awareness of one's own limits in our attempt to place the sick person at the centre of our attention and in the belief that contact with him can teach us many things and important truths. A healthy realism will help those who accompany suffering people not to see themselves as being indispensable, to recognise that their task is not to solve the problems of those they are speaking to but to become their companions on a voyage, to comfort them as they hope, and to be the bearers of relief and comfort during their moments of pain.

3. Listening
   'O Lord, thou wilt hear the desire of the weak; thou wilt strengthen their heart' (Ps 10:17).
   'Be quick to hear, and be deliberate in answering' (Sir 5:11).

A person finds relief when he has the opportunity to share what he has inside him. Allowing his deep concerns, his frustrated hopes, to come to the surface requires a deep breath on the part of the person who suffers. Comfort presupposes as regards those who seek to provide it a capacity to inspire trust in the disconsolate, to overcome their fear that they will not be listened to or understood.

To listen means to offer welcome to the experiences of the other, to give space to his individuality and his personal history. The art of listening is a difficult one: we are more inclined to judge the attitudes and the states of mind of others than to accept them and offer hospitality; we tend to minimise their worries and propose solutions that they cannot adopt, to be impatient towards them or to blame them.

To listen is not easy. It requires sensitivity, a capacity to enter into harmony with another person in order to read what the other says to us with his words and above all with his silences, his gestures and his look…To listen is an art. It has to be learnt and practiced.

Knowing how to listen requires us to put ourselves in the place of the person who is suffering, to receive his personal history, to perceive the impact that suffering has on each suffering person, to immerge oneself but without falling into the well of suffering, to keep the right distance which will allow us to follow but remain ourselves, and maintain our autonomy and clarity so that we can help.

Listening is cultivated through practice, through reflection and through trying to discover, every time with greater clarity, everything that fosters and everything that obstructs.

When I ask you to listen to me and you begin to give me advice, you are not doing what I asked you to do.

When I ask you to listen to me and you begin to tell me why I should not feel bad, you are not respecting my feelings.

When I ask you to listen to me and you think that you have to do something to deal with my problem, you are disappointing my hopes.

Listen to me! All that I ask you is to listen to men, not to talk to me or to be inconvenienced by me.

Listen to me, this alone do I ask of you.

It is easy to give advice. But I am not useless. Perhaps I feel discouraged and think that I have problems, but I am not useless.

When you do for me what I can do myself and I must do myself, you are only encouraging my fears and my insecurity.

You must simply accept that what I feel belongs to me and only to me, however irrational it may be. So I must not make you understand anything else and I must begin to discover what is inside me. Certainly it is for this reason that prayer works: God is always there and is listening.

4. Welcoming with laments and tears

'Cast your burden on the Lord, and he will sustain you' (Ps 55:22).

'Cast onto him every care, because he is looking over you'(1Pt 5:7).

Tears have a thousand meanings. There are tears which conceal emotion, joy, and tenderness, but there are also tears of anger, of lament, of desperation, of bitterness, or of repentance and of sadness. We should receive them in silence, respect them, and try to discover what they express.

Cardinal Pironio said: 'Now the Lord irrupts in my cross. I weep like a child, which does not cause me shame, but specifically because of this there grows within me the experience of the Father's love and the motherly nearness of Our Lady. I feel the need to cry out to the world, above all to young people, that God is the Father, even though he shakes me with His love: if the ear of corn does not fall…How much would I like to write about the cross and the Father's love for the young! I can see very clearly that the only way for me to redeem (and to redeem myself) is to become a participant in the sufferings of the Lord, completing his passion in his Body, the Church. 'For this reason I rejoice'. Even though in human terms it costs me to accept this and I weep in silence, I understand more those who suffer and weep, and I want to venerate them'.

5. Understanding

'The Lord… fashions the hearts of them all, and observes all their deeds' (Ps 32:13,15).

We cannot comfort anyone if we do not understand their desolation, if we do not place ourselves at their feet, if we do look together for them for what is really a source of a comfort for those who suffer. Listening constitutes the key with which we can open the door to understanding suffering: their afflictions, their expectations and hopes, their feelings, what they lack but also their resources. Understanding gives us the ability to see life with the eyes of a person who is disconsolate. The understanding of a person who is suffering is a therapeutic means that alleviates the burden of a wounded heart. Vice versa, incomprehension constitutes a further pain for the person who is suffering.

Brother Roger writers: 'The most beautiful thing of my life is to discover through a conversation a person in his wholeness, marked at the same time by an internal drama or a fracture and by irreplaceable gifts by which the life and force of God can provide the ability to work miracles in the same person.

It is essential to try to understand the situation of a person beginning with a few words or stances rather than with long explanations. It is not enough to share what makes him suffer in his innermost self. We must also look for the specific gift that God has given him and which will be the column of his existence. At the moment at which this gift or these gifts are revealed, the paths open up before one.

We should not dwell a great deal upon his problems, his failures and those contradictory forces that lead nowhere. We must first pass as soon as possible to the essential stage – discover his unique gift, the talents that are entrusted to each human being, so that they do not remain hidden and bear fruit in God'.

6. Respecting the other, his feelings, his rhythms and his decisions

'a bruised reed he will not break, and a dimly burning wick he will not quench' (Is 42:3).

'be patient with them all… Do not quench the Spirit… test everything; hold fast what is good' (1 Thes 5:14,19,21).

Respect for every person that we meet is an approach that we must cultivate: this is the capacity to consider every human being as a person created in the image and likeness of God, endowed with dignity, uniqueness, and unrepeatable originality. As the poet declared: 'nobody, yesterday or today, will go down the same path as me. For every man the sun has a new ray, and God will reserve to him a pathway unknown to others'.

To comfort means to help and not to rebuke, to forgive and not to accuse, to animate and not to reproach, to care and not to criticise, to help someone to get up and not to fall down. To comfort means simply to put oneself at the side of an afflicted person with all the respect of the world and say to him that you care for him, but this should be said in the only consoling way: with love, with respect and with disinterested devotion.

The feelings of the other person should be seen as sacred, worthy of respect, a limit to his way of behaving, and even when they impede consolation, they should not be forced. Instead, one must try to overcome them, breaking down their defences, freeing the fears that support them, nourishing new hopes.

Every person has a psychology, a culture, a history and unique moments of life. For this reason, each situation requires its own rhythm. We must try to adapt ourselves to each disconsolate person in order to help him in a concrete way and with what he needs.

'What a relief is produced',

writes Emma, 'to feel that someone takes upon their own shoulders your situation and does not try to offer you consolation on the cheap or try to draw away from the truth of reality, however hard it may be, or to hide your true feelings. This is the moment to recognise and thank the 'angels' who along your pathway allow you, have allowed us, to rise up, to feed ourselves with the bread of solidarity, of nearness, of free giving, of struggle, so as to go on walking'.

7. *Speaking to the heart*
'so that I may know how to sustain with a word he who is weary' (Is 50:4).
'Anxiety in a man's heart weighs him down, but a good word makes him glad' (Prov 12:25).
'The light of the eyes rejoices the heart, and good news refreshes the bones' (Prov 15:30).

A word that rises from the heart and speaks to the heart of he who suffers has a great power: it comforts, it consoles, it animates, it guides and it directs, it gives life and hope. It is a word that is kept, which one gives thanks for and which one never forgets: 'I have laid up thy word in my heart….I will not forget thy word…Thy word makes me live…How sweet are thy words to my taste, sweeter than honey to my mouth…Thy word is a lamp to my feet, and a light to my path' (Ps 119).

The same does not apply to empty words that are said more to alleviate one's own cares than those of people immersed in their own pain. Not only do they not comfort but they actually cause damage to he who listens to them: 'I have heard many such things; miserable comforters are you all. Shall windy words have an end?...I also could speak as you do, if you were in my place…How long will you torment me, and break me in pieces with words? (Jb 16, 1-6;19:2).

'Faced with pain he and I discuss matters; the others remain outside; for this reason words are too much, everything sounds hollow, distant… *It is easy to say fine words, to give all kinds of consolations and explanations when nothing harms you and you are 'absorbed' by suffering*. It is easy to speak about a harsh reality and try to find solutions from without. But if it is in you and you experience powerlessness, your powerlessness and that of others, your need profound silence to receive. Silence is the word that reveals his Presence to you, because all of his being generates silence. You need that silence to 'bear' things in peace. God, too, becomes silence in these moments, He is your peace. Pain becomes prayer and the whole of your body seems to breath a name – Jesus. This is your constant prayer'.[16]

8. *Being at the side of a suffering person, accompanying him along his pathway, helping him to find meaning in what is happening to him*.
'Jesus himself drew near and walked with them' (Lk 24:15).

One can look with serenity and inner peace at people who are looking for comfort only through solidarity, company, love, friendship and service to others. We can take on ourselves these situations and accept them when we do not feel alone, when we feel the presence of other people.

The search for meaning keeps man on the pathway that leads to authentically human health. To accompany a suffering person on their journey to finding a meaning to pain is one of the ways of helping that person find consolation.

'Jesus did not come to explain suffering or to justify its existence. He revealed something else to us: that all suffering, all wounds, can become offerings and be transformed into a source of life and thus be fecund. In human terms it is not understandable or possible, only through the grace of the Holy Spirit can we, if not understand suffering (and we will never understand it), at least lean to offer it and to perceive in this very humble gift a mystery of love and communion'.[17]

'Pain', writes Cecilia Puertas, 'cannot be understood. God does not answer, it has to be accepted. This non-understanding and the apparent absence of God because of His silence leads us to rebel, to protest, to reject pain, to close ourselves up within ourselves or to receive it as an inevitable reality which is here and from which we cannot escape. You fall between two stools: despair or acceptance that leads you to surrender.

God explains nothing, pain is here, He does not remove it, He gives it a meaning because He fills it with His presence. Often the cry goes up: 'Father, if it is possible distance this chalice from me'. And here, in this cry, you feel a hand that supports you, and which is here even though you do not see it. At other times the answer seems to be non-meaning because His silence is a burden. Everything is dark, overwhelming. God does not reply, pain has to be received, one as to live at the feet of the cross. From here, looking at the Crucified Christ enables you to discover the crucified God who is in you, helping you to experience pain rather than allowing it to suffocate you. The Cross will save you and not through pain but with the limitless Love of God that you feel being born inside you.

In pain I can continue to love god, not a God who sends me pain and suffering but a God who becomes pain and who suffers with me to dress it in festive clothes: the feast of Love, because He is here, next to me, in me, to help me to suffer with joy.

I have found no pleasure in pain and I do not like it. I accept it because it is here. I look at the Crucified Christ and from here the cross becomes a pathway that leads me to the fullness of life because he is here with me. In him I find the peace and serenity to suffer with Joy. He is my hope because I do experience pain alone but in communion with him. I do not love pain, I love life, I love happiness. But on this journey I have encountered pain and I accept it as a dark and painful part of my life. This does not weaken happiness because happiness comes from God'.

'I believe', Cecila Puertas

goes on, 'that the key by which to experience pain with joy – or so I have heard – is faith. Our God is not a God of the dead but a God of the living. He wants Life, the happiness of man. Pain does not make man happy and for this reason pain cannot have the last word, and I feel that inside me it does not have the last word. There is something deeper, or to put it better, something that is in you that receives this pain making itself pain with you in order to sprout life amidst an 'apparent death' as well. For this reason I venture to speak about pain experienced in the light of faith as a MYSTERY OF LOVE'.[18]

9. *Encouraging healthy attitudes and forms of behaviour in the situation experienced by the person who suffers*
'When Jesus saw him and knew that he had been lying there a long time, he said to him, "Do you want to be healed?... "Rise up, take up your pallet and walk"' (Jn 5:6,8).

A person faced with desolation and cares can adopt attitudes and forms of behaviour that are positive and fertile or negative and sterile. Some will allow him to face up to and experience pain in a constructive way; others, in contrary fashion, will make his pain more unbearable and destructive. Spiritual accompanying must help the suffering person to discern his own attitudes and forms of behaviour and to cultivate those that are positive.

'During the course of an illness', says Jesús Burgaleta, 'I tried to maintain an approach of life even during the most difficult moments. Illness was a stage in my life that deserved to be lived through with intensity, with profundity, in a radical way, and with a certain enthusiasm and happiness…Who could have assured me that it would not have been the last stage of my life? And how could it not have been lived unto the end?'

'I suppose', declared the writer Javier Tusell to the newspaper *El País*, 'that one can reach conformity with pure rationally but in my case with religious faith as well. For some perhaps to believe means to find consolation in the continuation and the promise of a reward when faced with suffering. I see it more as conformity, both in relation to the future and in a personal assessment of the past. It is born from seeing God as the Father and yourself as an apostle who was able to fail and who turns to Jesus with a phrase that denotes at one and the same time submission and a recognition of this fallibility: 'My Lord and my God'.

10. *Sharing out personal witness and the witness of other people who have experienced or are experiencing the same situation*
'Then they told what had happened on the road, and how he was known to them in the breaking of the bread' (Lk 24:35).

For a person who is going through a difficult time, it is more comforting to hear someone who says to him, 'it happened to me but thank to God I emerged victorious', than to listen to a person who is referring to something that they have not experienced.

'I learnt', wrote Marisol, 'to be with sick people without being able to treat them. To enjoy the presence of children without having them with me. To love the poor without being able to serve them. I learnt 'to hope' because when you depend on so many people you experience the reality of a poverty that places you last, but pain is a real mystery that we cannot feel when we arrive; you have to receive it and experience it.

I live without time because life for me is not to be busy but TO LIVE simply, smelling everything, tasting everything, waiting for everything, dreaming of everything, thinking about everything…so as not to fall into the sadness of my pain or pessimism about my future, a future that perhaps I will not have, or getting depressed about the limitations of the present, which certainly exist… even though they are increasingly less… my life is him, he is my health and my peace. He is my joy, my patience, my consolation and my strength. He is my love. The love that has enabled me to love all men, making them brothers in a Church that I love passionately. A love that I would not change for any treasure here on earth. I dream of the day when he will allow me to walk with my feet and breathe independently, the day when I will have recovered my health and can place my life at the service of other people; in the meanwhile… I live simply and I love'.

'I believe', declared Cardinal Pironio, 'that only a few days remain to me. I had dreamed, despite my illness, that after reaching this age I would have had time to read, to write, to withdraw from the world to pray, to listen to people. However, the Lord has disposed otherwise. I can no longer see, I can no longer walk, I can do nothing. The end is drawing near. I suffer a great deal, I suffer great pain, but I do not want other people to realise this in case they will suffer in their turn. I await, alone, eternal life, which will come in a few days' time. Despite my physical suffering, I am serene and tranquil. I am going to the house of the Lord'.

11. *Praying*

'pray for one another, that you may be healed (Jm 5:16).

To pray means to enter a deep inner solidarity with our fellow men so that in them and through them we are touched by the curative power of the Spirit of God. In prayer of compassion we place suffering people, and not only 'those far away' but those here and now, in our innermost selves, in front of the eyes of God.

My prayer, Lord, is this:

Give me the strength to bear my joys and my displeasures easily.

Give me the strength so that my love produces useful fruit.

Give me the strength not to deny anything to the poor

And not to bend my knee in front of the power of the insolent.

Give me the strength to raise my thought beyond low daily routine.

Lastly, give me the strength to ensure that my strength is in line with your will.(R. Tagore)

12. *Preparing for the encounter with God and withdrawing beforehand so a sto favour the encounter*

Behold I stand at the door and knock; if any one hears my voice and opens the door, I will come in to him and eat with him, and he with me' (Ap 3:20).

We ourselves have the task of preparing a pathway so that the suffering meet the God of life, the compassionate and merciful God, the God who has already come to the meeting with them and is waiting for them. For this reason, we must enter into harmony with their lives and with the Spirit that is already present and active in their hearts and in our hearts. Let us listen to the following words which after a certain fashion reflect what is addressed to us through yearnings and questions and which, at times, without them knowing this, are searching for the God of life:

Do not deceive me.
Do not speak to me so much about God.
I do not understand God.
Do not seek to close up
My life in certain rules.
I want to live.
Show me a God like that.
I want to be happy.
Show me a God like that.
I want to be me.
Show me a God
With whom I can breathe.
Tell me what you know about God
Through your lives.
Tell me what you experience of God
With your lives.
Tell me what you love about God
Through your lives.
Don't tell me about faith by forcing me to accept it.
Do not judge me if I follow other paths.
Do not see me as a danger
If I times a make a mistake.
Respect my slow, in decisive, processes.
Learn my languages.
Appreciate my life in its searching.
Don't close the door on me, I may return
Do not close up the spring to me, I may be thirsty.
Do not sadden your lives because of my absences.
I know that in discovering myself, I discover you.
I know that something is missing in your building if I am not there.
I know that my presence will make you happy.
But…
Why don't we begin al lover again?
Without words
Going further than facts.
Perhaps respecting each other,
We can discover the God who respects us.
If things will be like that, I will sign up to this adventure.
Living life.
As you did, Father, the friend of life.
Living life in the morning,
At mid-day, at night.
Giving life for others
Without the woodworms consuming it, preserved in a trunk.
Giving life smiling, speaking,
Doing something for other people, in sharing.
Giving life as you did, Jesus.
Encouraging, infusing hope.
Giving a hand in communion.
Giving forgiveness and gifts.
Giving life as you did, Spirit,
Who gives life without end.
Giving flowers, details.
Living opportunities.
Laying the foundation for a new humanity.
Giving love.
Giving without getting tired,
As the sun does with his light,
And a spring does with its water.
But will the spring dry up?
No, because it gurgles day and night.
No, because this spring is God Himself,
The spring of every life.
Giving life![19]

Let us now pray all together this beautiful prayer by Cardinal Martini 'Comforting our Brothers'.[20]

Jesus, you know that the first thing that we need
Is strength, relief, spirit and consolation.

Allow us to be comforted by you
So that we can in our turn comfort and console others.

You who patiently listened to,
Cured, revived and warmed
The hearts of the two disciples of Emmaus,
Teach us to contemplate you from far off,
In prayer and worship,
So as to make us participants
In your ministry as the good shepherd.

Give us, Mary, comfort in the afflictions
That we encounter on our journey
And which we often cannot solve with human words.

Teach us to comfort the very many physical woes of people
That constantly arrive
And above all else, the bitterness and secret inner afflictions
That have made difficult
The pathways of so many men and so many women,

Of so many young people
and teenagers.
Perhaps these sufferings are
not expressed
And await from us
A word, a gesture
That is a signal of the
consoling action of the Holy
Spirit.
Lord, through the
intercession of Mary
Open our hearts
To the merciful action of the
Spirit
To the beneficial power of
Holy Scripture,
of the Gospel
and to the comforting rest of
the words
and the gestures of the
Church!
Amen.

Let us finish with the final chorus of the Messiah: 'Amen' (n. 52).

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Bibliography

AUGRIN C., 'Consolación', in X. Léon Dufour, *Vocabulario de teología bíblica* (Herder, Barcelona, 1965).

BERMEJO J.C., *Relación de ayuda en el misterio del dolor* (San Pablo, Madrid, 1996); *La escucha que sana* (San Pablo, Madrid, 2002).

CABARRÚS C.R., *Cuaderno de Bitácora, para acompañar caminantes. Guía psico-histórico-espiritual* (Desclé de Brouwer, Bilbao, 2000).

CASAUS Mª E., *Misericordia y consolación. Nuestro carisma, desde Dios a la vida* (Hermanas de Nuestra Señora de la Consolación, 1999).

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

DALMAU B., *Consolad, consolad a mi pueblo* (Hermanas de Nuestra Señora de la Consolación, 2001).

FRAKL V., *El hombre doliente* (Herder, Barcelona, 1987); *El hombre en busca de sentido* (Herder, Barcelona, 1988).

KUSHNER H.S., *Cuando a la gente buena le pasan cosas malas* (Los Libros del Comienzo, Madrid, 2000).

MARTÍNEZ LASANTA Mª C., *Consolar* (Montecarmelo, Burgos, 2002).

MCNEIL, MORRISON AND NOUWEN, *Compasión. Reflexión sobre la vida cristiana* (Sal Terrae, Santander, 1982).

MELENDO, M., *La escucha* (Desclée de Brouwer, Bilbao, 2001).

MONGE M.A. AND LEÓN J.L., *El sentido del sufrimiento* (Edic. Palabra, Madrid, 1998).

GONZÁLEZ NÚÑEZ A, *Antes que el cántaro se rompa* (San Pablo, Madrid, 1993).

PANGRAZZI A. (ed.), *El mosaico de la misericordia* (Sal Terrae, Santander, 1990); *¡A Ti grito, Señor! Oraciones desde el sufrimiento* (Sal Terrae, 1988); *Girasoles junto a los sauces. En diálogo con los enfermos* (Sal Terrae, 2000).

PRONZATO A., *Tras las huellas del Samaritano. Peregrinación al santuario del hombre, Sal Terrae* (Santander, 2003).

Labor Hospitalaria, n. 235 (1995) 'El sufrimiento en la enfermedad: claves para vivirlo sanamente'.

Sal Terrae, Revista de Teología Pastoral, 'El sufrimiento humano. ¿Es posible la gracia en la desgracia?', Feb. 1992; 'Consolad, consolad a mi pueblo', March 1998.

Teología y catequesis n. 28 (1989), 'Vivir la fe desde el dolor'.

Notes

[1] Cf. STEFAN ZWEIG, *Momentos estelares de la humanidad, El Acantilado el nacimiento de "El Mesías" de Händel en 1741.*

[2] GABRIELA MISTRAL, 'Al Cristo del Calvario'.

[3] *Lumen gentium,* n. 8

[4] *Gaudium et Spes,* n. 1

[5] *Apostolicam actuositatem,* n. 8

[6] JOHN PAUL II, *Ecclesia in Europa,* n. 29.

[7] BENEDICT XVI, *Deus Caritas est,* n. 28.

[8] *Lumen gentium,* n. 68.

[9] Cf. DALMAU B., *Consolad, consolad a mi pueblo* (Hermanas de Nuestra Señora de la Consolación, 2001), p. 78.

[10] Ibid. p. 79.

[11] MADRE TERESA DE CALCUTA and HERMANO ROGER DE TAIZÉ, *La oración. Frescor de una fuente* (PPC, Madrid, 1997), p. 87.

[12] FERNÁNDEZ MORATIEL J., *La escuela del silencio.*

[13] Cf. GONZÁLEZ BUELTA B.GRACIAS, *En el aliento de Dios. Salmos de gratuidad* (Sal Terrae, Santander, 1995), p. 169.

[14] Cf. ULIBARRI F., *Al hilo del Espíritu. Plegarias para nuestro tiempo* (Ed. Verbo Divino, Estella, 2004), pp. 404-405 (freely translated into English).

[15] Cf. NEIL, MORRISON AND NOUWEN, *Compasión. Reflexión sobre la vida cristiana* (Sal Terrae, Santander, 1995), pp. 27-28 (freely translated into English).

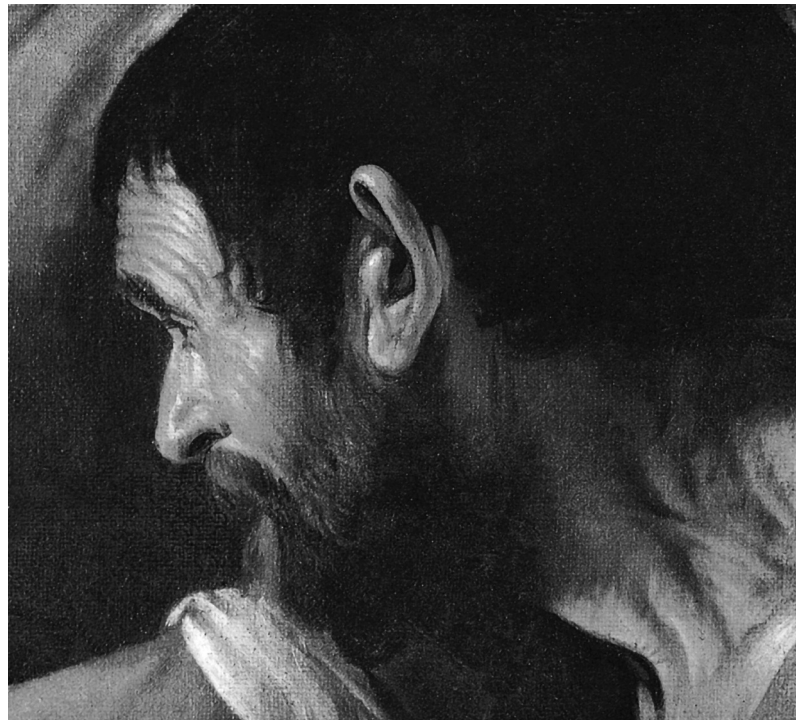
[16] Cf. PUERTAS CECILIA, 'El dolor a la luz de la fe, un misterio de amor', in *Teología y Catequesis* n. 28 (1989), p. 126

[17] Cf. VANIER JEAN, *La fuente de las lágrimas* (Sal Terrae, Santander, 2004), p. 127.

[18] Cf. CECILIA PUERTAS, *op. cit,* p. 124.

[19] Cf. Centro de Iniciativas de pastoral de Espiritualidad (CIPE)

[20] MARTINI C.M., *Al alba buscaré* (Verbo Divino, Estella, 1995).



The Role and Importance of Pastoral Care for Disabled People in the Ministry of the Church

PAPER GIVEN BY H.E. MSGR. J.L. REDRADO ON THE OCCASION OF THE PILGRIMAGE OF THE 'HOSPITALITAT DE LA MARE DE DEU DE LOURDES DELS BISTATS DE BARCELONA, TERRASSA I SAINT FELIU' ON THE 150TH. ANNIVERSARY OF THE APPARITIONS OF OUR LADY, 26 SEPTEMBER 2008

Introduction

The Experience of Malady and Suffering: the Inadequacy of the Human Analysis

It has never been easy to speak about disability or handicap – one is always dealing with situations of profound physical, psychological or spiritual suffering, of malaise due to compromised personal autonomy. In simple words, we are all in some way emotionally involved. Thus our analysis of the subject becomes a personal testimony and to such an extent that the emotional and subjective aspects prevail over an objective analysis of the phenomenon and its implications.[1] In addition, our words do not always manage to well express our feelings and the realities that underlie them because our experience encounters difficulty in being easily expressed in human words. Thus with the complicity of contemporary culture which conceals and marginalises pain and suffering, relegating them to the private, there is the temptation to remove everything or keep everything inside one.[2] The greatest difficulties, however, are experienced when an attempt is made to give meaning to one's own suffering and to the suffering of other people. The paths diverge incredibly despite the universality of suffering and malady in the human experience.

Nowadays, fortunately, disability is no longer a taboo, something to be hidden away, of which to be ashamed or not talked about, if not in whispers with veiled words and to those who are closest to one. Even public institutions, national and international organisations, as well as various associations, debate the subject profusely, calling for resources and seeking effective ways by which to address disability and alleviate the difficulties of people disabilities and their family relatives. In this sense, state and semi-state bodies, as well as international organisations and agencies, draw up laws, protocols and agreements that defend the right of people with disabilities to suitable forms of care and the highest form of participation in the life of the societies in which they live.[3] This interest and commitment require an effort that is choral and supported by everybody.

The subject of the role and importance of pastoral care for disabled people in the ministry of the Church is very broad and complex. It therefore requires greater space than is available in this circumstance, but also, certainly, a thick series of abilities. Despite this, the subject will be addressed in a summarising fashion, following three axes of reflection. First of all there will be a rapid reference to its relationship to the broader reflection on malady, pain and suffering in ancient cultures and the great religions of the East. There will then follow a rapid presentation of the vision of this subject in Jewish and Christian revelation. Subsequently, a discussion will be offered on the concrete and practical response of the Christian community to suffering and pain during the course of history, before presenting a brief reflection on the approach and the contemporary relevance of the activities of the Church on behalf of sick people and the suffering in its evangelising mission.

1. The Ancient Cultures and Religions: the Origins and Meaning of Malady and Suffering[4]

The analysis of disability that is experienced every day is connected with the broader analysis of the origins and meaning of malady and suffering in the world. The further back one pushes research the more one discovers that suffering, pain, illness and death have always and strongly aggravated the human condition of worry and uncertainty.[5]

Thus in the oldest cultures and religions we find an immense but constant attempt to explain and exorcise both pain and death through a search for their meaning and origins. The results vary according to the conception that is had of the world and man and they are often incomplete and contradictory.

In the infinity of stances adopted by ancient cultures and religions, *four summarising principal approaches* to explain the condition of malady and suffering that besieges man stand out.

First of all, there is the traditional approach according to which the universe and man are substantially good and thus suffering is an intruder that prejudices this goodness. It originated in a sin that was committed or in a malevolence of which the forces opposed to man were the perpetrators. In this context God is invoked as a liberator and a support. *Secondly*, we encounter the position of the three

great religions of the East which sustains, amongst other things, the line of thought which envisages the extinction of suffering. For *Hinduism*, suffering is structural in relation to the future of the cosmos because it is the consequence of the fall of man from divine eternity to the temporality of creatures, whereas for *Buddhism* the being of man is painful because it is changing because of its substantial inconsistency. His liberation passes by way of a laborious process of purification involving different levels whose summit is the ending of every desire and the achievement of tranquillity. *The third approach* is the dualist approach which affirms two principles, both of which are original and antithetical: good and evil, spirit and matter, light and shadows… coexistent in the fallen word but destined to be separated at the end thanks to the redemptive intervention but also to ascetic and penitential practice. Lastly, there is *the fourth approach*, which is typically philosophical, which is that of divine apathy, according to which the principal characteristics of God are immutability and apathy as the absence in Him of every form of suffering (Aristotle). For Plato and Plautus the divine One is beyond the multiple and the future. Plato argued that 'one should search for the causes of bad things in other causes and not in God'. And the suffering of men in the world? It is seen as the path of wisdom and liberation to the point of reaching apathetic indifference.[6]

2. Jewish Revelation: the Origins and Meaning of Malady and Suffering

Against this cultural background was grafted Jewish thought and tradition in relation to malady and suffering with, however, and despite the fact that the Old Testament offers no systematic answer, 'a richness and a originality that are completely singular'.[7] The central element is the intervention of God on behalf of man in the history of salvation sealed by the Sinai covenant as a result of which 'suffering, too, is understood and experienced in the space of this personal and salvific relationship with God'.[8]

The origin of suffering in the Old Testament is given to us by the sapiential reflection on human existence in the context of the vast horizon of the Covenant with Jehovah. According to the accounts of the Book of Genesis, this is 'sin, that is to say the free choice of man who opposes God and upsets the correctness of his relationship with his fellows and with nature'.[9] Addressing the question of whether without sin there would not have been suffering, the answers vary. In the Book of Wisdom 1:13-14 and 11:26 the answer is in the affirmative whereas in general realism is established in the face of the human condition confronted with the limit point, tiredness and pain.

In relation to the meaning of suffering, as well, there is a plurality of answers in the Bible which, however, converge on a central point: the relationship between God and man. There are four principal arguments. The first presents the *punitive and pedagogic character of suffering*. This approach is not to be found in the Book of Genesis where suffering is presented as a punishment for the sin committed by man and of which mankind, in an overall sense, is the heir (Gen 3:16-19). With respect to the condition of an individual, this approach takes concrete form in the *theory of reward*: the righteous are happy and the wicked are unfortunate (cf. the position of the friends of Job – Job 32-37).

Since this thesis is not corroborated by personal experience, a *second idea* thus become affirmed – that of the *liberation-compassion* emphasised by the Book of Exodus (Ex 22:20-24). God intervenes freely, without asking for anything, as the redeemer of His people and because of faithfulness to His name, to the choice of Israel as His people and His alliance with that people:[10] God is the Merciful One.

The intertwining of these last two approaches helps in the furthering of the analysis of suffering, above all when it strikes the innocent. We have meditation on the *silence of God* when faced with unjustified suffering (Jeremiah, 11:18-12,6;20:1-2) or lamentations, (Job 20,14-17). The response of God, which is always to hand, is His nearness which never goes away even amidst the torment of pain. Thus 'suffering, beyond its near or remote origins, has meaning to the extent to which through it man continues to live as a son of God, having full trust in Him, with patient perseverance'.[11]

The fourth approach in the search for the meaning of suffering in the Old Testament is where the ultimate answer is configured, no longer the work of man but of God himself. This is suffering as *atonement or an instrument of redemption*. This takes concrete form in the figure of the Servant of God of the poems of Deutero-Isaiah. The victim does not suffer because of his own faults but because of the faults of other people. Thus, albeit with its harsh reality, suffering become an 'instrument of salvation'.[12]

In this perspective, suffering is not willed by God for its own sake but, rather, it is inherent in the human condition which itself is disturbed by sin. However, experienced in obedience to God it becomes an instrument of redemption through atonement for sins. The exploration of this approach leads to the concept of life after death (2 Mac 7:9).

3. Christian Revelation: the Kingdom of God as Liberating Compassion and the Paschal Event as a Work of Redemption[13]

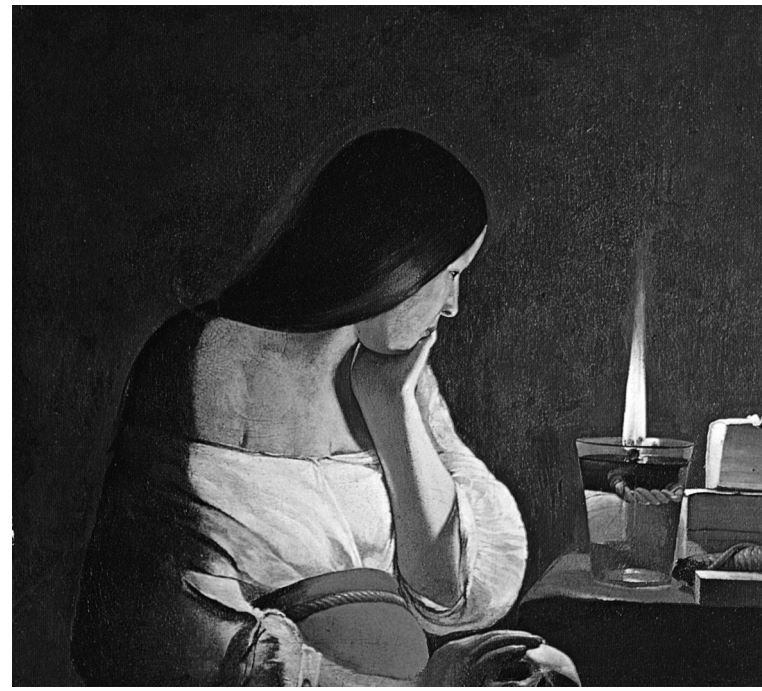
3.1 *The proclaiming/advent of the Kingdom as compassion and liberation*

The earthly ministry of Jesus in its dual character of proclamation of the Good News and concrete action manifests itself as the effective realisation of the advent of the promised Kingdom of God among men, and is characterised by the messianic and filial authority that emerges from his person. Indeed, 'Jesus presents himself as the perceptible face of the merciful compassion of God for His children and in a particular way for the poor and the marginalised, those who are afflicted by all kinds of suffering, and sinners. At a personal level suffering is not linked to sin. Jesus, rather, came to forgive sins, opening a new space of life with the Father and amongst a person's brethren and… to free man from the various forms of physical, mental and spiritual suffering'.[14] The fifteen or so miracles of healing which condiment the earthly activity of Jesus irradiate his relationship of compassion and trust with the crowds of suffering people of every hue and colour. Hence the dual meaning of Jesus' approach: on the one hand in this is manifested the will of God and His plan of the liberation of man from his situations of suffering whatever their origins may be, whether personal sin or sin of the world; on the other, there is the fact that such liberation, although its completion is promised in the world to come, is at work from that point onwards in history thanks to his followers. It should be observed, in addition, how much Jesus' consciousness of himself is characterised by a sense of obedience to the design of the Father as the necessary path to the realisation of redemption in the approach of the servant of God of the Poems of the suffering Servant of Deutero-Isaiah (Is 42,1-7; 49,1-9; 50,4-9; 52,13-53,12).

3.2 *The paschal event and the taking on of suffering as a means of redemption*

One should distinguish between two dimensions in our understanding of the meaning of the passion, death and resurrection of Jesus, without ever separating them. Namely, the experience undergone by him with the meaning he gave to it and the interpretative reading of it by the apostolic community.

In Jesus' consciousness, given the multiple explicit references of his preaching, his predictions and the last supper, his suffering and his death, are the signs of the offering up of his life for the salvation of mankind.



As regards the post-paschal understanding of the death and resurrection of Jesus, of one thing there is no shadow of doubt: the 'crucified Christ' is the advent of salvation. This event became the key by which to understand the messianism of Deutero-Isaiah and above all of the teaching and the overall action of Jesus and of God himself. Not only does God reveal Himself to be the Father of mercy, but also, through his incarnated Son, he dons the human condition by taking on all of its implications and the consequences of the sinful action of mankind in order to redeem mankind.

The novelty of the New Testament as regards the existence of malady and suffering is that God Himself takes on human suffering through His son, efficaciously revealing its redemptive and expiatory meaning in the light of love.

3.3. *Theological reception*

How has our subject been received and developed during the course of the two-millennia old history of the Church? The Patristic and Scholastic traditions addressed it by following the directives deduced both from the Old and the New Testaments as well as from Greek thought, without, however, achieving a synthesis that does justice to Christological originality.

Traditional doctrine excludes any involvement of God in the suffering of the world, seeing its cause in the sin of man. For this reason, Jesus Christ, through his human nature, suffered in atonement for the sins of humanity and taught us to bear all kinds of trials and pain in order to expiate, through him, our sins and the sins of other people.[15]

Pushed to its extreme developments, this position reached its culminating point, but also its definitive crisis, with the theodicy of Leibnitz who believed that God created 'the

best of possible worlds' and thus that suffering is a necessary evil with a view to a greater and more definitive good.

Being unsatisfactory, this solution provoked derision and criticism to such a point that protesting atheism entered the picture with vehemence, arguing that malady and suffering are the demonstrable proof of the non-existence of God. Thus one returned to the point of departure.

In reaction against this rather regressive position, contemporary thought, whether theological or philosophical, has been trying to rediscover the central role of the Crucified Christ despite a widespread and disenchanted intolerance or, at the opposite extreme, the impelling appeal to ancient and certainly inadequate interpretative forms.[16] In addition to this, the question of the suffering of the innocent, which as such can be defined as being 'useless', remains intact in the consciousness of contemporary man. Can one still talk about God after Auschwitz? This was the question that Elie Wiesel posed. Any solution that is not very attentive to such questions or situations of poverty, injustice and suffering, which have been defined by the theologians of liberation as 'the other side of history', and which involve a great part of the population of the planet, will be irremediably impracticable.

Recently, theological thought and the thought of the Magisterium of the Church, directed towards a hermeneutic horizon of Revelation, has addressed the question of the relationship between God and suffering from a deeper and more renewed perspective.[17]

Suffering should be understood in the light of the Christological event and its paschal culminating point of the death and resurrection of Christ and the effusion of the Holy Spirit. This means that as suffering forms a part of the inheritance of man (as structural to his limited and historical condition that is disturbed by the reality of sin) God does not withdraw from it but takes it on in His Son Jesus Christ in order to convert it through the action of the Holy spirit into an instrument for human growth and salvation. Thus with a gaze directed towards Jesus Christ who was crucified and abandoned, suffering, although it has in itself a negative value, albeit one that can become pedagogic, expiatory, and involving the completion of man in his relationship with God, becomes more profoundly a 'sacrament of the encounter with God' because God made suffering His.

Reflection on the nature, the origins and the meaning of suffering and its relationship to God still has many days ahead of it. Multiple and pertinent problems remain open, such as, for example, the discussed and topical subject of the suffering of God or that of the relationship between God and the suffering of those who do not believe or are not conscious of their own suffering. This means that the Church will always be stimulated in her thought and practice by this mysterious reality, suffering, which 'constitutes in itself almost a 'world' that exists together with man, that appears in him and passes, and at times does not pass, but which is consolidated and explored in him'[18]

4. Historical References to the Evolution of the Church Structures of Assistance and Care for those Most in Need[19]

Reflection of the commandment of the Lord which makes love of God inseparable from love of neighbour led the early Christian communities to the fraternal sharing of possessions (Acts 4:34-5). Subsequently, with the growth and diversification of these communities, the organisation of hospitality and sharing became a necessity (Acts 6:1-6). At this stage initiatives in favour of the sick were sporadic but significant, rather like those of Jesus during his ministry (Acts 3:2-8; 14:8-10). Thus the activity of the Apostles was principally dominated by concern about preaching the Good News of the Paschal Mystery. It was above all beginning with the second century AD that the organisation of hospitality and assistance was structured in a permanent way, to meet new needs as well.

4.1 *The Church: from hospitality to hospitals*

The relationship between medicine, treatment and the sacred world are very old, as is borne out by the culture of Mesopotamia or Egypt where the theocratic-priestly element dominated. During the fifth and sixth centuries BC Greek culture, with Hippocrates first and then Aristotle, broke with the magical-religious approach in order to set medicine on the road of becoming an autonomous science.

In its action in the world of suffering, the Church was at one and the same time the heir of both these previous approaches. Its contribution, however, had its own originality which consisted in the charitable spirit which impregnated its work of care as well as the new assessment of human values in relation to the gospel message.

The first Church response that was structured to respond to the needs of gospel hospitality found practical expression in the deaconries that arose near to the oratories and churches of monasteries (I-III centuries AD). Deacons, in helping the bishops in the administration of the Church, had to deal with the sick, widows and foreigners. A little time afterwards, next to the deaconries there arose another autonomous structure, the xenodochium, which was initially intended for receiving, accommodating and looking after pilgrims travelling to St. James of Compostella, Jerusalem or Rome. Subsequently, travellers or traders staying for a time in town were also taken in. Until the ninth century this structure was seen, historically speaking, as an ecclesial structure equivalent to a modern hospital.

In 376 a large hospital was created in Caesarea in Cappadocia, the work of St. Basil. Fabiola and Pammacchius did the same in Rome. With the so-

licitude and encouragement of Pope Gregory the Great, numerous hospitals were built almost everywhere that the voice of the Church reached. The local ecclesiastical authority regulated their jurisdiction and organisation.

The move from feudalism to town authorities, which was a consequence of the decline in papal authority (the ninth to tenth centuries) gave rise to the well-known localism typical of the Medieval period, and, correspondingly, to a kind of hospital guild system with the name '*universitas*' under the leadership of a *magister*. The *universitas* was made up of sick people or healthy people called together in a brotherhood that was governed by religious rules. The development of cities and communes over the next two centuries led to the creation of the very large hospitals in place of the previous structures which were linked to the monastic churches or to the cathedrals. Whatever the case, in this turbulent context as well, the local ecclesiastical authority continued to watch over the supervision of organisations that provided health care.

Between the eleventh and the thirteenth centuries the first successes of the crusades against the Turks which had the goal of freeing the holy places gave rise to the birth of monastic orders for the defence of the conquered positions but also to take care of pilgrims during their journey through Palestine. One may cite here, for example, the Sovereign Military Order of Malta, the Teutonic Order, the Order of the Holy Spirit and the Hospitellers of St. Lazarus.

The beginning of the age of the Renaissance coincided with an extraordinary development in health-care structures.[20] It was in this context that an absolute novelty arose in health-care structures: the birth of hospital orders that were exclusively hospital orders. The most well-known are those of St. John of God or the Fatebenefratelli and of the Missionaries of the Infirm or Camillians, founded by St. Camillus de Lellis. Their expansion greatly improved the quality of medical and spiritual care, guaranteeing at the same time the continuity of the service that was provided.

The Renaissance period had generated numerous and profound social and political transformations which provoked negative consequences in the relationship between the State and the Catholic Church. After the sixteenth century, following the Protestant Reformation in England and Germany, responsibility for care passed into the hands of the municipalities.[21] In this way health care became the task of the state even though, despite the difficulties and through the Orders and new religious congregations, the presence of the Church in this sector would never disappear over subsequent centuries.

The twentieth century experienced a profound revolution in medicine thanks to various scientific discoveries: the practice of anaesthesia, antibiotics etc., but thanks also to an organisation of hospitals that was more suited to the development of research in medicine and surgery.

In this new context, although confirming the previous orientations of its physical and spiritual presence in health care, the Church sought to commit itself strongly to the promotion of human rights, in particular in relation to the protection of life from conception until its natural end.

4.2 *The Church and the world of health: an increasingly qualified presence*

The Catholic Church is present in a capillary way in the world of suffering through her own health-care structures or ones that it manages. In recent decades the Catholic Church has endowed itself, at a universal level as well, with bodies for reflection on, and the promotion, coordination and animation of, pastoral care in health. On 11 February 1985 Pope John Paul II, with his Motu Proprio 'Dolentium Hominum', established the Pontifical Commission for Pastoral Assistance to Health Care Workers. This Commission was changed with the reform of the Roman Curia (Apostolic Constitution 'Pastor Bonus', 28 June 1988) into a Pontifical Council. Its task is to express the concern and care of the Church for the sick by helping those people who engage in service for the sick and suffering so that the apostolate of mercy, which they await, responds in an increasingly better way to new needs.[22] It is within this framework that every year, side by side with various publications, a World Day of the Sick is organised as well as an international conference on a health-care subject of contemporary relevance. Cooperating with the local Churches, international Catholic organisations and other institutions, the Pontifical Council has to the task 'of making the doctrine of the Church on the spiritual and moral aspects of illness and the meaning of human pain known about'.[23] In order to address the difficult problems raised by bioethics, on 11 February 1994 the Pontifical Academy for Life was established. There are also associations of Catholic medical doctors, nurses or pharmacists, without mentioning the very large number of foundations and federations of groups of volunteers active in the world of health care who work in very difficult and varying situations.

The role of the Church in the field of health and illness is vast. The space available to me does not allow me to consider all its aspects. I will thus entrust to readers the data[24] on Catholic health care and care institutions for their own assessment, always, however, being aware that although these institutions are very important and indispensable none of them can take the place of the human heart 'when it is a question of dealing with the sufferings of another'.[25]

5. Living the Gospel or the Choice of the Last

Amongst the teachings of Jesus about the choice of the Kingdom, there is one that is rather disquieting but very significant for the subject of this paper: the choice of the last as a criterion by which the pres-

ence of the Kingdom of God in a disciple is recognised. We find this teaching in Christ's reflections on the choice of the guests (Lk 14:12-14) and the reaction of the king who experienced invitations of his to the wedding feast of his son being refused. On the choice of the people to invite Our Lord said: 'When you give a dinner or a banquet, do not invite your friends or your brothers or your kinsmen or rich neighbours, lest they also invite you in return, and you be repaid. But when you give a feast, invite the poor, the maimed, the lame, the blind, and you will be blessed, because they cannot repay you. You will be repaid at the resurrection of the just' (Lk 14:12-14). In the second episode, after noting the refusal of his invitations by people in great favour, the king said to his servant: 'Go out quickly to the streets and the lanes of the city, and bring in the poor and maimed and blind and lame… For I tell you, none of those men who were invited shall taste my banquet' (Lk 14:21.24). The passages quoted above provide the believer in Christ with criteria for choosing in his daily life, in line with the heart of God, and translate into the practical the supreme commandment of love of God and neighbour (Mt 22:37-40ff). With such criteria and following the example of the approach of Jesus towards the last, the Church has tried to translate into practice the other commandment of the Lord which intimately connects the proclaiming of the Kingdom of God present amongst men and care for those suffering in their bodies and souls: 'And preach as you go, saying, 'The kingdom of heaven is at hand.' Heal the sick, raise the dead, cast out demons. You received without pay, give without pay' (Mt 10: 7-8ff).

These references to the teaching of Jesus on witness to gospel love in the life of individual believers or in communities emphasise how much the dedication of the Church to receiving and caring for people who are sufferings in body and in spirit is an integral part of its mission[26] – that of being a sign and instrument of intimate union with God of the unity of the whole of mankind (*LG*, n. 1).[27]

In treating and caring for sick people and suffering people, the Church affirms and defends the primacy of life and the overall health of the suffering members of the Body of Christ who, to follow St. Paul, complete in their flesh what is lacking in the tribulations of their Teacher in favour of the Church (cf. Col1:24). The Church is profoundly certain of what Cardinal Deskur says. He does not hesitate to call a person with a disability who allows himself to be shaped by the Spirit of God an 'instrument of salvation for human society'.[28] Calling to mind the episode of the invitation of the risen Christ to St. Thomas to touch the signs left behind by the spear and the nails on his body, Cardinal Anthony J. Bevilacqua clarifies in what ways people with disabilities are the instrument of salvation: 'The body of Christ still bore the wounds of his passion. Once the signs of suffering, they had become the proof of his transformation in glory. Like Thomas, the world needs proof that the Church is truly the Body of Christ through the presence of our disabled brothers and sisters amongst us'.[29] The Servant of God John Paul II is on the same wave length, but with a different perspective: 'Following the parable of the Gospel, we could say that suffering, which is present under so many different forms in our human world, is also present in order *to unleash love in the human person,* that unselfish gift of one's 'I' on behalf of other people, especially those who suffer. The world of human suffering unceasingly calls for, so to speak, another world: the world of human love; and in a certain sense man owes to suffering that unselfish love which stirs in his heart and actions'.[30]

The Church is aware of the fact that it not only gives to people who are suffering or to handicapped people but also receives from them in abundance. However, it is necessary to know how to cultivate those purest flowers of faith and love which, according to the French writer François Mauriac, flower on the polluted earth of pain.[31] Cardinal Deskur writes on the subject as follows: 'Taking into account existing reality, I believe that it is of urgent importance for society to be aware of the fact that the isolation and loneliness that surround disabled people suffocate in them the gifts of the mind and the spirit which are received from on high. Experience shows that where the community enters into physical, moral or spiritual contact with those who encounter difficulty in communicating with the external world through the normal channels, disabled people become capable of generating high works of human inventiveness'.[32]

Awareness of all of this does not eliminate, unfortunately, the very many problems that disabled people encounter every day on their path. The barriers to be overcome remain innumerable and complex. These barriers are of various kinds: cultural (stigma, the cult of the beautiful and healthy body), physical (architectonic barriers), social (work, relational and recreational), religious (formative, pastoral) etc. In relation to this last, Cardinal Bevilacqua reports the following statement of a woman with a sight and hearing handicap who nonetheless managed to take part in her parish choir: 'We burningly want the Word and we want to hear it like everyone else. We disabled people have the right to the truth and to be members (sic) of the body of Christ with the equal privilege of sharing at his table'.[33] The author of this article would like to observe straightaway that disabled people have the right to full participation in the liturgical and sacramental life of the parish because of their baptism. This was a concept stressed by the Servant of God John Paul II in his address to those taking part in the seventh international conference organised by the Pontifical Council for Health Care Workers with the title 'Disabled People in Society' (19-21/11/1992): 'handicap, every form of handicap, never compromises the dignity of the person or his right to a better quality of existence… You are, in fact, members of the Body of Christ, the body of the Risen Christ! This is the true foundation of an indestructible dignity! A dignity that resists the setback of death'.[34] Hence the appeal of Cardinal Bevilacqua as regards our attitudes and behaviour towards disability so that this dignity is not compromised: 'it is necessary to be aware not only of the presence and the needs of disabled people but also and above all else of our attitudes and feelings towards them because these are those who are the first and tenacious barrier that we have to address'. Indeed, 'often for us it is easier to isolate and ignore those people whose experiences are face to face with the myth according to which we have control over our lives and our destiny'.[35] From the attitude towards a disabled person transpires after a certain fashion not only the level of faithfulness of each person to Christ and to his Gospel of salvation but also of his simple and genuine human sensitivity.

I would like to end this article with the prophetic words of the Holy Father Benedict XVI, who encourages everyone, both individuals and societies, through his invitation to each one of us to address the reality of the mystery of malady and suffering: 'the true measure of humanity is essentially determined in relationship to suffering and to the sufferer. This holds true both for the individual and for society. A society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through "com-passion" is a cruel and inhuman society'.[36]

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Select Bibliography

CARRIER HERVÉ, *Dizionario della cultura. Per una analisi culturale e l'inculturazione* (LEV, Vatican City, 1997).

CINA' GIUSEPPE, LOCCI EFISIO, ROCCHETTA CARLO, SANDRIN LUCIANO (ed.), *Dizionario di teologia pastorale sanitaria* (Ed. Camilliane, Turin 1997).

DUFOUR Xavier-Léon, (a cura di), *Dizionario di teologia biblica* (Marietti, Genoa, 1976[5]).

RUSSO GIOVANNI (ed.), *Enciclopedia di bioetica e di sessuologia* (LDC, Leumann (TO), 2004).

ROSSANO PIETRO, RAVASI GIANFRANCO, GIRLANDA ANTONIO (a cura di), *Nuovo Dizionario di teologia biblica* (San Paolo, Cinisello Balsamo (MI), 1988).

CONCILIO VATICANO II, 'Costituzione Pastorale sulla Chiesa nel mondo Contemporaneo', in *Enchiridion Vaticanum 1962-1965* (EDB, Bologna, 1993), pp. 1264-1466.

GIOVANNI PAOLO II, *Lettera Enciclica Redemptor Hominis* (4 March 1979), in *ASS*, 71 (1979), pp. 257-324.

GIOVANNI PAOLO II, Lettera Enciclica *Evangelium Vitae*, 25 March, Vatican City, 1995.

GIOVANNI PAOLO II, Lettera Apostolica *Salvifici Doloris*, Vatican City, 1984.

PONTIFICIO CONSIGLIO PER LA PASTORALE PER GLI OPERATORI SANITARI, *Carta degli operatori sanitari* (Vatican City 1995).

COMMISSIONE TEOLOGICA INTERNAZIONALE, 'Fede e inculturazione', in *Enchiridion Vaticanum,* vol. 11 (EDB, Bologna, 1990), pp. 846-895.

COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E DELLA SALUTE (CEI), '*Predicate il Vangelo e curate i malati.' La comunità cristiana e la pastorale della salute* (Nota pastorale) (EDB, Bologna, 2006), n. 11.

ASURMENDI JESÚS, *Job* (Éd. De l'Atelier/Éd. Ouvrières, Paris, 1999).

BOVON FRANÇOIS, *L'Évangile selon Saint Luc 9,51-14,35* (Labor et Fides, Geneva,1996).

CODA PIETRO, D*ieu et la souffrance*, Cours Études pour la mission, huitième leçon (UPM, 2004)

FAGGIONI MAURIZIO PIETRO, *La vita nelle nostre mani. Manuale di bioetica teologica* (Ed. Camilliane, Turin, 2004).

FILIPPI NELLA, *Le voci del popolo di Dio* (Edacalf, Rome, 2004).

FUKUYAMA Francis, *L'uomo oltre l'uomo. Le conseguenze della rivoluzione biotecnologia* (Mondadori, Milan, 2002).

GOURGUES Michel, *Le Parabole di Luca. Dalla sorgente alla foce* (LDC, Leumann (TO)).

JEREMIAS JOACHIM, *Le Parabole di Gesù* (Paidea, Brescia, 1973^2).

JONAS HANS, *Il principio responsabilità. Un'etica per la civiltà tecnologica,* (Einaudi, Turin, 2002).

JONAS HANS,*Tecnica, medicina ed etica. Prassi del principio responsabilità* (Einaudi, Turin, 1997).

HULTGREN ARLAND J., *Le parabole di Gesù* (Paidea, Brescia, 2004).

PANGRAZZI ARNALDO (ed.), *Salute, malattia e morte nelle grandi religioni* (Ed. Camilliane, Turin, 2002), pp. 101-144.

RAVASI GIANFRANCO, *Fino a quando Signore? Un itinerario nel mistero del dolore e della sofferenza* (San Paolo, Cinisello Balsamo (MI), 2002).

RIBUSTINI JEAN, *Les structures d'assistance de l'Église dans l'histoire*, Cours Études pour la mission, Cinquième leçon (UPM, 2004)

SANNA IGNAZIO, *Immagine di Dio e libertà umana. Per un'antropologia a misura d'uomo* (Città Nuova, Rome, 1990).

SIX JEAN-FRANÇOIS, *Les Béatitudes aujourd'hui* (Seuil, Paris, 1984).

SPINK KATHRYN, *Una vita di comunione. Jean Vanier e l'Arca* (Ed. San Paolo, Cinisello Balsamo (MI), 2007).

TANGORA GIOVANNI, POMPILI Domenico (ed.), *Il male e i suoi volti* (Ed. San Lorenzo, Reggio Emilia).

VARILLON FRANÇOIS, *La Pâques de Jésus. Une semaine de méditation d'Évangile* (Bayard Éditions, Paris, 1999).

VARILLON FRANÇOIS, *Joie de croire, joie de vivre* (Le Centurion, Paris, 1981).

ZAVOLI SERGIO, *Se Dio c'e'. Dialogo con Piero Coda* (Rai-Mondadori, Rome/Milan, 2000).

BACCARINI EMILIO, 'Il male tra libertà e responsabilità', in Giovanni TANGORA and Domenico POMPILI (eds.*), Il male e i suoi volti* (Edizioni San Lorenzo, Reggio Emilia), pp. 201-222.

BEVILACQUA ANTHONY J., 'I disabili: una parte vivente e vitale della comunità religiosa', *Dolentium Hominum*, 22 (1993/1), 23.

CAMBIER JULES, DUFOUR XAVIER-Léon, 'Misericordia', in DUFOUR Xavier-Léon (ed.), *Dizionario di teologia biblica* (Marietti, Genoa, 1976^5), coll. 699-705.

CAPPELLETTI VINCENZO, 'Dove c'è amore per l'arte medica c'è amore per l'uomo', *Dolentium Hominum*, 31 (1996/1), 12-14.

CINA' GIUSEPPE, 'Antropologia nel mondo della salute', in CINA' Giuseppe, LOCCI Efisio, ROCCHETTA Carlo, and SANDRIN Luciano (eds.), *Dizionario di teologia pastorale sanitaria* (Ed. Camilliane, Turin, 1997), pp. 55-78.

COLZANI GIANNI, 'La paternità di Dio e il male nel mondo. Confronto tra fede e ragione', Giovanni TANGORA and Domenico POMPILI (eds.)*, Il male e i suoi volti* (Edizioni San Lorenzo, Reggio Emilia), pp. 153-174.

CONDE JESÚS, 'La sofferenza e il significato della vita', *Dolentium Hominum*, 31 (1996/1), 127-132.

CREMONA CARLO, 'L'attenzione al malato nei Padri della Chiesa', *Dolentium Hominum*, 31 (1996/1), pp. 37-41.

DESKUR ANDRZEJ MARIA, 'La persona disabile, strumento di salvezza per la società umana', *Dolentium Hominum*, 22 (1993/1), 12.

DUFOUR XAVIER-LÉON, 'Prossimo', in Id. (ed.), *Dizionario di teologia biblica* (Marietti, Genoa, 1976^5), coll. 1015-1017.

ENDERS MARKUS, 'Dio può soffrire? La sofferenza di Dio nella teologia dei Padri', *Communio*, 192 (2003), 19-33.

FALA' MARIA ANGELA, 'Tradizione Buddhista', in PANGRAZI, *Salute, malattia e morte nelle grandi religioni*, pp. 119-144.

FARGE ARLETTE, 'L'existence méconnue des plus faibles', *Études*, 1 [4041] (2006), pp. 35-47.

GAMEIRO AIRES, 'Ospitalità', in CINA' Giuseppe, LOCCI Efisio, ROCCHETTA Carlo, and SANDRIN Luciano (eds.), *Dizionario di teologia pastorale sanitaria*, pp. 811-814.

GÓMEZ JESÚS ÁLVAREZ, 'L'assistenza ai malati nella storia della Chiesa', *Dolentium Hominum,* 31 (1996/1).

KLEIN ÉTIENNE, 'Les nouvelles questions posées à la Science', in *Études*, 6 [4046] (2006), pp. 774-785.

MANDE' VITTORIO, 'La sofferenza nella cultura contemporanea', in COMOLLI Gian Maria and MONTICELLI Italo, *Manuale di Pastorale sanitaria* (Ed. Camilliane, Turin, 1999), pp. 117-123.

MAIANO VINCEZO, 'L'ateismo', in ZOLTAN Alszeghy *et al*., *La Costituzione pastorale sulla Chiesa nel mondo contemporaneo* (LDC, Leumann (TO)), pp. 478-508.

MESSINA ROSARIO, 'Storia degli ospedali cattolici', *Dolentium Hominum*, 52 (2003/1) 80-86.

PETRINI MASSIMO, 'Ospedale cattolico', in CINA' Giuseppe, LOCCI Efisio, ROCCHETTA Carlo, and SANDRIN Luciano (eds.), *Dizionario di teologia pastorale sanitaria*, pp. 800-804.

RAMLOT MARIE-LÉON and GUILLET JACQUES, 'Sofferenza', in Xavier-Léon DUFOUR (ed.), *Dizionario di teologia biblica* (Marietti, Genoa, 1976^5), coll. 1208-1210.

SANNA IGNAZIO, 'Mysterium Iniquitatis. Il male e i suoi volti', in TANGORA GIOVANNI and POMPILI DOMENICO (eds.), *Il male e i suoi volti* (Ed. S. Lorenzo, Reggio Emilia) pp. 123-150.

SCAIOLA DONATELLA, 'Il tema del male/sofferenza nella Sacra Scrittura: diversi modelli interpretativi', in Giovanni TANGORA and Domenico POMPILI (eds.)*, Il male e i suoi volti* (Edizioni San Lorenzo, Reggio Emilia) pp. 71-90.

SISTI ADALBERTO,'Misericordia', in ROSSANO Pietro, RAVASI Gianfranco, and GIRLANDA Antonio, *Nuovo Dizionari di teologia biblica* (San Paolo, Cinisello Balsamo (MI), 1988), pp. 978-984.

SVAMINI HAMSANANDA GIRI, 'Tradizione induista', in PANGRAZI, *Salute, malattia e morte nelle grandi religioni*, pp. 101-118.

TANGORA GIOVANNI, 'L'esperienza del male nella letteratura', in Giovanni TANGORA and Domenico POMPILI (eds.)*, Il male e i suoi volti* (Edizioni San Lorenzo, Reggio Emilia), pp. 39-67.

VANHOYE ALBERT, 'Il Buon Samaritano (Lc 10,25-37). Ermeneutica biblica', in *Dolentium Hominum*, 31 (1996/1), 198-202.

Notes

[1] 'Disabled people do not make us feel comfortable because they remind us of our vulnerability: the inevitable reality that the life of each one of us leads, in the end, to death. Our disabled brothers and sisters are prophets amongst us who contradict what others have called the 'cult of perfection', a false religion whose gods, perpetual youth and beauty, are venerated without discussion, above all in the nations of the first world': BEVILACQUA Anthony J., 'I disabili: una parte vivente e vitale della comunità religiosa', *Dolentium Hominum*, 22 (1993/1) , p. 23.

[2] Cf. COMMISSIONE EPISCOPALE PER IL SERVIZIO DELLA CARITÀ E DELLA SALUTE (CEI), *'Predicate il Vangelo e curate i malati.' La comunità cristiana e la pastorale della salute* (Nota pastorale) (EDB, Bologna, 2006), n. 11.

[3] In recent decades various initiatives have been taken to improve the lives and the social integration of disabled people. One may refer here, for example, to the recent convention of the United Nations on the rights of disabled people (cf. *www.un.org/esa/socdev/enable/*); the European Year of the Disabled (Official Gazette of the European Communities of 19.12.2001) and so forth.

[4] RAVASI GIANFRANCO, *Fino a quando Signore. Un itinerario nel mistero della sofferenza e del male* (San Paolo, Cinisello Balsamo (MI), 2002), pp. 11-35; CODA Pietro, D*ieu et la souffrance* (PUM, 2004), pp. 3-5. This is the eighth lecture of the course for missionary studies organised by the Pontifical Missionary Union; PANGRAZZI Arnaldo (ed.), *Salute, malattia e morte nelle grandi religioni* (Ed. Camilliane, Turin, 2002), pp. 101-144.

[5] 'In each one of us there is a resistance to the change we are inevitably called to by dialogue with the poor. The cry of a person in need irritates those who are well off and satisfied with themselves and their condition. The anxiety of people with handicaps reveals their own anxiety, their shadows are our shadows, and thus we distance them': Jean Vanier, *Drawn into the Mystery of Jesus through the Gospel of John* (Danton, Longman and Todd, 2004/Paulinist Press, 2004 – Novalis, 2004), quoted by SPINK Kathryn, *Una vita di comunione. Jean Vanier e l'Arca* (Ed. San Paolo, Cinisello Balsamo (MI), 2007), pp. 6-7.

[6] CODA PIETRO, *Dieu et la souffrance*, pp. 4-5; SVAMINI Hamsananda Giri, 'Tradizione induista', in PANGRAZI, *Salute, malattia e morte nelle grandi religioni*, pp. 101-118; FALA' Maria Angela, 'Tradizione Buddhista', in . PANGRAZI, *Salute, malattia e morte nelle grandi religioni*, pp. 119-144; ENDERS Markus, 'Dio può soffrire? La sofferenza di Dio nella teologia dei Padri', *Communio*, 192, (2003) 19-33.

[7] CODA PIETRO, *Dieu et la souffrance*, p. 5; RAVASI, *Fino a quando Signore*, pp. 21-24.

[8] CODA PIETRO, *Dieu et la souffrance*, p. 5.

[9] IBID.; RAMLOT Marie-Léon, GUILLET Jacques, 'Sofferenza', in Xavier-Léon DUFOUR (ed.), *Dizionario di teologia biblica* /Marietti, Genoa 1976^5), coll. 1208-1212: RAVASI, *Fino a quando, Signore,* pp.42-63.

[10] CODA PIETRO, *L'agape come grazia e libertà alla radice della teologia e della prassi* (Città Nuova Editrice, Rome, 1994), pp. 43-44.

[11] CODA PIETRO, *Dieu et la souffrance*, p. 5

[12] *IBID*.

[13] CODA PIETRO, *Dieu et la souffrance*, pp. 7-8; RAMLOT Marie-Léon, *op. cit*., pp.1212-12114.

[14] CODA PIETRO, *Dieu et la souffrance*, p. 7.

[15] The spiritual and mystical experience of many saints, like pastoral care, leads towards a richer and more faceted position.

[16] One needs only think of what happens in the New Age movements or the various religious sects.

[17] Cf. JOHN PAUL II, Apostolic Letter *Salvifici Doloris*, 11 February 1984.

[18] JOHN PAUL II, Apostolic Letter *Salvifici Doloris*, n. 8.

[19] RIBUSTINI JEAN, *Les structures d'assistance de l'Église dans l'histoire*, Cours études pour la mission, Cinquième leçon, 2004; MESSINA ROSARIO, 'Storia degli ospedali cattolici, *Dolentium Hominum*, 52 (2003/1) 80-86; GAMEIRO AIRES, "Ospitalità", in CINÀ GIUSEPPE, LOCCI EFISIO, ROCCHETTA CARLO, and SANDRIN LUCIANO (eds.), *Dizionario di teologia pastorale sanitaria* (Ed. Camilliane, Turin, 1997), pp. 811-814; PETRINI MASSIMO, 'Ospedale cattolico', in CINÀ GIUSEPPE, LOCCI EFISIO, ROCCHETTA CARLO, and SANDRIN LUCIANO (eds.), *Dizionario di teologia pastorale sanitaria*, pp. 800-804.

[20] Despite the shortage of published historical sources, it is estimated that during the fourteenth century the number of hospitals in England reached the number of six hundred in a population estimated at 3,750,000 souls. There were many more in France and Italy.

[21] In England Henry VIII had all the monasteries and convents closed, thereby causing the collapse of the Catholic care and hospital system, with the exception of the London hospitals of St. Bartholomew's, St. Mary's of Bethlehem and St. Thomas's which passed under the administration of the Crown, In Germany, where the same events had taken place, Frederick I in 1710 founded the Hospital of Charity in Berlin. In France the absolute monarchy wanted to build its own hospitals to compete with the Church organisations. But in France as well the situation was destined to degenerate beginning with the revolution of 1789.

[22] JOHN PAUL II Apostolic Constitution *Pastor Bonus on the Roman Curia* (Tipografia Poliglotta Vaticana, Vatican City, 1988), art.152.

[23] *IBID*., art. 153.

[24] Cf. *Annuarium Statisticum Ecclesiae* (Libreria Editrice Vaticana, 2005) where in a summary 114,738. Catholic healthcare structures are listed: hospitals, clinics, leper hospitals, orphanages etc.

[25] X Apostolic Letter *Salvifici Doloris*, n. 29.

[26] JOHN PAUL II, *Dolentium Hominum* (Motu Proprio), 11 February 1984, n. 1.

[27] In the same perspective, as the Holy Father Benedict XVI states: 'Following the example given in the parable of the Good Samaritan, Christian charity is first of all the simple response to immediate needs and specific situations: feeding the hungry, clothing the naked, caring for and healing the sick, visiting those in prison etc.' (*Deus Caritas est*, n. 31)

[28] DESKUR ANDRZEJ MARIA, 'La persona disabile, strumento di salvezza per la società umana', in *Dolentium Hominum*, 22 (1993/1), 12.

[29] BEVILACQUA ANTHONY J., 'I disabili: una parte vivente e vitale della comunità religiosa'', *Dolentium Hominum*, 22 (1993/1), 26. In his meeting with sick people in Wellington, on the occasion of his pastoral visit to New Zealand (23.11.1986), the Servant of God John Paul II addressed these people in the following terms: 'While I prayed and prepared my pastoral visit to New Zealand, I waited in particular to meet the sick, the elderly, the handicapped and the infirm… Now that I am with you I can assure you that you occupy a special place in my heart and in the life of the Church.. Your prayers and your sacrifices have great power because they contribute a great deal to the mission of salvation of the Church': *Insegnamenti di Giovanni Paolo II*, IX/2 1986, p.1565.

[30] JOHN PAUL II Apostolic Letter *Salvifici Doloris* 11 February 1984, n. 29. The parable to which he refers is the parable of the Good Samaritan (Lk 10:29-37).

[31] Quoted in RAVASI Gianfranco, *Fino a quando Signore?,* p. 21.

[32] DESKUR, Loc. cit. p. 13.

[33] BEVILACQUA, Loc. cit., p. 24.

[34] JOHN PAUL II "The disabled have to be received into society and to become its authentic protagonists". 'Discorso ai partecipanti alla Conferenza Internazionale: Persone disabili nella società', in *Dolentium Hominum*, 22 (1993/1) 10.

[35] BEVILACQUA, *op. cit*., p. 23.

[36] BENEDICT XVI, Encyclical *Spe Salvi*, 30 November 2007, n. 38.

Does Suffering have Meaning?

1. The Search for an Answer

Somebody once said: 'God speaks but He does not give answers'. Humans address a great deal of questions to Him, implicitly or explicitly, in the same way as the Apostles did with Jesus: 'Lord, will you at this time restore the kingdom of Israel?' (Acts 1:6).

In all the epochs of human history men and women have experienced the question of the presence of pain in the world. Wise men, philosophers, theologians and simple people have tried to provide an answer to this immense question.

We constantly pose questions to ourselves about the meaning of life, the meaning of death, the meaning of love, the meaning of friendship, the meaning of pain, and so forth. Managing to give a meaning stimulates and infuses courage both in crucial moments and in the routine of daily life.

Suffering often generates perplexity, amazement and scandal. The question of pain is present in all religions and in all creeds. There are an infinity of reasons for this. But this reality appears in all its crudity and does not seem to receive a convincing answer. The question (which could already become a subject) which reflects the anxiety of man when faced with pain is the following: 'can one believe after Auschwitz?'.

The answer comes from antiquity. We can find it, for example, in the Book of Job. The aim of the author is to end the mentality of the epoch which associated illness and in general human pain with the wrongs and the sin of the person who was suffering, an idea that is also present in the New Testament. Assailed by his friends who sought to convince him that he was a sinner, Job defended himself against their arguments: '"If I have walked with falsehood, and my foot has hastened to deceit; (Let me weighed in a just balance, and let God know my integrity!) (Job 31:5-6). Job argues tenaciously in favour of his innocence and God says that he is right.

However the question persists: why do the innocent suffer? Why does wrong triumph? In answering God's challenge Job acknowledged divine superiority as regards realities that go beyond the human mind: 'I heard of thee by the hearing of the ear, but now my eye sees thee; therefore I despise myself, and repent in dust and ashes' (Job 42:5-6). Although Job laments loudly and with a series of contradictions, what we admire in this great figure is his obstinate trust in God: 'For I know that my Redeemer lives…and after my skin has been thus destroyed, then from my flesh I shall see God' (Job 19:25-26).

In the heart of the Christian life there is the figure of Christ whom the Church celebrates every day as Risen in the Sacraments, and in particular in the sacrament of the Eucharist. But the Risen Christ is also the Crucified Christ and thus he who believes in Jesus cannot but contemplate him on the cross, although he is inseparable from the empty tomb on Easter Sunday.

This question is also present in the Christian because not even he is without pain. The difference lies in the fact that thanks to faith he recognises his Saviour in the suffering Christ. The gospel does not provide us with explanations of malady and pain but it presents us with God who takes it on himself, illuminates it with his divine-human presence, and transforms it.

God the Father did not release the Son from the cross, nor did He offer declamations on its meaning when Jesus uttered the cry: 'My God, my god why has thou forsaken me?' God the Father remained silent, a 'magisterial' silence'. In raising him from the dead, however, He pronounced for Jesus, He gave him justice, corroborating his teaching, his action and his entire life; the Father sealed the image of God that Jesus had transmitted. He put Himself on his side because the only thing that had moved Jesus was his Love in carrying out the will of the Father. And the Father acknowledged him as His Son by raising him from the dead, or rather by placing him on the throne at His side in glory and power: this was His answer.

2. The Answer of Love

Can one believe after Calvary? The only answer lies in *Love*. Why? Because the secret that Jesus kept steady and serene during the passion and the cross, was specifically his great Love for the Father and for the men and women of all epochs. It was his Love without limits that made Jesus able to overcome pain in the face of incomprehension, injustice and sin. And it is here that there appears for the believer the meaning of suffering. In taking upon himself human suffering Jesus redeemed it, that is to say he turned it into a channel of life. In the light of the paschal mystery, pain, rather than being an obstacle is transformed into an effective means of liberation. Thus the fruit of the passion of Jesus acts in us: it frees is from our finitude, it heals us of our sin and our frailty: 'even when we were dead from our trespasses, [God] made us alive together with Christ (Eph 2:5). Through him, everyone takes part in the Life of God. As Anselm Grün says: 'He who looks at Jesus, the true physician, already has now on the cross eternal life and experiences the mystery of Easter, the passage from this world to God'.[1]

Can one believe after Auschwitz? Edith Stein, whom the Church has recently begun to venerate as a saint and a martyr, can wonderfully illustrate this courageous answer of love. She knew extreme suffering to the point of heroically giving her own

blood in the Nazi death camps as a holocaust for the people from which she sprang, the Jewish people, for peace in the world and for the Church. In this way she was fully configured with the Crucified Christ whom she loved passionately after meeting him and giving herself to Him by living with faithfulness her vacation in the Carmel.

Discerning beforehand her tragic end, she wrote in her book 'The Science of the Cross': 'our end is union with God, our pathway is the Crucified Christ'. How Edith behaved during the last months of her life is described by another member of the Carmelite Order, Mother Cristina Kaufmann, who died a year later in the Carmel of Mataró. She had studied Edith Stein profoundly and admired her profoundly: 'from the testimonies that we have, we know that she never stopped thinking of possible salvation even when she was already in the transfer camp of Amersfoort, that she devoted herself with serene love and competence to caring for the children in the camp, that she recited the breviary, that she looked after her sister Rosa, that she consoled people that she knew and that she wrote to her community. In definitive terms, she did what she had always done: she lived the truth of self-giving to God and her brethren *in the reality she found in front of her*'.[2]

3. Where is God when Man Suffers?

We have to acknowledge that when evil takes on unprecedented forms and the absence of God is perceived as being total and definitive, the 'dark night' can be experienced as a great temptation, along the lines of Job and so many others: is God not concerned about the sufferings and the afflictions of his children? Where was God when in New York or the station of Atocha in Madrid there were the terrible attacks of 11 September and 11 March? A spark of light: solidarity with those who suffered there could be a space for experience of God, 'although in the night', as with Job, Jesus, and Edith Stein. Yes: the light arrived through people who drew near to the victims: volunteers, medical doctors, nurses, people in prayer who placed garlands of flowers or candles or who provided a presence of silence and solidarity.

What remains, however, of all of this after the time that has passed since those events? The possibility of an initiative for peace, justice and forgiveness in a world that still destroys these values. Every initiative to provide space of greater humanity, initiatives to alleviate the suffering around us; the family, work, community, neighbours, even though one cannot provide convincing reasons for this, all of this is transformed into good and thus has a redemptive value. Thus communion with one's brothers and sisters always has a human and divine value.

Recently, the frightening earthquake that struck Peru and hurricane Dean which devastated the coasts of Mexico and a part of the Antilles provoked deaths, epidemics, a shortage of water, homeless people and people without food, the loss of possessions. Yes, the sensitivity exists and soon aid will arrive from all over the place, even though with a certain delay. And the war in Iraq? Two days ago the news spoke about five hundred deaths: a mixture of religious and political motivations. To adjudge that God is impassive in the face of all of this would be inappropriate. Without wanting to be simplistic (today's thinkers will analyse the facts beginning with their respective spheres of expertise), we can say that beginning with the faith we have been given a perception of the 'protest' of God who penetrates the heart of each of the victims, the clamour of whom is an echo of that 'My God, my God, why…' of Christ on the cross. For this reason, therefore, the believer is not allowed to be indifferent or passive. Instead he must join the peaceful but active fight, denounce and, something that is more important, become aware of our possible complicity in situations of this kind: to complain about our virtual or real violence (all of us have a killer insider us). 'God is at our side and takes part in the pain felt at this evil that devastates the earth. He is not a disinterested spectator or a cold and distant judge. Rather he 'has compassion' for us and with us, for our forms of loneliness that are unable to love, because He loves us. Divine 'suffering' is not incompatible with divine perfections: the suffering of love includes 'active and free compassion', the outcome of free-giving without limits'.[3]

I would like here to cite another aspect. In our community we have just experienced a painful fact which took place within a family that is very close to us. A beautiful little six-year-old girl, Mariebeth, was hit by a motorcycle in the street and died in hospital after three long hours of fighting between life and death. Her parents, aunts and little brothers and sisters were desperate. Some of us drew near to them and tried to help them as much as we could. In these cases it is not words that console; what alone matters is the presence of people. A very important thing is that this family belongs to the Filipino community of Barcelona. In the ardent chapel people were crying but also praying. The church was overflowing. One could feel the sense of belonging that characterises the Filipino people, its idea of the family! Pain unites; the tragedy exists but it can be transformed by love and become communion, help.

The family relatives of this little girl are recovering their serenity.

4. In Christ Our Hope

To go one: where there are those who suffer without ceasing to love and to hope despite the apparent lack of meaning, there we can see the Crucified Christ of Calvary who died for love, but who is the Alive Christ through his spirit, the source of hope. It is from him and in him that the Christian recovers his strength in the face of suffering and carries on along the pathway of life.

Prayer: this is an effective instrument in the challenge of life. In the Christian tradition, prayer is essential. Jesus prayed and exhorted people to engage in prayer entrusted to our Father in heaven. He prayed during his life, he prayed in Gethsemane and on Calvary. Death on the cross was not spared him but in prayer he nourished his trust in the Father and his immense love: love for God and for all human beings. In Auschwitz there were those who prayed with ardour, just as there were at the station of Atocha, in the Filipino community and in the Benedictine community of Barcelona. Prayer is like the breath of faith.

Suffering does not have a value in itself and to affirm the opposite could have a masochistic aspect. More than asking ourselves about the meaning of suffering, I believe that the best thing to do beginning with faith is to penetrate its cortex and enter its spinal column, in resemblance of Jesus, that is to say to see it beyond reasons and give it a meaning as he did, opposing spoliation with dedication, physical torture with forgiveness, and hatred with love. And through the stubbornness of *Love* never forgo the hope that is born from faith.

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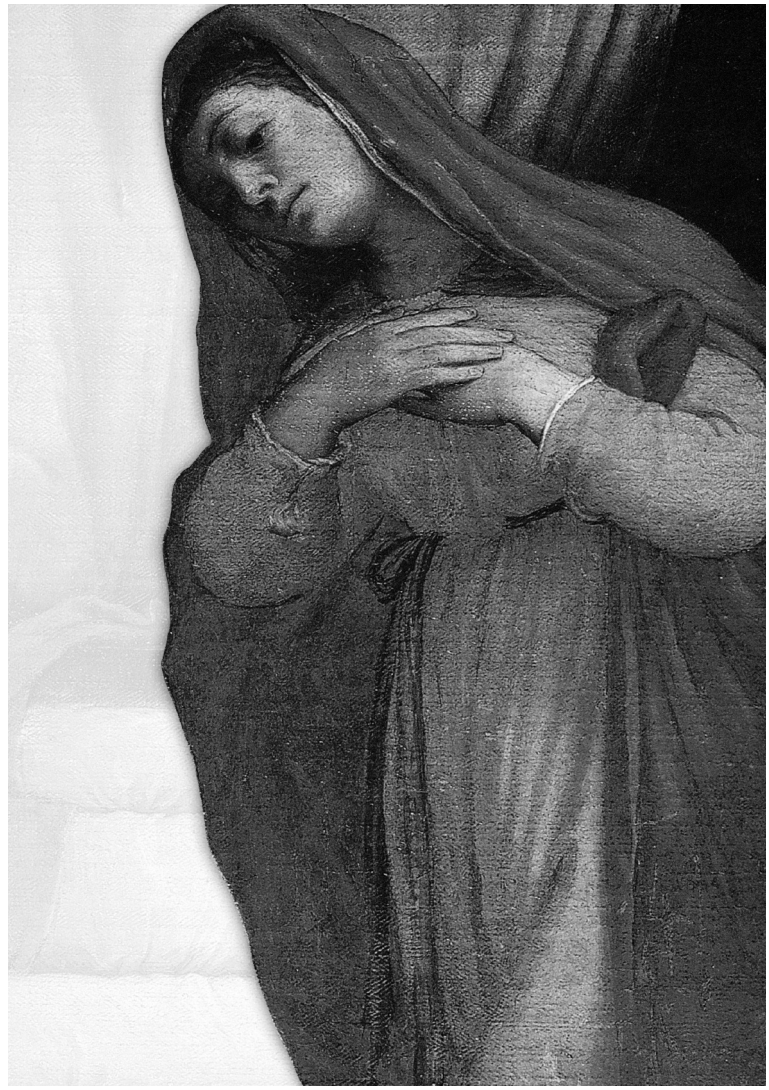
Notes

[1] ANSELM GRÜN. *Redenzione. Il suo significato nella nostra vita* (Ed. Verbo Divino, 2005), p. 101

[2] CRISTINA KAUFMANN., *La fascinación de una presencia* (Editorial de Espiritualidad, 2007), p. 165.

[3] CARLO M. MARTINI, Cardinal and former Archbishop of Milan, *Un camí per a l'Església del nou mil.leen* (Claret, 2000), p.16



The Humanization of Medicine – a Religious Viewpoint

The subject of the humanization of medicine and health care has been widely discussed for many years. It is a paradox that a matter such as health, which by its very nature is a humanitarian reality, should need to be humanized. But the facts prove the urgent need "to make health realities human, i.e. worthy of man".

Such calls for a "personalization" or "humanization" of medicine reflect an increased critical capacity in the health field, and today the literature often carries references to the topic. When we speak of man or the person, we are referring both to the irreducible identity and interiority that make up each single individual and to the fundamental relationship with others that is basic to the human community.

Personal beings are also social beings. Human beings are truly human insofar as they actualize the essentially social element of their constitution as persons who are members of groups, be they social, religious, civil, professional, or other, who together form the surrounding society to which they belong. Although affirming the basically social character of human existence, Christian civilization nonetheless recognizes the absolute value of the person as well as the importance of individual rights and cultural diversity. However, in the created order, there will always be a certain tension between the individual person and the demands of social existence.

"Criticisms of hospitals are these days presented with certain keywords: technology, prohibition, and isolation. Hospitals are seen as total institutions. But patients, even in hospital, continue to be living beings, i.e. people with needs that are not only physical but also social, psychological, and spiritual. The distance between the outside world and the hospital world should be overcome or reduced as much as possible."[1]

The problem of the humanization of health also has a clear cultural and social dimension. One need only think of WHO's definition of health. However, the ministers and servants of life all too often today live submerged in a culture of death. To illustrate this aspect, Veronesi has this to say: "The way a society treats the dying is a photograph of the particular moment in history which that society is going through."[2] But if health is a value and not a mere biological fact, it becomes a priority to re-establish a proper scale of values in society and to disseminate the culture of life and solidarity.[3]

We have mentioned cultural and social dimensions. We cannot forget the political, juridical, and economic aspect, which turns the subject of medicine, its objectives, and its actual practice into something that is very complex. To put it in a nutshell, it is easy enough to explain these principles but very hard to carry them out in practice.

The explosive increase of scientific knowledge and technological capacity in the modern epoch has brought mankind considerable advantages, but it also poses some difficult challenges. In the light of our knowledge of the immensity and the antiquity of the universe, the position and importance of man within it appear much less weighty and certain. Technological progress has considerably increased our capacity to control and direct the forces of nature, but it has also had the effect of producing an unexpected and possibly uncontrollable impact on our environment and even on humanity itself.[4]

For all these reasons a profession, mission, and vocation such as that of the health worker naturally requires a solid preparation and continuous training in moral matters in general and in bioethical matters in particular. In the presence of cases that have been rendered ever more complex by the possibilities offered by biotechnology, health workers – and in particular doctors – cannot and must not be left alone under the weight of unsustainable responsibilities. This is all the more the case if we consider that many of these possibilities are still in an experimental phase and are of great sociosanitary importance in the field of personal and public health.[5]

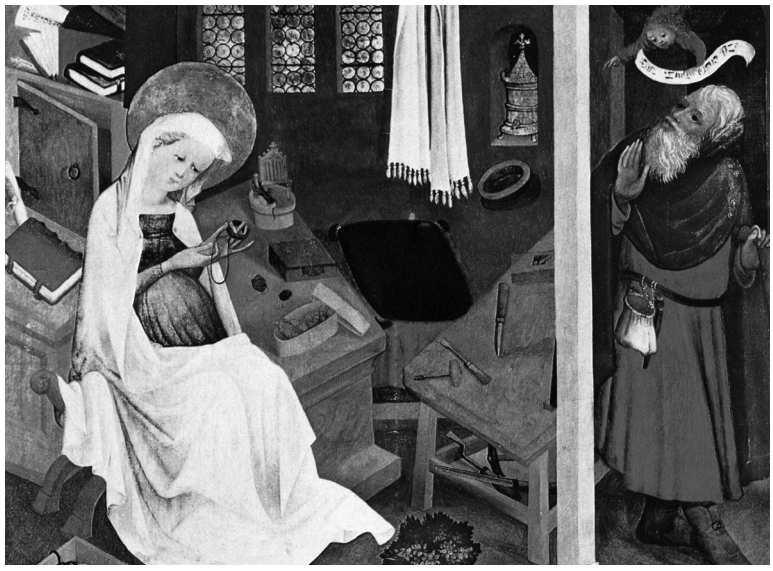
Bioethical profiles are not just one of the many aspects of the matter – they are one of its essential nuclei. For if the doctrine and practice of medicine occupy a central position in the panorama of bioethical studies, the consideration of human conduct in the sector of life sciences and health care is one of its principal objectives.[6]

Without a doubt the true humanization of science and medical technology is at stake, i.e. also in the field of medicine it is necessary to construct "that civilization of love and life without which the existence of individual persons and of all society loses its most authentically human meaning."[7]

The problem of the humanization of medicine is closely related – also chronologically speaking – to the birth of bioethics. Among other things, this was triggered by certain savage forms of medical experimentation on man. For example, it came to be known that in Willowbrook State Hospital (New York) some 700 retarded children were deliberately infected with the hepatitis virus between 1965 and 1971;[8] and the fact that in 1964, in the Jewish Chronic Disease Hospital (New York), live cancerous cells were inoculated into 22 elderly men and women set up a strong reaction among the population in general and in the world of scientists.[9]

And that is not all: from 1932 to 1972, in a town in Alabama, 399 Afro-American farm workers suffering from syphilis were not treated nor even informed of the true nature of their disease[10]. Nuremberg was very soon forgotten, too soon. In the 1960s, in the context of the Cold War, fear about the nuclear threat and for the future of our planet began to spread. Hence the birth of bioethics.

Of all the sciences that study nature, medicine is the only one that should never be entirely thought of as mere technique. For a doctor, technique and "theoretical" knowledge is never enough. There must also be practical know-how. In people's collective imagination, doctors are people who cure the sick, who look after patients. All their activity involves a holistic activity of the organism, which is a vital activity. Indeed, "the term and the concept of health mean everything related to the prevention, diagnosis, therapy, and rehabilitation for a better equilibrium and physical, psychological, and spiritual welfare of the person". This concept should not be confused with that of the person, who instead "regards policies, legislation, programming and health facilities"[11].



The exceptional and rapid progress of medical science gives rise to repeated ethical and deontological questions, and the finding of an adequate response, on the ethical level, ultimately depends on the concept one has of medicine.

"Today the medical profession is at a sort of crossroads: in today's cultural and social context, in which medical science and art run the risk of losing their native ethical dimension, doctors may sometimes be strongly tempted to transform themselves into ministers of the manipulation of life or even into operators of death. In the face of such a temptation their responsibility is today enormously enlarged and finds its deepest inspiration and strongest support precisely in the intrinsic and inalienable ethical dimension of the health profession."[12]

Medical action is – and must be – intrinsically moral because it is intrinsically human. An amoral, aseptic, neutral medicine that does not wager on behalf of man is inhuman and immoral because it goes against man and because it has failed in what was its basic function: to serve life.

The peculiarity of the art of medicine is the fact that it acts not on agriculture or on the breeding of animals but on human beings who have to be treated. This condition defines the sphere of the doctor's scientific competence from a new point of view. It means that the sick, the patients, are, above all, people. When this personal condition is neglected, forgotten, or ignored, medicine loses its specificity and becomes a different art, one that is all too often perverse and inhuman.

"Their action [i.e. that of doctors or health workers], as human action, contains in itself a truth that does not depend on them, on their will, or on their feelings. It depends, on the contrary, on the reality of the people to whom they direct their action and whose vital principle is intrinsic, and depends only extrinsically on doctors, in a vicarious or surrogate form, inasmuch as they are capable of eliminating the pathology or accompanying it in its development. That is how the truth of medical practice should be understood, on which the very goodness of such action depends and in which the very goodness of doctors is at stake, as they establish the right relationship with their patients, in such a way as to treat them with objective reality and to support and promote what is good for them and what they rightly deserve."[13]

" … The basic evaluation criterion," as John Paul II affirmed, "lies in the defence and promotion of the integral good of human beings, according to their individual dignity. To this regard it is worth remembering that all medical action on a person is subject to limits that are not limited to any technical impossibilities of realization but rather are linked to respect for human nature itself, taken in its fullest meaning: what is technically possible is not for that simple reason morally admissible."[14]

We said here at the start that "in the created order there will always be a certain tension between individual people and the demands of social existence". Freedom, responsibility, law, and duty are firm categories of which we speak at length. At this point – almost provocatively – I would like to recall some thoughts expressed by Joseph Ratzinger, published in his book Truth – Tolerance – Freedom.

"Freedom is related to a criterion, the criterion of reality – to truth. The freedom to destroy oneself or to destroy another person is not freedom but its diabolical parody. [...]

The freedom of man is a shared freedom, freedom in the togetherness of freedoms, which limit each other reciprocally and thus reciprocally support each other: freedom has to measure itself by what I am, by what we are – otherwise it suppresses itself. [...] The law is not a limitation of freedom, it constitutes freedom. The absence of law is the absence of freedom. […]

What is a law that conforms to freedom? How must a law be structured for it to constitute a right to freedom? For there undoubtedly exists an apparent right, which is a slaves' right and therefore not a right but a regulated form of injustice. [...] The criterion for a real law that can authentically define itself as such, and therefore as a right to freedom, can thus only be the good of all, i.e. goodness itself. Understanding this, Hans Jonas declared that the concept of responsibility was the central ethical concept. This means that freedom, to be properly understood, must always be considered together with responsibility.

[...] The question of the way in which responsibility and freedom have to be set in their proper relation cannot be decided simply by a calculation of effects. [...] The reality of the individual person, properly comprehended, brings with it a reference to the collectivity, to the other person. We will therefore say: there exists in every one of us the common truth of the unique human essence, which traditionally was called "human nature". […] Responsibility would therefore mean: to live our lives as an answer – an answer to what we really are.[15]

In the context of the reform of the United Nations, I should like to conclude with a few words pronounced by Cardinal Angelo Sodano:

"To the human race, exposed to the pandemics of today and to others that threaten to develop, to the masses of people denied access to basic health, aspirin, and drinking water, we must not offer an ambiguous, oversimplified, or even ideological vision of health. For example, would it not be better to speak clearly of "the health of women and children" instead of using the expression "reproductive health"! Can it be that there is a desire to speak once again of a right to abortion?"[16]

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Notes

[1] VON ENGELHARDT D., Cultura e Medicina. In: "Dizionario di Bioetica", 218-9, Leone S., Privitera S. (eds.), EDB-ISB, Bologna-Acireale, 1994.

[2] Cf. VERONESI U.: Eutanasia ed etica del medico. Bioetica: Rivista Interdisciplinare, 11: 228-9, 2003.

[3] Cf. COMMISSION EPISCOPALE PER LA PASTORALE DEI VESCOVI SPAGNOLI. Final document of "Chiesa e Salute" National Congress, Bioetica: Rivista Interdisciplinare, 11: 556-564, 2003.

[4] Cf. COMMISSIONE TEOLOGICA INTERNAZIONALE, Comunione e servizio, la persona umana creata a imagine Dio, n. 1.

[5] See Father Bonifacio Honings, O.C.D., Consultor of the Congregation for the Doctrine of the Faith and of the Pontifical Council for Health Pastoral Care, citing "Charter for Health Care Workers", no. 5.

[6] Cf. Parere sugli scopi, rischi e limiti della medicina, Italian National Bioethics Committee, 14 Dec. 2001.

[7] *Evangelium Vitae,* 27.

[8] Cf. KRUGMAN S., Experiments at the Willowbrook State School,Lancet 1971, I: 966-967; Id., The Willowbrook hepatitis studies revisited: ethical aspects, Review of Infective Diseases 1986, 8: 157-62.

[9] FADEN R.R., Beauchamp T.L., and King N.M.P., A Historyand Theory of Informed Consent, New York – Oxford: OxfordUniversity Press, 1986, pp. 161-167; MacKlin R., Mortal Choices, New York: Pantheon, 1987, pp. 167-194.

[10] BENEDEK, T.G., The Tuskegee study of syphilis: analysis of moral versus methodological aspects, Journal of Chronic Diseases 1978, 31: 35-50; King P.A., Edgar H., and Caplan A.L., Twenty years after. The legacy of the Tuskegee Syphilis Study, Hastings Center Report 1992, 22(6): 29-38; Corbie-Smith G., The continuing legacy of the Tuskegee Syphilis Study: considerations for clinical investigation, American Journal of Medical Sciences 1999, 317: 5-8; White R.M., Unraveling the Tuskegee Study of Untreated Syphilis,Archives of Internal Medicine 2000, 160: 585-598; Id., The Tuskegee syphilis study, Hastings Center Report 2002, 32(6): 4-5.

[11] Cf. JOHN PAUL II, To the Plenary Assembly of the Pontifical Council for Health Pastoral Care, 9 Feb. 1990. In: Teachings XIII/2, p. 405, n. 4.

[12] JOHN PAUL II, "Nothing can justify the elimination of a life which can be a gift of love for a family even in the suffering of the final days". In: Medicina e Morale, 50 (IV): 761, 2000.

[13] NORIEGA J.: L'azione medica e la sua bontà. La cura del malato in stato vegetativo permanente. In: "Né accanimento né eutanasia", 153-162, Lateran University Press, Rome, 2002.

[14] Speech by His Holiness JOHN PAUL II, Eighteenth International Congress of the Transplantation Society, August 2000. Cf. Donum Vitae, no. 4.

[15] RATZINGER J.: "Truth – Tolerance – Freedom", 261-269.

[16] Speech by Cardinal ANGELO SODANO, Secretary of State, on 16 September 2005 in New York during the Summit Meeting of Heads of State and Government, United Nations Organization.

The Right to Die: a Neglected Document

1. Premise

To proclaim the right to die appears at first sight to be in radical contrast with what is a fundamental right of the person: namely the right to live, that is to say to preserve and to realise one's own life in the best way possible. Although human life raises frequent disquieting questions, 'in the face of death the enigma of the human condition reaches its high point' (*GS*, n. 18). And yet there are circumstances in which the right to die is invoked and/or implemented. The obscuring of the meaning of living removes all hope. One may be dealing with an active intervention that directly causes death, forgoing an intervention intended to preserve life, and which thus passively brings about death, or simply allowing the course of health-care events to lead to their natural fatal conclusion.

Today all of this is without ease of manner identified as 'euthanasia'. However, competent people have clearly acknowledged that euthanasia is a word around which much confusion is always created, with the attribution to it of various meanings (Prof. I. Marino, 'Dialogo sulla vita', *L'Espresso*, 27.4.06). This was confirmed by research carried out by the University of Milan-Bicocca in which medical doctors of various backgrounds and specialisations in their answers to questionnaires defined euthanasia in terms of how it was carried out in and in this they expressed surprising divergences of view. The conclusion of the journalist was: is what is being spoken about here really understood? (*Corriere della Sera*, 22 Oct. 2006. p. 61).

The technical-scientific advance of medical science, in allowing the prolongation of the lives of people in dramatic situations and situations of great concern, both as regards patients and the family relatives looking after them, when faced with the prolongation of life induced artificially has provoked the request for euthanasia as the right to end a life that has become unbearable. The problem lies in determining when an action that is inflicted or omitted, and which brings about death, is authentic euthanasia. One is dealing with opinions expressed by various sectors of society, both secular and religious in character, with equally diverse motivations which are always apparently rational but which are strongly marked and conditioned by emotional-sentimental considerations.

In such initiatives, including those that come specifically from the Catholic world, there does not seem to be taken into consideration an extremely lucid and demanding declaration of the *Catechism of the Catholic Church* (*CCC*). It appears, in fact, that no reference is to be found to it, about from it being fully quoted by Prof. I. Marino ('Dialogo', *L'Espresso*) and by Cardinal Martini (*Il Sole 24-ore*, 21 Jan. 2007).

2. The Document

The text is the third paragraph of the section entitled 'Euthanasia'. In this short section, after the special respect that is due to handicapped or sick people so that they can lead lives as normal as possible has been emphasised (n. 2276), in the second paragraph direct euthanasia, which consists in putting an end to the lives of the handicapped, sick or dying, is considered. It is deemed to be morally unacceptable. This paragraph further specifies: 'Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and to the respect due to the living God, his Creator. The error of judgement into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded'.

According to what is said here, an action or omission that causes death is totally separate from the act of suicide. Secondly, there is a precise distinction between an objective fact, which should always be condemned, and a subjective fact which may also involve good faith and which is in moral terms, therefore, not to be condemned. This line of argument is indispensable in understanding the next paragraph, the document which this paper seeks to examine in conformity with Church law: 'the laws of the Church should be understood in line with the specific meaning of the words considered in the text or context (*CIC*, 17). Now this document, or better paragraph 3 of the section headed 'Euthanasia', lays down specifically what euthanasia is not: '2278. Discontinuing medical procedures that are burdensome, dangerous, *extraordinary, or disproportionate* to the expected outcome *can* be legitimate; it is the refusal of 'over-zealous' treatment. Here one does not *will to cause death*; *one's inability* to impede it *is merely accepted*. *The* decisions *should be made* by the patient if he is competent and able or, if not, by those legally entitled to act for the patient, *whose reasonable will* and legitimate *interests must always be respected*'.

The central and unequivocal statement is to be found in the legitimacy of discontinuing specific medical procedures which will inevitably cause death. In other words, we are dealing with the legitimacy of the right to die by refusing the prolongation of one's life by other medical procedures. The reason for the legitimacy of this discontinuation of medical procedures from which death results is to be found in the statement of this paragraph: 'it is the refusal of 'over-zealous' treatment. Here one does not will to cause death; one's inability to impede it is merely accepted'. In other terms one is not dealing with 'making a person die', that is to say causing death, but

with 'allowing a person to die', with not obstructing the natural process of fatal events. This paragraph is in direct contrast with the preceding one which condemns euthanasia.

3. The Implications of this Document

The conditions which legitimate this discontinuation are identified as being medical procedures that are burdensome, dangerous, extraordinary, or disproportionate as regards the outcomes that are expected. The person who has the power to make this decision is specified – the patient or those who legally have the right to do so. Clearly the medical doctor or the medical team is excluded.

The text of the document is lucid and concise and does not hesitate to descend into details. Certain clarifications emerge from it and they are as follows:

1. Reference is made to legitimacy and not to what is simply licit, and thus there is a precise reference to juridical laws that are already in existence or which are desirable.

2. Reference is made to what is legitimate and what is licit but no obligation is imposed. Nobody has the duty to decide such a discontinuation. The freedom of conscience of the individual is totally respected.

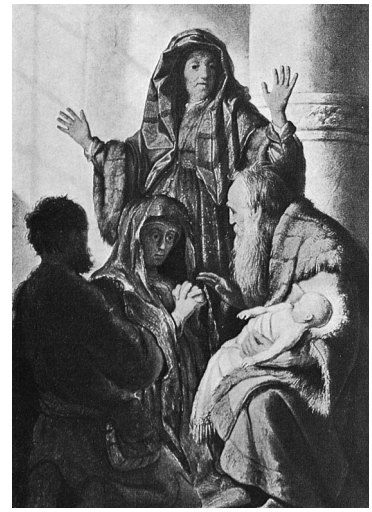
3. A possible discontinuation of treatment is not conditioned by the varying degrees of suffering of the patient or third parties. Even in the case of a lack of suffering, where the envisaged conditions exist, the legitimacy of the discontinuation of the treatment remains valid. Suffering of any kind is not taken into consideration.

4. Emotional motivations are thus excluded. Only rational motivations can lie behind such a decision.

5. Consciousness or sufficient lucidity in the patient is not required. A decision taken at the time of mental lucidity which it is understood has validity when the conditions for the discontinuation of treatment exist, even when absent in a moment of consciousness, cannot be neglected. The decision of the patient has pre-eminence over the contrary views of third parties even when these last are in possession of legitimate rights.

6. The conditions that are listed must be taken individually and not cumulatively. When any of the four envisaged conditions is present, the legitimacy of the discontinuation continues to be effective.

7. In the text and context of this document – with the sole exception of the reference to respect for the living God, the person's creator, which is quoted above – the whole of the argument has its foundation not in reasons relating to religious faith, whatever they may be, but solely in arguments that are purely rational in character.



This is therefore a document, both at the level of its text and its context, which is of an anthropological character and which is not in itself religious, even though it has obvious religious consequences and because, it is to be found in the *Catechism of the Catholic Church*, it is primarily addressed to Catholics.

The detailed examination of this document attempted in this paper belongs to the same anthropological and not religious approach.

The anthropological language in the other part of the document, and paragraph 2278 will now be considered in particular, reflects no reference to ideologies of some philosophical school other. It may be defined simply as being 'phenomenic'. This characteristic has the notable advantage of expressing its 'universal' relevance. According to the general norm, which is expressed by the Code of Church Law, 'Ecclesiastical laws that…restrict the free exercise of rights…are subjected to strict interpretation' (c. 18), and this corresponds to the juridical principle: '*odia restringi et favores convenit ampliari*. The application of this norm to this document as well must be interpreted in individual cases with a breadth of understanding. Every attempt to restrict its application is completely abusive.

4. The Conditions for the Discontinuation of Treatment

The text of the document is simple and clear, without having specific practical references, as to its precise goal. Possible difficulties in its interpretation and thus as regards the application of the legitimacy of discontinuing medical procedures derive form these procedures being identified as burdensome, dangerous, extraordinary or disproportionate to the outcome that is expected.

The quality of being burdensome concerns in itself the patient and/or his family relatives. Today, however, this is alleviated, if not removed, by various forms of social security, which means that it falls on the whole community. Everyone knows about how much the costs of health care weigh upon state budgets. There thus arises the question of whether the burdensome character of certain medical procedures, which are, albeit, borne by the whole community, and even more where these procedures are very expensive and prolonged and often not proportionate to the expected outcome, really meets a criterion of justice and is not persuasive as regards the legitimacy of discontinuation.

The dangerousness of medical procedures clearly consists in the possible direct or indirect causing of mutilations, for example (even partial) paralysis, blindness, the inability of speak etc., which lead to a grave injury to the dignity of life itself. In the face of such heavy risks the right exists to the discontin-

uation of medical procedures that are very dangerous and disproportionate to the expected outcome of a prolongation, which is above all else uncertain, of life. The fundamental principle lies in the proportionality between dangerous medical procedures designed to prolong life and the negative physical-mental situations that are induced in a life that may be prolonged. Anybody can consciously decide whether to run a risk with, or discontinue, these overly dangerous forms of treatment.

Extraordinary medical procedures are specified in the fourth and last paragraph (n. 2279) which brings the section of 'Euthanasia' to an end. This paragraph declares: 'Even if death is thought imminent, the ordinary care owed to a sick person cannot be legitimately interrupted'. It is also made clear that the use of pain-killers to alleviate suffering, even if they run the risk of shortening life, are morally acceptable, making the situation of the patient more in conformity with human dignity and where death is not sought but tolerated as inevitable. Thus extraordinary medical procedures are those that go beyond the ordinary care due to a sick person. With the technical-scientific advance of modern medicine it may perhaps not always be easy to ascertain the limits of 'ordinary' care. This, however, does not remove the validity of the principle. It is certainly the task of medical science to be sensitive to reasonable discretion in generally ascertaining these limits and to when these limits are exceeded in individual cases. One should, therefore, already have two criteria – one that is qualitative and one that is quantitative. The first refers to the kind of proportionate medical procedures for each individual patient; the second refers to the length of time that the medical procedure is used – whether within ordinary limits or not.

The medical procedures that are ordinarily due to a sick person are here especially related to cases where death is considered imminent and this is further emphasised by the licit character of using pain-killers, even though they may shorten life.

These references could lead one to understand ordinary forms of care as being simply those in conformity with practical situations in order to keep a very precarious situation under control and in the end with the goal of ensuring that this final period is as little burdensome as possible for the patient and prepares him in a dignified way for death, in contrast with the exaggerated treatment directed towards prolonging his life at any price.

The last circumstance that is considered as being possibly determining as regards he decision to discontinue the medical procedures is, amongst others, the most relevant and frequent and is today strongly debated because of particular cases that are publicised in an indiscriminate way – the disproportion between *medical procedures and the outcome that is expected*.

The crucial point of the question is therefore: what are the expected outcomes and what is disproportion? Obviously enough, the expected outcomes in the context are radically in contrast with keeping the patient alive at any cost and for the longest possible time until his inevitable final collapse. The reasonably expected result, as something that can be seriously hoped for, cannot be identified with a serious improvement in the life of the patient which is really dignified in human terms, in particular without frequent physical-mental suffering, and endowed with sufficient mental lucidity and sufficient autonomy. Obviously enough, the expected outcomes can of necessity only be referred to that specific health-care situation which involves the patient being near to death.

The disproportion between medical procedures and the outcomes that are hoped for is never easy to establish when we bear in mind, above all else, the contemporary advances in medical science. To this sphere belong, in particular, artificial methods of respiration and nutrition achieved through intubation and/or phleboclysis, accompanied at times by traumatic surgical operations. It is right to quote the reaction of the venerable Pope John Paul II after he had had a tracheotomy which meant he could not speak. He was even led after other forms of treatment to ask that 'he be allowed to go'. One is not dealing here with excluding all forms of resuscitation, above all during the first stage of the outbreak of malady. It is in the exaggerated adoption of such procedures that the question necessarily arises of the proportion or disproportion between these procedures and the outcomes that are expected.

It must also be clear that absolutely certainty as regards disproportion between the outcomes expected and the medical procedures involved cannot be sought. This applies, for that matter, to other conditions: the burdensome character, the dangerousness and the extraordinary character of the medical procedures that are engaged in. Absolute certainty in cases and in choices in practical life is impossible, apart from cases that are totally extraordinary. To seek absolute certainty is to make life impossible. Human decisions are normally dictated by moral certainty, that is to say that certainty based upon motivations that because of the maximum probability lead in a specific direction. In the presence of this moral certainty of disproportion between medical procedures and outcomes that are expected, in practical terms where there is a lack of a valid prospect of real results, the legitimacy of the decision to discontinue the medical procedures is perfectly justified.

Reference has been made to very rare cases of people coming out of a comas which had lasted for years through the continuing of medical procedures by which the patient had been kept in a state of vegetative life. But three questions are obligatory: what is the percentage of these cases? What is the kind of life the patient experiences after coming out of such a coma? And does this return to a life that is supposed to be, but not proved to be, dignified constitute in fact reasonable hope as regards an expected outcome which justifies in all cases a

sensible proportion at the level of 'exaggerated treatment', thus involving the denial of the legality of the decision to discontinue treatment? The expected outcomes must be reasonably clear and seriously based. To prolong a life with a view to results that are totally hypothetical means not to respect the dignity of the human person. If we are called to live with dignity we must also be called to be able to die with dignity. To live through artificial means, and even worse for years, a life that is almost completely vegetative, can this be said to be to live with dignity? And can the death that takes place be said to be a dignified death?

Paul VI, without basing himself on arguments of faith, observed: 'in very many cases would it not be useless torture to impose vegetative resuscitation during the final stage of an incurable illness? The duty of a medical doctor consists, rather, in working to reduce suffering rather than prolonging for as long as possible by any means and in any conditions a life that is not fully human and going naturally towards its end' (Letter of Cardinal Villot, Secretary of State, sent 'in the name of the Pope to the General Secretary of the FIAMC', 3 Oct. 1970', quoted in the *Dizionario Enciclopedico di Teologia Morale*, 1985, G. Davanzo, p. 937).

The legitimacy of the discontinuation of care, in the absence of the results that have been hoped for, is in itself independent of being near to death in situations of suffering of varying degrees of atrocity or even that are without suffering. The legitimacy of the discontinuation of care is solely linked to disproportion in relation to expected outcomes. Possible suffering, even more so if it is atrocious, would only strengthen the legitimacy of the decision to discontinue the treatment in the face of a life that was unbearable. In analogous fashion, the presence or absence of a sufficient mental lucidity is not relevant. The legitimacy of the discontinuation of care in these situations as well depends solely on the disproportion of the medical procedures in relation to the outcomes that are expected.

5. The Right to Die

These observations are unequivocally in favour of the right to die. It is not useless to clarify that the right to die in the immediate and simple sense does not exist. Death is a reality that nobody can escape and that nobody has the freedom to obtain for themselves. But it is understood as a right to decide not to impede the arrival of death in contrast with 'exaggerated treatment', that is to say the continuation of medical procedures in order to keep a patient alive at any cost.

The right to die is thus not in the least in contrast with the right to live, specifically because the right to live includes by its nature the right to a dignified death.

Indeed, death is an integral part of life. If a medical doctor is pro-life he can but be pro-death as well, death prepared for in the most dignified conditions possible.

6. The Fundamental Principle: Freedom

The document that has been examined in this paper has the notable advantage of retrieving the true hierarchy of the most relevant personal decisions, those pertinent to the purpose of one's life, namely the first fundamental value of the human person – freedom.

As has already been observed, the freedom of choice here is limited solely to the patient or to those have the legal right to make such a decision. However, it remains clear that although the medical doctor does not have any right to decide on the discontinuation or otherwise of medical procedures, with adequate information, which can only come from the medical doctor, the patient himself or those who have the right to decide, he will nonetheless be able to assess whether the medical procedures are so burdensome, dangerous, extraordinary or disproportionate in relation to the outcomes that are expected that a decision should be made as to their possible discontinuation.

This therefore involves on the part of the health-care workers a loyalty and honesty that are exempt from tendencies to do the very utmost, even worse if dictated by personal interests, or to see the patient as a guinea pig, on whom experiments can be carried out, albeit with the intention of discovering new efficient remedies but always in a way that is radically opposed to the dignity of the human person. Information and the possible advice of the medical doctor, without *any* attempt to influence the decision of those who have the responsibility of deciding, is thus indispensable, bearing in mind the obligation of the medical doctor to respect and implement legitimate decisions.

In extreme cases, where 'exaggerated treatment' is out of the question, that is to say procedures that are burdensome, dangerous, extraordinary or disproportionate to the outcomes that are expected, it appears obvious that the medical doctor himself can freely decide not to intervene further, solely helping the patient to prepare himself for a dignified death. This is a part of the 'ordinary' practice of the medical profession.

7. The Italian Legal Situation

The document that has been examined in this paper encounters in Italy, still today, the impossibility of being applied because of antiquated legislation which condemns any cause of death of a man because it is in error as regards the term 'euthanasia'. The declaration that is clearly ratified in the document of the *Catechism of the Catholic Church*, which has been examined in this paper, as regards *dying* and *allowing to die*, thereby legitimating the decision to discontinue with medical procedures in the case of well specified conditions, has remained neglected.

There are indeed certain innovative projects for legislation now underway. Probably, the excess of case studies taken into consideration, a concern not to open the door to any form of authentic euthanasia, in strong contrast with the most liberal and the most restrictive cur-

rents, and the usual ill-advised non-acceptance of what is proposed by political opponents, all lead to interminable delays that work totally against the wellbeing of the community and in this case in particular the wellbeing of patients.

The document examined in this paper, in its valuable clarity, should also be of use to legislators in making a distinction between true euthanasia and equivocal and unreal euthanasia, in stressing the true dignity of the human person in both life and death, and in providing essential coordinates, beyond emotionally and not very rational arguments, so as to expound what, on the one hand, cannot be legalised, and, on the other, to legitimate in an explicit way the right to forgo invasive medical procedures and procedures that are opposed to human dignity.

To legitimate does not oblige anyone to engage in a specific choice. Personal freedom must also be respected by the law. Recourse to the essential conditions listed in the document that has been examined could and should be as enlightened as possible. After all, a law in its wording cannot take into consideration all the cases that might be the subject of that law. It is the general subjects, the principles and the determining motivations that constitute the contents of legislation. It is the task of jurisprudence in its examination and judgement of individual cases to specify in a detailed way if and how a particular circumstance falls or not under that law Some cases publicised by the mass media, and many others concealed in the private world, require urgent legislative action.

8. The Biological Testament

The awaited law must also take into account the biological testament, that is to say it must adjudge the juridical validity of the readiness, expressed in conformity with legal norms, of a healthy person who has mental lucidity to want to discontinue medical procedures that are burdensome, dangerous, extraordinary or disproportionate to the outcomes that are expected were he to be near to death. However, this testament encounters opposition for various reasons that are not of interest to the analysis of this paper but which can be summed up, after a certain fashion, in the prediction that the situation at the moment of the ending of the life of the patient can strongly alter his mental state and make him wish to be treated in contrast with what is expressed in his biological testament, which was written in the cold light of day. Two observations should be made. The first is this: a biological testament as well, like any other testament, is not irrevocable. It can always be annulled or perhaps changed. The second is that the mental state of a patient at the extremes of life, especially if he is undergoing atrocious suffering, should not be sufficiently accredited to abolish what was decided when he enjoyed full mental lucidity. This would be to give preference to decisions or, more than decisions, to very strong emotional reactions that gravely diminish his mental lucidity. A biological testament written far from a person's death and in full consciousness should certainly pre-suppose due information from a medical doctor but this does not mean at all that it should be dictated by a medical doctor.

9. Death Faced with Life

The basic problem lies, in definitive terms, in the education both of the health-care classes and of individuals in receiving death as an integral part of life. Not, therefore, as an accident of life, the supreme misfortune that can occur, which should be avoided with all the means to hand, or at least delayed for as long as possible, but as the inevitable conclusion of one's own life which is to be experienced in dignified way like any other moment of life itself.

Life, in an antecedent vision and independent of any religious faith, is a gift that everyone receives but which is not self-given, and which everyone is called to live out in a dignified way by cultivating the riches that are connected with it: the capacity to know, to admire the universe that surrounds one and makes one live, to complete life through one's own creativity pursued in the largest number of spheres, to enjoy that love with which one is surrounded and to which one responds, and to enjoy the solidarity of the human community. The experience of everyone constantly reveals that life, with its satisfactions, is nonetheless accompanied by tribulations, sufferings, worries and failures which burden it and at times make it unbearable.

It is precisely these circumstances that educate us to grasp the true meaning and value of life, from a purely anthropological, non-religious, point of view as well, and the same may be said of death. Whereas life has its positive sides and its negative sides, it is specifically the shadows that most point up the wonders brought out by the light. A person knows himself, the wealth of his life, specifically through its limits and deficiencies. And these limits and deficiencies emphasise its precariousness. Its insuperable direction towards death. Death, an integral part of life, illuminates the value of the fleeting moment, of living with a sense of responsibility towards oneself and the community so that life does fall vainly, wasted.

Maturity, which every person should develop increasingly effectively, to become increasingly fully himself, a fundamental quality of the person, which is never perfect but always able to

grow, essentially involves an understanding of true values and a mastery of one's own instinctive interior movements by directing them towards true values in contrast with emotional and capricious tendencies.

It is this maturity that constitutes the primary element in educating oneself to receive death in a dignified way. A maturity that opens a person to meaning of death as a seal of one's own life, of values that have been looked for, of good that has been performed, despite the weaknesses and the inefficiencies that have accompanied it. A maturity that obscures and transcends reactions of fear, disquiet and anxiety that accompany feeling that one is at the end of life.

The end of something that is worthwhile experiencing through being committed to achieving one's own identity. This document is an incentive and a wish to live the last moments of one's life near to death with a sufficient maturity of emotions in order to receive death in the lucidity of its meaning, so as to open oneself to the decision to forgo further medical procedures, accepting that one cannot impede death.

This is not an imposition. It is an invitation, if one wants an exhortation, both to individual patients and to the medical world to see death in its most pregnant meaning as an integral part of life. The gratitude that is due to medical doctors for all the efforts that they make to save a human life reaches its fullness when their role is joined by forgoing exaggerated treatment, which is in itself inconclusive and deliberately excluded by the patient.

These observations, of a purely anthropological character outside any vision of religious faith, and thus applicable to every human person, acquire great justification for those who, prior and independently of any religious faith, whatever it may be, carry within them the conviction, of varying degrees of steadiness, that there is survival after natural death. This is a conviction which presents death not as an absolute end but as a passage to a life which is indeed unknown, and which infuses comfort and consolation into accepting death more serenely by forgoing medical procedures which must take place in precise conditions.

10. Conclusion

One cannot but be grateful to the Catholic Church which with this document to be found in the *Catechism of the Catholic Church*, which goes back to 1992, and which has been considered in this paper, a document it may be observed that has been unfortunately almost totally neglected, expounds a valid clarification of the solution to many unhappy situations which today provoke so much uncertainty and tribulation and encourage the indiscriminate legitimation of euthanasia.

In providing a precise distinction between true euthanasia, which should always be condemned, and false euthanasia, that is to say the legitimacy of discontinuing with medical procedures that are not suited to a prolongation of life at any cost, namely 'exaggerated treatment', with a specification of what the corresponding conditions are, a fundamental distinction is made between 'making die' and 'allowing to die'.

Human rights are based upon the dignity of the human person, which primarily consists of freedom. It is a part of the freedom of every person to decide about their own destiny when faced with the decisive moment of life – death. This is the subject of this document.

An attempt has been made in this paper to explore its significance as regards its purpose and the conditions that are required. It is an imposition in relation to nobody specifically because it is an expression of personal freedom. The right to die, with the exclusion of exaggerated medical procedures, is one of the rights of the person, which he can freely make use of or otherwise.

It is important, therefore, to clarify the conditions involved and to grasp its consequences for an understanding of life itself and death, which is an integral part of life.

My analysis does not seek to be exhaustive but, rather, wants to refer individuals and legislators to a fundamental principle for the clarification of various situations and the ethical acceptability of possible choices.

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Testimonies

A Protocol of Agreement between the Regional Government of Tuscany and the Ecclesiastical Regional government of Tuscany

Pedro Julião (John XXI): the Physician and Pope of Thirteenth-century Europe

Pastoral care for the Sick–Coming Alive in Uganda

A Protocol of Agreement between the Regional Government of Tuscany and the Ecclesiastical Regional Government of Tuscany for the Regulation of the Service of Catholic Religious Assistance in Structures Admitting Patients of Health-care Companies

The year 2008, the first day of the month of April, the central office of Via Cavour, 18,

BETWEEN

The Regional government of Tuscany, with its central office in Florence, Via Cavour n. 18, represented by its President, Claudio Martini,

AND

The Ecclesiastical Regional Government of Tuscany, with its central office in Piazza S. Giovanni, 3 – 50129 Florence, represented by its President, Cardinal Annio Antonelli, Archbishop of Florence.

GIVEN THAT

1) article 38 of law 23/12/1978 n. 833 envisages that in structures that admit patients of the national health service there must be assured a service of religious assistance and in particular lays down that the organisation of Catholic religious assistance must take place through specific agreements between the local health-care agency and diocesan Ordinaries responsible for the local area;

2) article 11 of law 25/3/1985 n. 21, which contains the ratification and the execution of the agreement between the Republic of Italy and the Holy See making modifications to the Lateran Concordat of 11 February 1929, assures religious freedom and the carrying out of the practices of the cult of Catholics who have been admitted to hospitals, nursing homes and homes for public assistance, and envisages that spiritual assistance for these people is assured by ecclesiastics appointed by the relevant Italian authorities after designation by the ecclesiastical authority and in accordance with the juridical status, the personnel and the modalities established by agreement between such authorities;

3) the regional health-care plan of 1999-2001, part IV, section A, in conformity with what is laid down by the provision cited above, envisaged that health-care companies would be obliged to regulate the organisation of the service of Catholic religious assistance in agreement with the diocesan Ordinaries responsible for the local area and to this end established that the regional Committee would provide, in agreement with the Tuscan Bishops' Conference, a suitable proposal for a special agreement;

4) the Regional Committee, by its decision n. 119 of 7 February 2000, approved the plan of a protocol of agreement with the Regional Government of Tuscany and the Tuscan Bishops' Conference (subsequently signed on 29 February 2000) for the regulation of the service of Catholic religious assistance in structures admitting patients of health-care companies and the proposal for a special agreement to be signed between health-care companies and diocesan Ordinaries;

5) the regional health-care plan of 2002-2005, section 5, point 5.3.2.19, with respect to the service of religious assistance, confirmed the provisions contained in the previous regional health-care plan and committed the Regional Committee to provide for the updating, in agreement with the Ecclesiastical Regional Government of Tuscany, of the proposal for a special agreement that had been adopted;

6) the Regional Committee, by its decision n. 274 of 24 March 2003, implementing the regional health-care plan of 2002/2003, approved the new proposal for a protocol of agreement between the Regional Government of Tuscany and the Tuscan Bishops' Conference (subsequently signed on 24 January 2005) for the regulation of the service of Catholic religious assistance in structures admitting patients of health-care companies and the consequent new proposal for a special agreement to be signed between the health-care companies and the diocesan Ordinaries;

7) the regional health-care plan of 2005-2007, at section 5, point 5.2.2.8, confirmed the provisions made by the previous regional health-care plan of 2002-2004 relating to religious assistance, and envisaged that the Regional Committee would update, in agreement with Tuscan Bishops' Conference, the proposal for a special agreement adopted within the context of the previous health-care plans and communicated this to the Regional Council;

8) to implement what is envisaged by the regional health-care plan of 2005-2007 it is necessary to proceed both to the updating of the proposal for a special agreement for the regulation of the service of Catholic assistance in the structures admitting patients of health-care companies and of the proposal for a special agreement to be signed between the health-care companies and the diocesan Ordinaries;

IT IS AGREED

ART. 1

1. In the present agreement:

a) local health-care agency companies and hospital companies are designated with the term 'health-care company';

b) diocesan Ordinaries responsible in the local area for the Catholic cult are referred to as 'diocesan Ordinary'.

ART. 2

1. The service of religious assistance has the task of assuring in structures that admit patients the exercise of religious freedom, the carrying out of the practices of cult and the meeting of the specific spiritual needs of the Catholic confession, respecting the will and the freedom of conscience of citizens.

2. The present agreement, in conformity with what is laid down by the provisions of the Concordat and of state and regional laws in operation in this area, defines directions and directives for the regulation of the service of religious assistance, as defined in the above point.

3. On the basis of the directions and directives contained in the present agreement and respecting the attached proposal for a special agreement, the health-care companies and the diocesan Ordinaries will sign suitable agreements for the regulation of the service of religious assistance to be assured in the structures that admit patients that are present in the local area of the company.

4. The Regional Government of Tuscany, within six months of the signing of this protocol, will commit itself to open talks between the parties involved for the promotion of agreements intended to define the conditions and the modalities for the extension of the service of religious assistance to the private hospital structures that act under the regime of accreditation by the national health service.

ART. 3

1. The health-care company, in agreement with the diocesan Ordinary, will determine the number of religious assistants to whom will be entrusted the service of religious assistance.

2. The number of religious assistants will be agreed by taking into account the scale of admissions in line with the forecasts of the company concerning the pathway of assistance, in order to assure high quality, efficiency and efficacy in the performance of this service.

The number of religious assistants will be agreed upon according to the following criteria:

- the number of admissions, referring to the previous year;
- the number and scale of the structures that admit patients, their possible distribution between different locations and the way in which they are distributed in the local area under the responsibility of the diocesan Ordinary.

3. Where there are more than one assistant in the same hospital structure or recognised single centre one may identify the figure of the co-ordinating assistant who will be appointed by the diocesan Ordinary.

4. In relation to the diversified needs of religious assistance, in health-care companies in which two more religious assistants are to be designated, the diocesan Ordinary can confer this position not only on priests but in exceptional circumstances on permanent deacons and on women religious to a number not higher than a half of the total number of envisaged assistants.

ART. 4

1. The service of religious assistance is performed by religious assistants employed permanently by the health-care company, after hearing the proposal of the diocesan Ordinary. On the basis of the relevant agreement between the parties, the above service can also be assured by religious assistants appointed under a system of special agreement.

2. In health-care companies in which two or more religious assistants employed under a system of special agreement have to be designated, the diocesan Ordinary and the health-care company can sign a single agreement relating to the various individuals entrusted with religious assistance; their designation or replacement, decreed by the diocesan Ordinary and communicate to the company, does not require a modification of the special agreement in operation.

3. For the performance of religious assistance both in already activated structures that admit patients and in those being planned, the use will be assured of areas for the functions of cult, of areas for religious activity connected with the mortuary services, with connected sacristies, and areas to be used as offices and living accommodation; the number of such areas will be determined in the relevant special agreement signed by the two parties;

4. In order to assure continuity in the service of religious assistance, the health-care company can sign relevant agreements with other health-care companies of the Regional Government of Tuscany or of another Region so as to address situations where there are difficulties as regards the filling of the positions of religious assistant.

5. The agreements indicated in the above point, in the signing of which the views of the relevant diocesan Ordinaries must be heard, can involve the filling of positions of religious assistant with employed personnel or with personnel who are given the position under a regime of special agreement.

ART. 5

1. The resolution of possible controversies between the health-care company and the diocesan Ordinary regarding the interpretation or the application of the agreements referred to in art. 2 point 3 is a matter for a regional commission.

2. This regional commission will be created specifically whenever a controversy arises in cases referred to in the above point.

3. This regional commission, which will be appointed by the Regional Committee, will be made up of:

a) a member designated by the Regional Committee;

b) a member designated by the Ecclesiastical Regional Government of Tuscany;

c) a member designated jointly by agreement between the members appointed as of a) and b) above.

ART. 6

The parties agree to assess the acceptance of possible proposals for the addition to, or modification of, this protocol following an initiative of the relevant ecclesiastical organs.

CLAUDIO MARTINI
President of the Regional Government of Tuscany

Cardinal ENNIO ANTONELLI
President of the Ecclesiastical Regional Government of Tuscany

Pedro Julião (John XXI): the Physician and Pope of Thirteenth-century Europe

Pedro Julião was born in Lisbon in about the year 120 (his date of birth is placed by various authors between the year 1210 and the year 1226). We know very little about the family into which he was born. In the view of some his surname is a patronymic (his father is said to have been called Julião) but in the view of others it comes from the parish of S. Julião in Lisbon (where it is said that he was born). Some think that the surname of his father was Rebolo (or Rebello or Rabello) and in the view of others his father was a physician.

After studying with success at the cathedral school of Lisbon (and perhaps also at the school of Santiago de Campostela) he was sent by his family to Paris to attend what was then thought to be the most prestigious university of the whole of Christendom (at the time Alberto di Bolstadt, Sigieri di Brabante and William Shireswood taught there and Thomas Aquinas, Bonaventure and Roger Bacon studied there). At this university he followed all of the disciplines of the Faculty of Arts and obtained the title of magister. He also probably subsequently attended a course in theology. To his stay in Paris he owed the name 'Petrus Hispanicus' (because he was a student of the *natio hispanica* of the *Studium*), by which he came to be principally called by those who came after him. Lastly, he engaged in the study of medicine at the University of Montpellier or (more probably) at the *Scuola Medica Salernitana* (it appears that he also went to Sicily to the court of Frederick II)

In the 1340s Pedro Julião, who was by then well versed in nearly all the branches of medieval knowledge (indeed he could be defined a *clericus generalis*), began his activities as a lecturer. Perhaps he taught logic for a period of time in the Kingdom of Castile and Lyon and perhaps he was also at the University of Toulouse where he may have taught natural philosophy. It is certainly the case that from the year 1246 onwards he was Reader in Physics at the *Studium* of Sienna where he remained at least until the year 1252.

In the 1350s he began a brilliant ecclesiastical career, becoming Dean of Lisbon and then Archdeacon of Braga in Lisbon. During this period he took part in the disputes between Alfonso III and the Portuguese clergy. To begin with he supported the positions of the monarch but he later entered into conflict with him.

In the 1360s he frequented the papal curia with a certain assiduousness in the various Italian localities he lived in (Anagni, Orvieto, Viterbo). In particular he was connected to Cardinal Ottobono Fieschi and he became a member as a medical consultant of this Cardinal's curia and accompanied him on a number of his journeys as a pontifical legate under Pope Clement IV.

In May 1272 Pedro Julião was elected Archbishop of Braga; in February 1273 the Pope appointed him prior of the college of the Church of St. Mary of Grimarães which was also in Portugal. Pope Gregory X, whom he had probably met when they were both students of the University of Paris, summoned him on 13 April 1273 to the Second Council of Lyons and on 3 June 1273 he was made the Cardinal-Bishop of Tuscolo. In the view of some historians he also occupied the position of pontifical archiater under Pope Gregory X (for the period 1271-1276), even though there is no sure evidence on the matter.

After the brief pontificate of Innocent V (from January 1276 to June 1276) and the even shorter pontificate of Adrian V (from July to August of the same year), at a conclave that was held in Viterbo in September 1276 Pedro Julião was elected Pope, with the powerful backing, it appears, of the influential Cardianal Giovanni Gaetano Orsini, the Dean of the Cardinal's College and the future Pope Nicholas III. The new Pope took the name of John XXI, even though the previous Pope to have been called John was John XIX (1024-1032). Probably what was borne in mind at the time in adding up the number of Popes who had been called John was another John who had reigned (he was elected Pope but not consecrated) for about four months between the end of the pontificate of John XIV (984) and the beginning of the pontificate of John XV (985).

In the first months of his pontificate John XXI followed the direction taken by his predecessors, Gregory X and Adrian V, and bore in mind the indications of the Council of Lyons (May-July 1274). He concerned himself with the procedures for the election of the Pope and announced a future reform of the conclave; he strove to strengthen papal power against temporal power; engaged in work of mediation in the conflicts between the Christian kingdoms (such as the controversies between Phillip III of France and Alfonso X of Castile); attempted to draw the Greek Church nearer in order to integrate it into the Roman Church; and preached the need to launch new crusades to counter Arab expansionism and convert the infidels. He also intervened in the dispute in Portugal which for a number of years had witnessed King Alfonso opposed to the Lusitanian Church. Pope John XXI invited the monarch not to reduce the privileges or the patrimony of the clergy. He also intervened in the contrast that had arisen at the University of Paris between Bishop Étienne Tempier and a number of lecturers who professed the doctrines of Averroes. The Pope invited this bishop to send a detailed report on the dispute

which in reality had witnessed the theological orthodoxy rooted in the thought of St. Augustine, influenced by neo-Platonism, in conflict with the doctrinal positions (which were considered heterodox by some theologians) of St. Thomas Aquinas who went back to the thought of Aristotle through such Arab authors as Avicenna and Averroes.

It seems, however, that after becoming Pope, Pedro Julião continued to dedicate himself to science and learning. In the view of some biographers, these studies distracted him from an effective government of the Church which was too often left in the expert hands of Cardinal Giovanni Gaetano Orsini. With the probable aim of continuing his beloved scientific and philosophical studies in solitude and tranquillity, John XXI had a new wing built onto a papal palace in Viterbo. This part of the papal apartments collapsed in 1277, bringing down the Pope with it, who died from his wounds in 20 May 1277. John XXI was buried in the cathedral of Viterbo in a tomb placed in the left nave where he is referred to as *Joannes Lusitanus XXI Pontifex Maximus*.

Pedro Julião was a physician and a philosopher as well as being an ecclesiastic. As a physician and philosopher after his death he was held to be the author of a large number of works, the attribution of which, however, is not always certain.

As regards medicine he was unanimously attributed with the authorship of the tract *Thesaurus pauperum*, a compendium of remedies taken from the three kingdoms of nature, at times deduced from previous prescriptions at times worked on by the same author. This book constitutes a practical primer to treat the most common maladies according to the dictates of the science of the time in which rational elements were mixed with fantastic elements and empirical elements were mixed with elements of magic. Thus, for example, the herb bettonica was advised for colic pain, bitter almonds as a diuretic, parsley against urinary stones, red coral for haemorrhages, the bones of the heart of a deer for heart disease, and for epileptic attacks people were advised to carry on their person the written names of the three wise men. Other works of medicine generally attributed to Pedro Julião were: *De aegritudinibus oculorum et curis*, *Tractatus mirabilis aquarum*, *De febribus*, *Dietae super cyrurgia*, *De phlebotomia*, and *Summa de conservanda sanitate*.

As regards philosophy, *Summulae logicales* was unanimously attributed to this Portuguese scholar. This was a tract on logic divided into twelve books, organised in a clear and schematic fashion. This work enjoyed widespread and lasting appreciation in the universities of Europe such as to become the most commonly used textbook on logic from the medieval period until the Renaissance. The great success of this text with medieval students was probably due to the ease with which it could be assimilated mnemonically at a time when written texts were rare and expensive (the similar success of *Regimen sanitatis salernitanum* derived from the ease with which one could remember the verses of which it was composed). Other works of philosophy attributed to Pedro Julião were: *Syncategoremata*, *Scientia libri de anima*, *Liber de morte et vita et de causis longitudinis ac brevitatis vitae*, and *Expositio librorum Beati Dioniysii*.

This Portuguese philosopher-physician conserved a certain fame during the period immediately after his death, and to the point of being cited by Dante Alighieri in his *Divine Comedy* with the following words '*Pietro Ispano/lo qual già luce in dodici libelli*' (Paradise, XII, vv. 134-135). However with the passing of time, and despite the lasting fame of a number of his works (above all else *Thesaurus pauperum* and *Summulae logicales*), his intellectual production began to be less appreciated by those who came after him. This may in part have been because Pedro Julião used Latin translations from Arab authors for his comments on ancient texts, whereas shortly afterwards the first humanists used Latin translations based directly on the original Greek texts. In addition, his works, although they belonged deeply to the Christian-based culture of the medieval period, were soon put in the shade by the philosophical-theological synthesis achieved by thinkers who were contemporaries of his but of greater stature, such as, for example, Alberto Magno and Thomas Aquinas.

As Pope, John XXI was the subject shortly after his death of malevolent gossip which depicted him as a man with a weak character, more inclined to philosophical speculations and scientific research than diplomatic affairs and matters of state. In particular, stress was laid on his interests in alchemy and magic (which for that matter characterised the *forma mentis* of the medieval intellectual), with the imputation of the tragic circumstances of his

death to unspecified secret experiments.

The historian of medicine, Kurt P. J. Sprengel, in his 'A Pragmatic History of Medicine' (Halle, 1792-1799) expressed a rather severe judgement on John XXI when he wrote 'historians state that he was a wiser physician than he was a wise Pope. But neither as a physician nor as a writer did he gain the esteem of posterity'. For his part Abbot Renè François Rohrbacher, in his 'A Universal History of the Catholic Church' (Italian edition Turin 1864-65), expressed a substantially positive judgement on Pope John XXI. Indeed, he praised his activity as a university lecturer in medicine ('he enjoyed a reputation as regards medicine…he favoured poor students and gave them financial help') and stressed his profuse activity as Pope in simplifying the procedures for the election of the Supreme Pontiff, thereby working against the inconvenience of long vacancies as regards the Holy See.

More recently, authors have expressed strong puzzlement as regards the attribution to Pedro Julião of the entire scientific-philosophical corpus handed down to us as being of his authorship. However, they have tended to reassess his role in the specific sphere of medieval scholastics (in so much as he was the codifier of his *Logic* and the initiator of empiricist positions).

It is not to be excluded that new studies and further research will manage to remove for ever the patina of mediocrity and marginality that have been accumulated, perhaps unjustly, over time by this Portuguese physician and scholar who became Pope in Rome and entered history with the name John XXI.

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Bibiographical References

A.A.V.V., *Vite dei papi* (Mondadori, 2006).

N. ABBAGNANO AND G. FORNERO, *Protagonisti e Testi della Filosofia: la Patristica e la Scolastica* (vol. A, tome 2) (Milan, 2000).

M. ALIVERTI, 'Nascita e sviluppo delle dottrine mediche', *In tema di medicina e cultura*, 90, XVI, March-April 1984.

L. BACARINI, *Appunti sulla farmacopea medievale. Il Thesaurus Pauperum di Pietro Ispano* (Udine, 2005).

D. BARDUZZI, 'Di un maestro dello studio senese nel paradiso dantesco', in A.A.V.V., *Dante e Siena* (Siena, 1921).

J. CARRERAS ARTAU, 'Pierre d'Espagne, Pape Jean XXI' in J. Carreras Artau and J. Tusquets Terrats, «*Apports hispaniques à la philosophie chrétienne de l'occident* (Louvain-Paris, 1962).

F.M. GETZ, 'Pietro Ispano (papa Giovanni XXI)' in R. Porter (ed.), *Dizionario Biografico della Storia della Medicina e delle Scienze Naturali* (Milan, 1985-89).

L. GUALINO, *Storia medica dei romani pontefici* (Turin, 1934).

J.F. MEIRINHOS, 'Giovanni XXI' in A.A.V.V., *Enciclopedia dei Papi* (Rome, 2000).

A. SABA, *Storia dei papi* (vol. I) (Turin, 1945).

Pastoral Care for the Sick–Coming Alive in Uganda

Introduction

Pastoral care for the sick consists in curing the sick and the suffering – making them hear Christ's voice; in feeding them to the point of giving up our life for them; in gathering them all in Christ's sheepfold; in defending them against wolves.[1] In a broad sense it consists in teaching, sanctifying and governing in the world of health and sickness.

The mission to care for the sick and promote health was entrusted to the Church by Christ: "And as you go, proclaim that the kingdom of Heaven is close at hand. Cure the sick, raise the dead, cleanse those suffering from virulent skin-diseases, drive out devils".[2] Pastoral care for the sick is therefore an action of obedience of the Church to Jesus Christ[3] and a participation in his grace of healing and care.

Faithful to the mandate the Church from her very beginnings has continued through the centuries the mission of teaching and healing the sick; so that we can rightly say that healing within the mission of the Church is not an option - something to be confined to the elite, or an extra/peripheral service which the Church may or may not perform, rather it is an integral part of what the Church mission is all about.[4]

In Uganda, caring for the sick has been a prominent part of the Catholic Church's mission since its establishment. Wherever the early missionaries established a mission with a church and school, there was also a dispensary to care for the sick. The dispensary for many early Christians was indeed the place where they first made encounter with the Good News of Christ through assistance to the suffering. Their environment was primitive yet their courage and commitment to the healing mission of Christ never wavered.

Based on their witness, the Catholic Church in Uganda today is proud to offer a formidable health care network comprising 27 hospitals, 12 training schools for nursing and midwifery, and 230 health units scattered in all corners of the country.

1. Health Care Challenges

Today care for the sick continues to be a question which involves and touches forcefully each one of the baptized. Today when the reality of the HIV/AIDS pandemic continues to bring home to all of us the suffering and dying across the country; when the geographical access to health care is still limited to a lesser population and even access to medicine for easily treatable diseases is still a challenge; today when many suffering people are still prey to the deceptive and pagan practices of witchcraft; when the cancer of corruption continues to eat away the resources at the expense of the lives of vulnerable groups; when poverty and illiteracy are still the underlying causes of poor health, not to mention serious and worrying health issues like arbotion pastoral care for the sick continues to be a question that involves and touches forcefully each of us the baptized. And so we continue to ask ourselves: "What kind of Action and what kind of Pastoral Action should we as the Church engage in, to respond in a healing way to the demands for health which either implicitly or explicitly come to us from those who live in this, our present society?"

A Task Force is Declared

The Health Commission of the Episcopal Conference at its meeting of 25 April 2001 saw the need to improve pastoral care for the sick. Earlier in 2000, the Executive Director of the Uganda Catholic Medical Bureau, Br. Daniele Giusti, had observed that while the Church in Uganda had invested a great deal in health infrastructure and service provision, somehow it seemed to have forgotten that our reason for health care is that the sick encounter in the context of their illness the Person of Christ.

This led the UCMB[5] being asked to set up a task force to look into the whole area of pastoral care at every level nationwide.

The declared objective of the Task force was "To Charter the way forward for the improvement of pastoral care of the sick". The task force set about its work at a specifically convened workshop.

Introduction of C.P.E[6] Training

Following the recommendations of the Pastoral Care for the Sick Task Force, clinical pastoral training for personnel of Catholic health services was started in 2002. Fr. Tom O'Connor, a Camillian priest in Uganda, identified the first supervisor (Fr. Anselm Zambotti) for formation in clinical pastoral education. Pastoral workers were chosen from various hospitals and health centers. The first group of trained Clinical Pastoral workers was mandated in April 2003. From 2003 to date, over 25 clinical pastoral workers have been trained. These are now working in cooperation with chaplains in the Catholic health institutions.

Each C.P.E unit is a programme of training lasting 10 weeks (40 hours per week) under the guidance of a supervisor. The weekly progamme include 10 hours of teaching, 3 hours of interpersonal supervised group interaction, one hour of individual supervision and 27 hours of clinical practice. In 2007 for example, the CPE units run as follows: Jan-

uary 8 – March 16 2007 and August 20 – October 26 2007. After 6 months from the time a pastoral worker has a CPE unit, he or she is invited for a refresher or continuing education. Through the presence of trained clinical pastoral workers within our hospitals, we begin to experience a movement from the traditional and sole presence of a chaplain

with his irreplaceable sacramental ministry to the new form of "chaplaincy" where religious and lay people bear witness to their faith among the sick and provide spiritual assistance. This represents an innovating experience because it is a task which must be carried out in a team.

Pastoral Care for the Sick Committee Established

As a follow-up to the abovementioned task force and given the increased sensitization on pastoral health care issues, in 2004 a pastoral care for the sick committee was established. This is now a permanent committee of the Health Commission of the Ugandan Episcopal Conference.

It comprises an appointee of the Health Commission, a UCS[7] Pastoral Department Executive Secretary, 2 ex-officios, and two co-opted members according to need.

This committee is charged with:

Promoting and strengthening clinical pastoral education in Catholic health services.

Planning and co-ordinating initiatives, activities and training in CPE.

Planning and organizing propedeutic courses/ongoing formation courses

Assessing suitability of candidates for CPE training.

Preparing a budget for the statutory and extraordinary meeting of the committee.

Establishing and managing a library for the committee and health pastoral care workers

In the long term, this committee should become the nucleus of a certifying Catholic body recognizing the validity of clinical pastoral trainees.

The Pastoral Care for the Sick Desk Co-ordinator

To oversee the effective work of the pastoral care for the sick committee, and to enhance the introduction and growth of professional pastoral care for the sick in RCC[8] health institutions, a national pastoral care for the sick coordinator was appointed in 2007 – with a desk at the Uganda Catholic Medical Bureau offices. This is:

i) Advocate for the pastoral care of patients and staff in Catholic hospitals.

ii) Collaborate with hospital administrations to enhance the quality of pastoral care offered in Catholic hospitals.

iii) Cooperate with bishops especially the bishop in charge of health concerning all issues related to pastoral care in Catholic hospitals.

iv) Inform the Uganda Catholic Medical Bureau and Health Commission of the works of the pastoral care ministry.

v) It is the secretariat to the Standing Committee for the Pastoral Care for the Sick and implements its decisions.

vi) Coordinate communication with pastoral caregivers and promote their ongoing education

vii) Accept applications for CPE and present them to the standing committee for approval.

viii) Handle the day-today correspondence and record-keeping of the Pastoral Care Office.

The Coordinator of the PCS Desk will operate under the direct supervision of the Executive Secretary of the Uganda Catholic Medical Bureau and account to him and to the Standing Committee for Pastoral Care for the Sick established by the Health Commission.

Working in close collaboration with the Pastoral Care for the Sick desk are the Camillian missionaries in Uganda.

The Camillians and Pastoral Care for the Sick

The Church's concern for an improvement in pastoral care for the sick has been taken to heart among others by the Camillian missionaries in Uganda. The Camillians are the members of the Order of St. Camillus – the patron saint of the sick and health-care workers. It is an international congregation of missionary priests, brothers, sisters and lay volunteers whose charism is to minister to the sick.

The Nyenga Mobile AIDS Clinic

In Uganda, the Camillian Missionaries (Anglo-Irish province) arrived in the year 2000 and are presently working in Nyenga hospital. Here they are operating a mobile clinic for AIDS patients – bringing medication and food for the dying and orphaned children. Fr. Tom Smith and

Fr. Fidelis Mushi work to provide pastoral care, palliative care and pastoral counseling to the patients and to the staff in the hospital and to the sick in the villages.

Fr. Tom O'Connor, who is pioneer and head of the mission in Uganda, is a member of the task force appointed by the Health Commision to charter a way forward for pastoral care for the sick in Uganda. He further identified Fr. Arnaldo Pangrazzi, a Camillian and Professor at the Camillianum.[10] Fr. Arnaldo has 5 times travelled to Uganda, where he has held animation/sensitization courses to different groups of people – priests, religious, nurses and volunteers in various dioceses.

Animation of Bishops

Following the example of St. Camillus, whose innovative method of teaching others how to care for the sick was not strictly the didactic method but one that belongs to the area of animation, Fr. O'Connor went out to begin animation starting with the bishops.

From his early experience, he narrates :" It is only since I came to Africa . that I got to know the "geography" of a bishops' range of ministry." In a short space of time, I got to know one or two of our Bishops on a personal and friendship level. One Bishop, pointing his finger inwards towards himself said: "I need animation when it comes to care for the sick."

From the brief but close encounters with the bishops, Fr. O'Connor sympathized with the bishops who in their busy administrative schedule are unable to give themselves quality time among the sick. Yet the here and now needs of the sick, from a pastoral point of view, can far outweigh even the most obvious needs of administration.

In other words, who needs animation? He asked himself. We all do and that includes the bishop who risk as much as any of us falling into the trap of being caught up in the administration problems to the detriment of their clear role as father, pastor and as such animator of their flock. Fr. O'Connor's animation encounters with the bishops are still being geared towards enabling them to think and devise distinct diocesan programs for the sick in hospitals and in their communities and homes.

Training of Priests

Pastoral workers in health need formation and special training. Thanks to the animation work of the Bishops, the Anglo-Irish Camillian province has set out a training program for diocesan priests in pastoral health care. A contractual arrangement with various Bishops in Uganda is made whereby, a carefully chosen priest from the diocese is seconded to the Order for a period of 4 years.

The selected priest must be a man of good standing and with a proven pastoral record of particular concern for the sick. He must be keen on and capable of learning. He must have some leadership qualities and as well be open to the wider church perspective in theology and ministry.

In the first 2 years, the priest has a training at the Camillianum in Rome. The second 2 years the priest lives with the Camillian community to practice and gain familiarity with the sick and with pastoral animation. Already 3 priests from the Kampala, Masaka and Kiyinda-Mityana dioceses have completed at Camillianum and are now putting in practice the knowledge acquired in Rome. 5 priests are still on training in Rome.

Still, within the training program of priests, courses are being arranged for the in-service parish priests and their curates. The above-mentioned Fr. Arnaldo Pangrazzi has accordingly held a number of short courses for the in-service clergy. The purpose of his encounters with the clergy has always been:

– First to enable the clergy to rediscover that pastoral care of the sick is not a peripheral service which the Church may or may not perform, rather it is an integral part of the Church's mission.

– To enable them to appreciate that in caring for the sick love is essential but not enough. It is also necessary to have certain skills in order to offer service with competence. Only competent hands manage to provide the therapeutic love which the sick person needs[11].

– To challenge them to move from a sacramental approach to a more integral and inclusive approach where the sick is not viewed as a mere sacramental case but as a person in need of respect, friendship and human warmth

– To stimulate them towards zealously sensitizing the faithful in parishes towards individual responsibility in promoting health care and caring for the sick, drug addicts, alcoholics, the aged and lame – but especially AIDS victims. And so gradually there can be a move from pastoral care which is solely hospital centered to a community-based care ministry.

– But above all, training of the in-service clergy has been geared towards what Francisco Alvarez called "An understanding that in our activity, curing and evangelizing are infectious, as it were or by osmosis". That is to say "training which does help the priests to become thoroughly familiar with their own therapeutic resources, for example, their own inner world, their reactions to the "serious side" of life, which does foster assimilation of their own penumbra and wounds, and which does aid in becoming reconciled to one's death."

Prospects for the Future of Pastoral Care for the Sick in Uganda

Through the above initiatives and others to come, we look forward to:

– Consolidating religious service in Catholic hospitals and health care institutions. We keep in mind that religious service cannot act on its own, independently of other ser-

vices, but must be part of the health facility's general organization.

– Fostering humanness in hospital care. Part of fostering humanness is preferential attention to the most abandoned and diminished of the sick, those who suffer most, as well as defending the rights of patients.

– Establishing a link between hospitals/clinics and the parish community. The parish community must be familiar with the field of health and the sick in and out of the hospitals (in the homes and communities). Thus from the parish community, groups of the Friends of the Sick can be foreseen and organized.

– Creating an increased awareness in the heart of every Christian and every Christian community that the apostolate among the sick is a responsibility of us all – and not only of health workers and priests alone. We are all responsible. In so doing we hope to gradually move from clericalised pastoral care to an ecclesial care that is the task and responsibility of the entire family of God.

Conclusion

In conclusion, today more than ever, the health care ministry in Uganda is encouraging reflection based on faith by pastoral workers in the health field. The goal is to deepen Gospel commitment and also promote exchanges, coordination, and structuring of health apostolate as part of the overall pastoral care in the Church. Thus, there is a gradual creation or renewal of areas and action attempting to foster insight into the task of evangelizing and humanizing the world of health.

Following the above developments, we rightly observe that the will and the way to enhance pastoral care in health is present and real in Uganda. The recovery of this pastoral dimension in health requires a deep synergy between the Bishops, priests, health institutions and Christian communities.

Together as a Church, which is the people of God, we must work together, beginning with the resources of our own skills and responsibilities, the resources of science and medicine, and above all with the great resource of our faith in Christ which gives us the assurance that God is always stronger than illness and death. May Mary Health of the Sick and the Ugandan Martyrs, our models in Christian suffering, continue to pray for us!

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Notes

[1] BARRAGAN LOZANO (Cardinal), Health Pastoral Car in "Dolentium Hominum" 62 (2006), p. 29.
[2] Matthew 10: 7
[3] TETTAMANZI DIONIGIO, The Italian Bishops' Conference and Evangelisation in the field of Health Policy and Care, in "Dolentium Hominum" 20 (1992), p 43.
[4] Dolentium Hominum No.1
[5] UCMB – Uganda Catholic Medical Bureau. This is the national coordinating body of Catholic health care services in Uganda. The Bureau is located at the Catholic Secretariat (Nsambya).
[6] CPE – Clinical Pastoral Education
[7] UCS – Uganda Catholic Secretariat
[8] RCC – Roman Catholic Church
[9] PCS – Pastoral Care for the Sick
[10] International Institute of Pastoral Health Care theology in Rome
[11] SANDRIN L., A Church as a healing community, in "Dolentium Hominum" 37 (1998), p. 73
[12] FRANCISCO ALVAREZ, The Challenge of Training for the Health Apostolate, in "Dolentium hominum" n.32 - 1996, p.23-24