DOLENTIUM HOMINUM

N. 69 – Year XXIII – No. 3, 2008

JOURNAL OF THE PONTIFICAL COUNCIL
FOR HEALTH CARE WORKERS
(FOR HEALTH PASTORAL CARE)

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

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

Printed by Editrice VELAR, Gorle (BG)

Cover: Glass window Rev. Costantino Ruggeri

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

Contents

The illustrations in this edition are taken from the book:
L'amore di Dio per noi, il Vangelo
published by Editrice Velar, Gorle (BG)

World Day of the Sick*
February 11, 2009

The Vatican City, 13.01.2009

Prot. N. 34.447/09

Your Eminence/Excellency,

We are by now near to 11 February, the liturgical memorial of the Blessed Virgin Mary of Lourdes and the annual celebration of the World Day of the Sick, according to the institutive Letter of 13 May 1992 of the Servant of God, the late lamented Pope John Paul II.

In this regard, I would like to observe the instructions of His Holiness Pope Benedict XVI who, through His Eminence the Cardinal Secretary of State, instructed that "*the annual celebration of the World Day of the Sick on 11 February remaining, I have instructed that this most solemn Celebration in the various continents, after that already celebrated in 2007 in Korea, will take place every three years, to conform to other similar Days, like that of Youth and that of the Family, and so that increasingly careful preparations can be engaged in*".

Thus the next most solemn Celebration of the World Day of the Sick will take place in the year 2010, in a place to be established.

I emphasise, once again, the importance and the value of this Day, which must be celebrated each year in a way that takes into account local needs and circumstances. Initiatives should always be promoted that involve, in addition to dioceses, Christian communities and religious families that are involved in pastoral care in health, also health-care workers, volunteers and all those who work in civil society for care for, and assistance to, the sick.

It is specifically the sick who are the protagonists of the celebration of this Day; in appreciating suffering to the full, we help the sick to suffer their pain in full and absolute communion with Christ in his passion, death and resurrection, and thus as a source of redemption and happiness. In this way they complete in their own bodies what is missing in the passion of Christ (Co 1:24; John Paul II, Apostolic Letter *Salvifici doloris*, n. 1). This is the principal meaning of this Celebration.

The Holy Father Benedict XVI in his Message of last year strongly called for a celebration of the World Day of the Sick throughout the Church and observed: *"I invite the diocesan and parish communities to celebrate the World Day of the Sick*" (Message WDS, 2008, n. 5). The various initiatives that will be taken in this field, according to a theme chosen locally and following the needs of the places that people work in, should always be essentially directed towards promoting the spiritual and moral formation of health-care workers and invoking the value of the importance of religious assistance for sick people in order to achieve full awareness of the salvific meaning of suffering.

I wish and hope, with the help and assistance of the Virgin Mary, *Salus Infirmorum*, that all those who are involved in the field of pastoral care in health will engage in a complete actuation of this Celebration so that 11 February 2009 will be, for the world of suffering, a Day of universal remembrance and of prayer

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

* Letter sent to the Apostolic Nuncios, Episcopal Conferences, Bishops in charge of Health Pastoral Care, Associations and International Organizations working in the field of health, on the occasion of the World Day of the Sick, February 11, 2009

Apostolic Journey to France on the Occasion of the 150th Anniversary of the Apparitions of the Blessed Virgin Mary at Lourdes

September 12-15, 2008

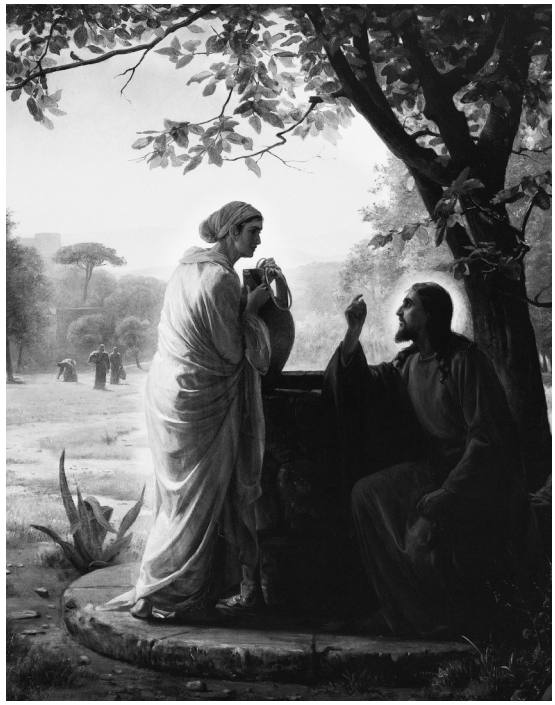
Torchlight Procession
Homily of His Holiness Benedict XVI

LOURDES, ROSARY SQUARE, SATURDAY, 13 SEPTEMBER 2008

Dear Bishop Perrier of Tarbes and Lourdes,
Dear Brothers in the episcopate and the priesthood,
Dear Pilgrims, dear Brothers and Sisters,

One hundred and fifty years ago, on 11 February 1858, in this place known as the Grotto of Massabielle, away from the town, a simple young girl from Lourdes, Bernadette Soubirous, saw a light, and in this light she saw a young lady who was "beautiful, more beautiful than any other". This woman addressed her with kindness and gentleness, with respect and trust: "She said *vous* to me", Bernadette recounted, "Would you do me the kindness of coming here for a fortnight?" she asked her. "She was looking at me as one person who speaks to another." It was in this conversation, in this dialogue marked by such delicacy, that the Lady instructed her to deliver certain very simple messages on prayer, penance and conversion. It is hardly surprising that Mary should be beautiful, given that – during the apparition of 25 March 1858 – she reveals her name in this way: "I am the Immaculate Conception."

Let us now look at this "woman clothed with the sun" (*Rev* 12:1) as she is described for us in Scripture. The Most Holy Virgin Mary, the glorious woman of the Apocalypse, wears on her head a crown of twelve stars which represent the twelve tribes of Israel, the entire people of God, the whole communion of saints, while at her feet is the moon, image of death and mortality. Mary left death behind her; she is entirely re-clothed with life, the life of her Son, the risen Christ. She is thus the sign of the victory of love, of good and of God, giving our world the hope that it needs. This evening, let us turn our gaze towards Mary, so glorious and so human, allowing her to lead us towards God who is the victor.



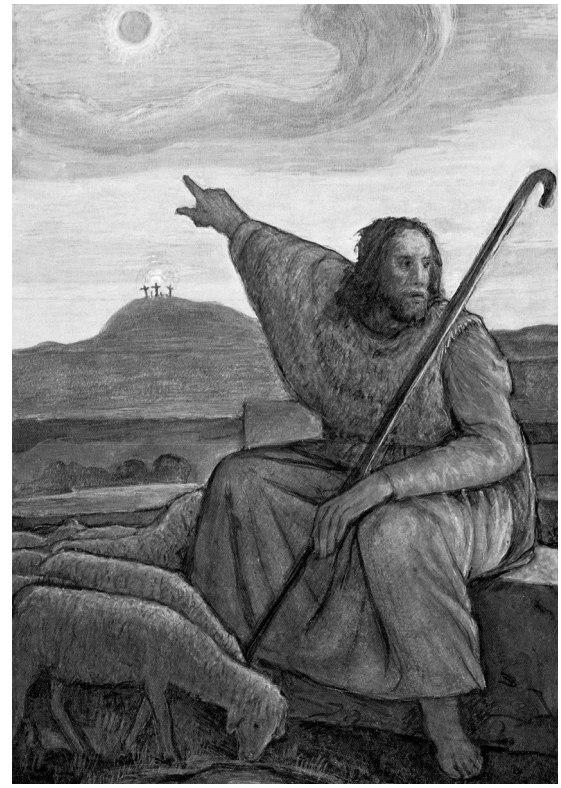
Countless people have borne witness to this: when they encountered Bernadette's radiant face, it left a deep impression on their hearts and minds. Whether it was during the apparitions themselves or while she was recounting them, her face was simply shining. Bernadette from that time on had the light of Massabielle dwelling within her. The daily life of the Soubirous family was nevertheless a tale of deprivation and sadness, sickness and incomprehension, rejection and poverty. Even if there was no lack of love and warmth in family relationships, life at the *cachot* was hard. Nevertheless, the shadows of the earth did not prevent the light of heaven from shining. "The light shines in the darkness …" (*Jn* 1:5).

Lourdes is one of the places chosen by God for his beauty to be reflected with particular brightness, hence the importance here of the symbol of light. From the fourth apparition onwards, on arriving at the grotto, Bernadette would light a votive candle each morning and hold it in her left hand for as long as the Virgin was visible to her. Soon, people would give Bernadette a candle to plant in the ground inside the grotto. Very soon, too, people would place their own candles in this place of light and peace. The Mother of God herself let it be known that she liked the touching homage of these thousands of torches, which since that time have continued to shine upon the rock of the apparition and give her glory. From that day, before the grotto, night and day, summer and winter, a burning bush shines out, aflame with the prayers of pilgrims and the sick, who bring their con-

cerns and their needs, but above all their faith and their hope.

By coming here to Lourdes on pilgrimage, we wish to enter, following in Bernadette's footsteps, into this extraordinary closeness between heaven and earth, which never fails and never ceases to grow. In the course of the apparitions, it is notable that Bernadette prays the rosary under the gaze of Mary, who unites herself to her at the moment of the doxology. This fact confirms the profoundly theocentric character of the prayer of the rosary. When we pray it, Mary offers us her heart and her gaze in order to contemplate the life of her Son, Jesus Christ. My venerable Predecessor, Pope John Paul II, came here to Lourdes on two occasions. In his life and ministry, we know how much his prayer relied upon the Virgin Mary's intercession. Like many of his predecessors in the Chair of Peter, he also keenly encouraged the prayer of the rosary; one of the particular ways in which he did so was by enriching the Holy Rosary with the meditation of the Mysteries of Light. These are now represented on the façade of the Basilica in the new mosaics inaugurated last year. As with all the events in the life of Christ, "which she preserved and pondered in her heart" (*Lk* 2:19), Mary helps us to understand all the stages in his public ministry as integral to the revelation of God's glory. May Lourdes, the land of light, continue to be a school for learning to pray the Rosary, which introduces the disciples of Jesus, under the gaze of his Mother, into an authentic and cordial dialogue with his Master!

On Bernadette's lips we hear the Virgin Mary asking us to *come here in procession* so as to pray with simplicity and fervour. The torchlight procession expresses the mystery of prayer in a form that our eyes of flesh can grasp: in the communion of the Church, which unites the elect in heaven with pilgrims on earth, the light of dialogue between man and his Lord blazes forth and a luminous path opens up in human history, even in its darkest moments. This procession is a time of great ecclesial joy, but also a time of seriousness: the intentions we bring emphasize our profound communion with all those who suffer. We think of innocent victims who suffer from violence, war, terrorism, and famine; those who bear the consequences of injustices, scourges and disasters, hatred and oppression; of attacks on their human dignity and fundamental rights; on their freedom to act and think. We also think of those undergoing family problems or suffering caused by unemployment, illness, infirmity, loneliness, or their situation as immigrants. Nor must we



forget those who suffer for the name of Christ and die for him.

Mary teaches us to pray, to make of our prayer an act of love for God and an act of fraternal charity. By praying with Mary, our heart welcomes those who suffer. How can our life not be transformed by this? Why should our whole life and being not become places of hospitality for our neighbours? Lourdes is a place of light because it is a place of communion, hope and conversion.

As night falls, Jesus says to us: "keep your lamps burning" (*Lk* 12:35); the lamp of faith, the lamp of prayer, the lamp of hope and love! This act of walking through the night, carrying the light, speaks powerfully to the depths of ourselves, touches our heart and says much more than any other word uttered or heard. This gesture itself summarizes our condition as Christians on a journey: we need light, and at the same time are called to be light. Sin makes us blind, it prevents us from putting ourselves forward as guides for our brothers and sisters, and it makes us unwilling to trust them to guide us. We need to be enlightened, and we repeat the prayer of blind Bartimaeus: "Master, let me receive my sight!" (*Mk* 10:51). Let me see my sin which holds me back, but above all, Lord, let me see your glory! We know that our prayer has already been granted and we give thanks because, as Saint Paul says in the Letter to the Ephesians, "Christ shall give you light" (5:14), and Saint Peter adds, "he called you out of darkness into his marvellous light" (*1 Pet* 2:9).

To us who are not the light, Christ can now say: "You are the light of the world" (*Mt* 5:14), entrusting us with the responsibility to cause the light of charity to shine. As the Apostle Saint John writes, "He who loves his brother abides in the light, and in him there is no cause for stumbling" (*1 Jn* 2:10). To live Christian love, means at the same time to introduce God's light into the world and to point out its true source. Saint Leo the Great writes: "Whoever, in fact, lives a holy and chaste life in the Church, whoever sets his mind on things that are above, not on things that are on earth (cf. *Col* 3:2), in a certain way resembles heavenly light; as long as he himself observes the brilliance of a holy life, he shows to many, like a star, the path that leads to God" (*Sermon* III:5).

In this shrine at Lourdes, to which the Christians of the whole world have turned their gaze since the Virgin Mary caused hope and love to shine here by giving pride of place to the sick, the poor and the little ones, we are invited to discover the simplicity of our vocation: it is enough to love.

Tomorrow, the celebration of the exaltation of the Holy Cross brings us into the very heart of this mystery. At this vigil, our gaze is already turned towards the sign of the new covenant on which the whole life of Jesus converges. The cross is the supreme and perfect act of the love of Jesus, who lays down his life for his friends. "So must the Son of man be lifted up, that whoever believes in him may have eternal life" (*Jn* 3:14-15).

As proclaimed in the songs of the Suffering Servant, the death of Jesus is a death which becomes a light for the nations; it is a death which, in intimate association with the liturgy of atonement, brings reconciliation, it is a death which marks the end of death. From that day onwards, the Cross is a sign of hope, Jesus' victory standard, "because God so loved the world that he gave his only Son, that whoever believes in him should not perish but have eternal life" (*Jn* 3:16). Through the Cross, our whole life gains light, strength and hope. The Cross reveals the whole depth of love contained in the original design of the Creator; through the Cross, all is healed and brought to completion. That is why life lived with faith in Christ dead and risen becomes light.

The apparitions were bathed in light and God chose to ignite in Bernadette's gaze a flame which converted countless hearts. How many come here to see it with the hope – secretly perhaps – of receiving some miracle; then, on the return journey, having had a spiritual experience of life in the Church, they change their outlook upon God, upon others and upon themselves. A small flame called hope, compassion, tenderness now dwells within them. A quiet encounter with Bernadette and the Virgin Mary can change a person's life, for they are here, in Massabielle, to lead us to Christ who is our life, our strength and our light. May the Virgin Mary and Saint Bernadette help you to live as children of light in order to testify, every day of your lives, that Christ is our light, our hope and our life!

Blessed Sacrament Procession
Meditation by His Holiness Benedict XVI

PRAIRIE, LOURDES, SUNDAY, 14 SEPTEMBER 2008

Lord Jesus, You are here!

And you, my brothers, my sisters, my friends,

You are here, with me, in his presence!

Lord, two thousand years ago, you willingly mounted the infamous Cross in order then to rise again and to remain for ever with us, your brothers and sisters.

And you, my brothers, my sisters, my friends,

You willingly allow him to embrace you.

We contemplate him.

We adore him.

We love him. We seek to grow in love for him.

We contemplate him who, in the course of his Passover meal, gave his body and blood to his disciples, so as to be with them "always, to the close of the age" (*Mt* 28:20).

We adore him who is the origin and goal of our faith, him without whom we would not be here this evening, without whom we would not be at all, without whom there would be nothing, absolutely nothing! Him through whom "all things were made" (*Jn* 1:3), him in whom we were created, for all eternity, him who gave us his own body and blood – he is here, this evening, in our midst, for us to gaze upon.

We love, and we seek to grow in love for him who is here, in our presence, for us to gaze upon, for us perhaps to question, for us to love.

Whether we are walking or nailed to a bed of suffering; whether we are walking in joy or languishing in the wilderness of the soul (cf. *Num* 21:4): Lord, take us all into your Love; the infinite Love which is eternally the Love of the Father for the Son and the Son for the Father, the Love of the Father and the Son for the Spirit, and the Love of the Spirit for the Father and the Son. The sacred host exposed to our view speaks of this infinite power of Love manifested on the glorious Cross. The sacred host speaks to us of the incredible abasement of the One who made himself poor so as to make us rich in him, the One who accepted the loss of everything so as to win us for his Father. The sacred host is the living, efficacious and real sacrament of the eternal presence of the saviour of mankind to his Church.

My brothers, my sisters, my friends,

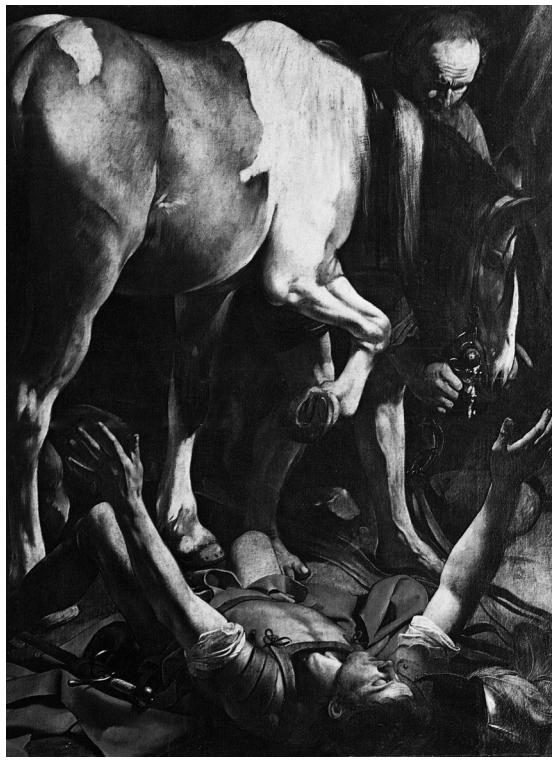
Let us accept; may you accept to offer yourselves to him who has given us everything, who came not to judge the world, but to save it (cf. *Jn* 3:17), accept to recognize in your lives the presence of him who is present here, exposed to our view. Accept to offer him your very lives!

Mary, the holy Virgin, Mary, the Immaculate Conception, accepted, two thousand years ago, to give everything, to offer her body so as to receive the Body of the Creator. Everything came from Christ, even Mary; everything came through Mary, even Christ.

Mary, the holy Virgin, is with us this evening, in the presence of the Body of her Son, one hundred and fifty years after revealing herself to little Bernadette.

Holy Virgin, help us to contemplate, help us to adore, help us to love, to grow in love for him who loved us so much, so as to live eternally with him.

An immense crowd of witnesses is invisibly present beside us, very close to this blessed grotto and in front of this church that the Virgin Mary wanted to be built; the crowd of all those men and women who have contemplated, venerated, adored the real presence of him who gave himself to us even to the last drop of blood; the crowd of all those men and women who have spent hours in adoration of the Most Holy Sacrament of the altar.



This evening, we do not see them, but we hear them saying to us, to every man and to every woman among us: "Come, let the Master call you! He is here! He is calling you (cf. *Jn* 11:28)! He wants to take your life and join it to his. Let yourself be embraced by him! Gaze no longer upon your own wounds, gaze upon his. Do not look upon what still separates you from him and from others; look upon the infinite distance that he has abolished by taking your flesh, by mounting the Cross which men had prepared for him, and by letting himself be put to death so as to show you his love. In his wounds, he takes hold of you; in his wounds, he hides you. Do not refuse his Love!"

The immense crowd of witnesses who have allowed themselves to be embraced by his Love, is the crowd of saints in heaven who never cease to intercede for us. They were sinners and they knew it, but they willingly ceased to gaze upon their own wounds and to gaze only upon the wounds of their Lord, so as to discover there the glory of the Cross, to discover there the victory of Life over death. Saint Pierre-Julien Eymard tells us everything when he cries out: "The holy Eucharist is Jesus Christ, past, present and future" (*Sermons and Parochial Instructions after 1856,* 4-2.1, "On Meditation").

Jesus Christ, past, in the historical truth of the evening in the Upper Room, to which every celebration of holy Mass leads us back.

Jesus Christ, present, because he said to us: "Take and eat of this, all of you, this is my body, this is my blood." "This is", in the present, here and now, as in every here and now throughout human history. The real presence, the presence which surpasses our poor lips, our poor hearts, our poor thoughts. The presence offered for us to gaze upon as we do here, this evening, close to the grotto where Mary revealed herself as the Immaculate Conception.

The Eucharist is also Jesus Christ, future, Jesus Christ to come. When we contemplate the sacred host, his glorious transfigured and risen Body, we contemplate what we shall contemplate in eternity, where we shall discover that the whole world has been carried by its Creator during every second of its history. Each time we consume him, but also each time we contemplate him, we proclaim him until he comes again, "*donec veniat*". That is why we receive him with infinite respect.

Some of us cannot – or cannot yet – receive Him in the Sacrament, but we can contemplate Him with faith and love and express our desire finally to be united with Him. This desire has great value in God's presence: such people await his return more ardently; they await Jesus Christ who must come again.

When, on the day after her first communion, a friend of Bernadette asked her: "What made you happier: your first communion or the apparitions?", Bernadette replied, "they are two things that go together, but cannot be compared. I was happy in both" (*Emmanuélite Estrade,* 4 June 1958). She made this testimony to the Bishop of Tarbes in regard to her first communion: "Bernadette behaved with immense concentration, with an attention that left nothing to be desired … she appeared profoundly aware of the holy action that was taking place. Everything developed in her in an astonishing way."

With Pierre-Julien Eymard and Bernadette, we invoke the witness of countless men and women saints who had the greatest love for the holy Eucharist. Nicolas Cabasilas cries out to us this evening: "If Christ dwells within us, what do we need? What do we lack? If we dwell in Christ, what more could we desire? He is our host and our dwelling-place. Happy are we to be his home! What joy to be ourselves the dwelling-place of such an inhabitant!"

Blessed Charles de Foucauld was born in 1858, the very year of the apparitions at Lourdes. Not far from his body, stiffened by death, there lay, like the grain of wheat cast upon the earth, the lunette containing the Blessed Sacrament which Brother Charles adored every day for many a long hour. Father de

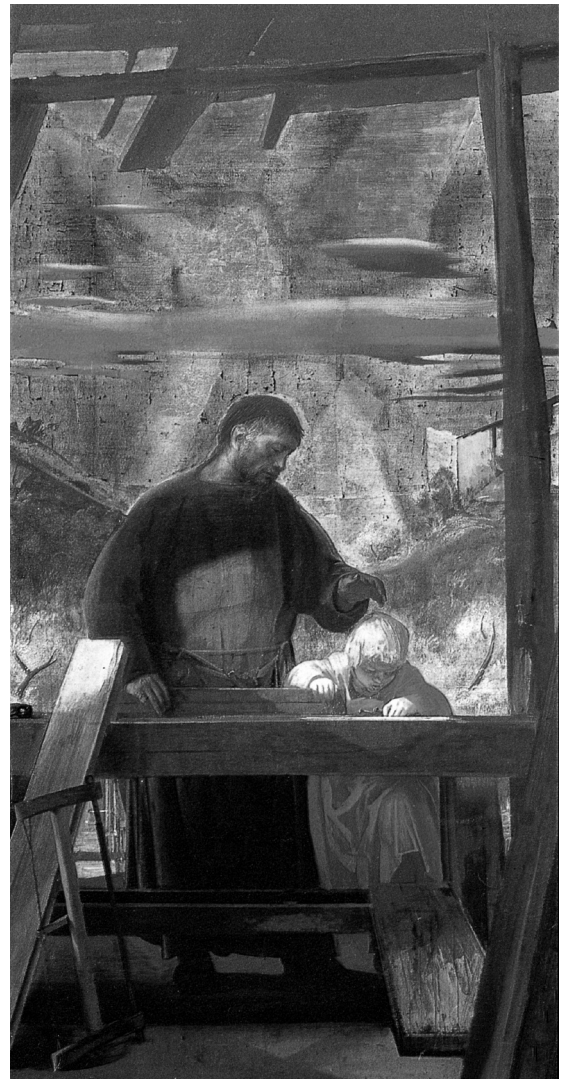
Foucauld has given us a prayer from the depths of his heart, a prayer addressed to our Father, but one which, with Jesus, we can in all truth make our own in the presence of the sacred host:

"'Father, into your hands I commend my spirit.'

This was the last prayer of our Master, our Beloved … May it also be our own prayer, and not only at our last moment, but at every moment in our lives:

Father, I commit myself into your hands; Father, I trust in you; Father, I abandon myself to you; Father, do with me what you will; whatever you may do, I thank you; thank you for everything; I am ready for all, I accept all; I thank you for all. Let only your will be done in me, Lord, let only your will be done in all your creatures, in all your children, in all those whom your heart loves, I wish no more than this, O Lord. Into your hands I commend my soul; I offer it to you, Lord, with all the love of my heart, for I love you, and so need to give myself in love, to surrender myself into your hands, without reserve, and with boundless confidence, for you are my Father."

Beloved brothers and sisters, day pilgrims and inhabitants of these valleys, brother Bishops, priests, deacons, men and women religious, all of you who see before you the infinite abasement of the Son of God and the infinite glory of the Resurrection, remain in silent adoration of your Lord, our Master and Lord Jesus Christ. Remain silent, then speak and tell the world: we cannot be silent about what we know. Go and tell the whole world the marvels of God, present at every moment of our lives, in every place on earth. May God bless us and keep us, may he lead us on the path of eternal life, he who is Life, for ever and ever. Amen.



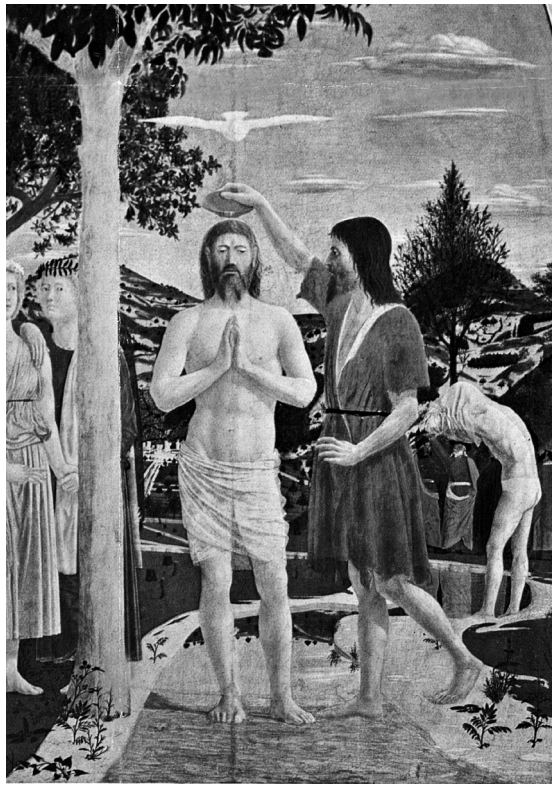
Eucharistic Celebration on the Occasion of the 150th Anniversary of the Apparitions of the Blessed Virgin Mary Homily of His Holiness Benedict XVI

PRAIRIE, LOURDES, SUNDAY, 14 SEPTEMBER 2008

Dear Cardinals,
Dear Bishop Perrier,
Dear Brothers in the episcopate and the priesthood,
Dear pilgrims, brothers and sisters,

"Go and tell the priests that people should come here in procession, and that a chapel should be built here." This is the message Bernadette received from the "beautiful lady" in the apparition of 2 March 1858. For 150 years, pilgrims have never ceased to come to the grotto of Massabielle to hear the message of conversion and hope which is addressed to them. And we have done the same; here we are this morning at the feet of Mary, the Immaculate Virgin, eager to learn from her alongside little Bernadette.

I would like to thank especially Bishop Jacques Perrier of Tarbes and Lourdes for the warm welcome he has given me, and for the kind words he has addressed to me. I greet the Cardinals, the Bishops, the priests, the deacons, the men and women religious, and all of you, dear Lourdes pilgrims, especially the sick. You have come in large numbers to make this Jubilee pilgrimage with me and to entrust your families, your relatives and friends, and all your intentions to Our Lady. My thanks go also to the civil and military Authorities who are here with us at this Eucharistic celebration.



"What a great thing it is to possess the Cross! He who possesses it possesses a treasure" (Saint Andrew of Crete, *Homily* X on the Exaltation of the Cross, PG 97, 1020). On this day when the Church's liturgy celebrates the feast of the Exaltation of the Holy Cross, the Gospel you have just heard reminds us of the meaning of this great mystery: God so loved the world that he gave his only Son, so that men might be saved (cf. *Jn* 3:16). The Son of God became vulnerable, assuming the condition of a slave, obedient even to death, death on a cross (cf. *Phil* 2:8). By his Cross we are saved. The instrument of torture which, on Good Friday, manifested God's judgement on the world, has become a source of life, pardon, mercy, a sign of reconciliation and peace. "In order to be healed from sin, gaze upon Christ crucified!" said Saint Augustine (*Treatise on Saint John*, XII, 11). By raising our eyes towards the Crucified one, we adore him who came to take upon himself the sin of the world and to give us eternal life. And the Church invites us proudly to lift up this glorious Cross so that the world can see the full extent of the love of the Crucified one for mankind, for every man and woman. She invites us to give thanks to God because from a tree which brought death, life has burst out anew. On this wood Jesus reveals to us his sovereign majesty, he reveals to us that he is exalted in glory. Yes, "Come, let us adore him!" In our midst is he who loved us even to giving his life for us, he who invites every human being to draw near to him with trust.

This is the great mystery that Mary also entrusts to us this morning, inviting us to turn towards her Son. In fact, it is significant that,

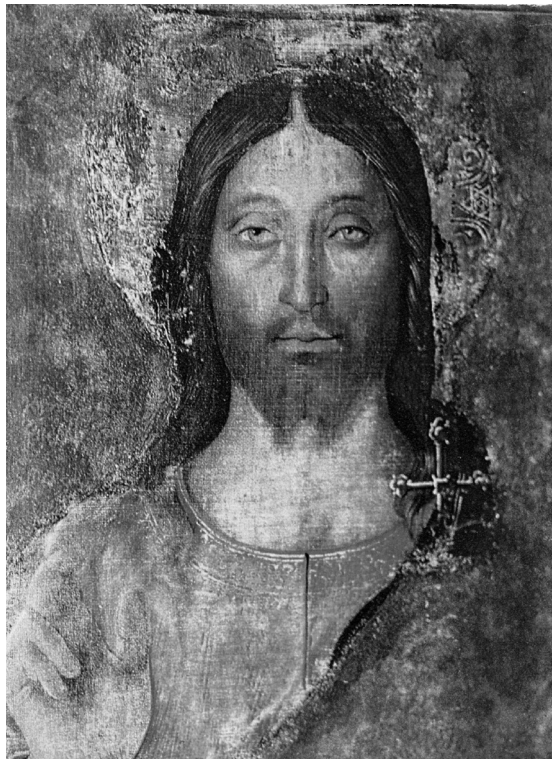
during the first apparition to Bernadette, Mary begins the encounter with the sign of the Cross. More than a simple sign, it is an initiation into the mysteries of the faith that Bernadette receives from Mary. The sign of the Cross is a kind of synthesis of our faith, for it tells how much God loves us; it tells us that there is a love in this world that is stronger than death, stronger than our weaknesses and sins. The power of love is stronger than the evil which threatens us. It is this mystery of the universality of God's love for men that Mary came to reveal here, in Lourdes. She invites all people of good will, all those who suffer in heart or body, to raise their eyes towards the Cross of Jesus, so as to discover there the source of life, the source of salvation.

The Church has received the mission of showing all people this loving face of God, manifested in Jesus Christ. Are we able to understand that in the Crucified One of Golgotha, our dignity as children of God, tarnished by sin, is restored to us? Let us turn our gaze towards Christ. It is he who will make us free to love as he loves us, and to build a reconciled world. For on this Cross, Jesus took upon himself the weight of all the sufferings and injustices of our humanity. He bore the humiliation and the discrimination, the torture suffered in many parts of the world by so many of our brothers and sisters for love of Christ. We entrust all this to Mary, mother of Jesus and our mother, present at the foot of the Cross.

In order to welcome into our lives this glorious Cross, the celebration of the Jubilee of Our Lady's apparitions in Lourdes urges us to embark upon a journey of faith and conversion. Today, Mary comes to meet us, so as to show us the way towards a renewal of life for our communities and for each one of us. By welcoming her Son, whom she presents to us, we are plunged into a living stream in which the faith can rediscover new vigour, in which the Church can be strengthened so as to proclaim the mystery of Christ ever more boldly. Jesus, born of Mary, is the Son of God, the sole Saviour of all people, living and acting in his Church and in the world. The Church is sent everywhere in the world to proclaim this unique message and to invite people to receive it through an authentic conversion of heart. This mission, entrusted by Jesus to his disciples, receives here, on the occasion of this Jubilee, a breath of new life. After the example of the great evangelizers from your country, may the missionary spirit which animated so many men and women from France over the centuries, continue to be your pride and your commitment!

When we follow the Jubilee Way in the footsteps of Bernadette, we are reminded of the heart of the message of Lourdes. Bernadette is the eldest daughter of a very poor family, with neither knowledge nor power, and in poor health. Mary chose her to transmit her message of conversion, prayer and penance, which fully accord with words of Jesus: "What you have hidden from the wise and understanding, you have revealed to babes" (*Mt* 11:25). On their spiritual journey, Christians too are called to render fruitful the grace of their Baptism, to nourish themselves with the Eucharist, to draw strength from prayer so as to bear witness and to express solidarity with all their fellow human beings (cf. *Homage to the Virgin Mary*, Piazza di Spagna, 8 December 2007). It is therefore a genuine catechesis that is being proposed to us in this way, under Mary's gaze. Let us allow her to instruct us too, and to guide us along the path that leads to the Kingdom of her Son!

In the course of her catechesis, the "beautiful lady" reveals her name to Bernadette: "I am the Immaculate Conception". Mary thereby discloses the extraordinary grace that she has received from God, that of having been conceived without sin, for "he has looked on his servant in her lowliness" (cf. *Lk* 1:48). Mary is the woman from this earth who gave herself totally to God, and who received the privilege of giving human life to his eternal Son. "Behold the handmaid of the Lord; let



what you have said be done to me" (*Lk* 1:38). She is beauty transfigured, the image of the new humanity. By presenting herself in this way, in utter dependence upon God, Mary expresses in reality an attitude of total freedom, based upon the full recognition of her true dignity. This privilege concerns us too, for it discloses to us our own dignity as men and women, admittedly marked by sin, but saved in hope, a hope which allows us to face our daily life. This is the path which Mary opens up for man. To give oneself fully to God is to find the path of true freedom. For by turning towards God, man becomes himself. He rediscovers his original vocation as a person created in his image and likeness.

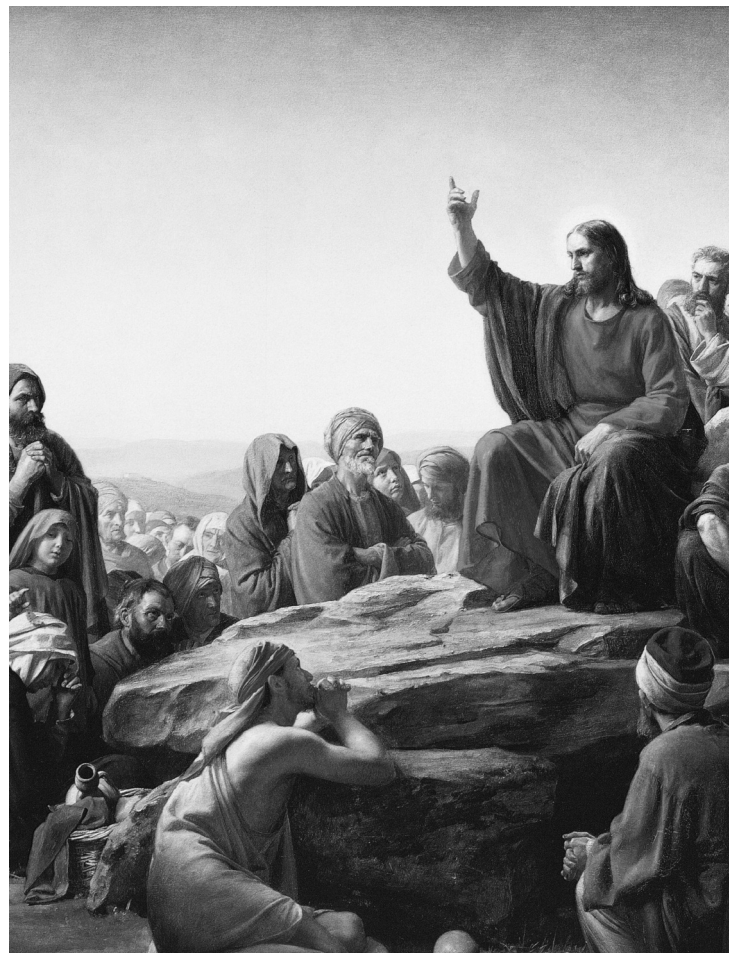
Dear Brothers and Sisters, the primary purpose of the shrine at Lourdes is to be a place of encounter with God in prayer and a place of service to our brothers and sisters, notably through the welcome given to the sick, the poor and all who suffer. In this place, Mary comes to us as a mother, always open to the needs of her children. Through the light which streams from her face, God's mercy is made manifest. Let us allow ourselves to be touched by her gaze, which tells us that we are all loved by God and never abandoned by him! Mary comes to remind us that prayer which is humble and intense, trusting and persevering, must have a central place in our Christian lives. Prayer is indispensable if we are to receive Christ's power. "People who pray are not wasting their time, even though the situation appears desperate and seems to call for action alone" (*Deus Caritas Est*, 36). To allow oneself to become absorbed by activity runs the risk of depriving prayer of its specifically Christian character and its true efficacy. The prayer of the Rosary, so dear to Bernadette and to Lourdes pilgrims, concentrates within itself the depths of the Gospel message. It introduces us to contemplation of the face of Christ. From this prayer of the humble, we can draw an abundance of graces.

The presence of young people at Lourdes is also an important element. Dear friends, gathered this morning around the World Youth Day Cross: when Mary received the angel's visit, she was a young girl from Nazareth leading the simple and courageous life typical of the women of her village. And if God's gaze focussed particularly upon her, trusting in her, Mary wants to tell you once more that not one of you is indifferent in God's eyes. He directs his loving gaze upon each one of you and he calls you to a life that is happy and full of meaning. Do not allow yourselves to be discouraged by difficulties! Mary was disturbed by the message of the angel who came to tell her that she would become the Mother of the Saviour. She was conscious of her frailty in the face of God's omnipotence. Nevertheless, she said "yes", without hesitating. And thanks to her yes, salvation came into the world, thereby changing the history of mankind. For your part, dear young people, do not be afraid to say yes to the Lord's summons when he invites you to walk in his footsteps. Respond generously to the Lord! Only he can fulfil the deepest aspirations of your heart. You have come to Lourdes in great numbers for attentive and generous service to the sick and to the other pilgrims, setting out in this way to follow Christ the servant. Serving our brothers and sisters opens our hearts and makes us available. In the silence of prayer, be prepared to confide in Mary, who spoke to Bernadette in a spirit of respect and trust towards her. May Mary help those who are called to marriage to discover the beauty of a genuine and profound love, lived as a reciprocal and faithful gift! To those among you whom he calls to follow him in the priesthood or the religious life, I would like to reiterate all the joy that is to be had through giving one's life totally for the service of God and others. May Christian families and communities be places where solid vocations can come to birth and grow, for the service of the Church and the world!

Mary's message is a message of hope for all men and women of our day, whatever their country of origin. I like to invoke Mary as the *star of hope* (*Spe Salvi*, 50). On the paths of

our lives, so often shrouded in darkness, she is a beacon of hope who enlightens us and gives direction to our journey. Through her "yes", through the generous gift of herself, she has opened up to God the gates of our world and our history. And she invites us to live like her in invincible hope, refusing to believe those who claim that we are trapped in the fatal power of destiny. She accompanies us with her maternal presence amid the events of our personal lives, our family lives, and our national lives. Happy are those men and women who place their trust in him who, at the very moment when he was offering his life for our salvation, gave us his Mother to be our own!

Dear Brothers and Sisters, in this land of France, the Mother of the Lord is venerated in countless shrines which thereby manifest the faith handed down from generation to generation. Celebrated in her Assumption, she is your country's beloved patroness. May she always be honoured fervently in each of your families, in your religious communities and in your parishes! May Mary watch over all the inhabitants of your beautiful country and over the pilgrims who have come in such numbers from other countries to celebrate this Jubilee! May she be for all people the Mother who surrounds her children in their joys and their trials! Holy Mary, Mother of God, our Mother, teach us to believe, to hope and to love with you. Show us the way towards the kingdom of your Son Jesus! Star of the sea, shine upon us and lead us on our way! (cf. *Spe Salvi*, 50). Amen.



Eucharistic Celebration for the Sick
Homily of His Holiness Benedict XVI

ESPLANADE IN FRONT OF THE BASILICA OF NOTRE-DAME DU ROSAIRE, LOURDES, MONDAY, 15 SEPTEMBER 2008

Dear Brothers in the episcopate and the priesthood,
Dear Friends who are sick, dear carers and helpers,
Dear Brothers and Sisters!

Yesterday we celebrated the Cross of Christ, the instrument of our salvation, which reveals the mercy of our God in all its fullness. The Cross is truly the place where God's compassion for our world is perfectly manifested. Today, as we celebrate the memorial of Our Lady of Sorrows, we contemplate Mary sharing her Son's compassion for sinners. As Saint Bernard declares, the Mother of Christ entered into the Passion of her Son through her compassion (cf. *Homily for Sunday in the Octave of the Assumption*). At the foot of the Cross, the prophecy of Simeon is fulfilled: her mother's heart is pierced through (cf. *Lk* 2:35) by the torment inflicted on the Innocent One born of her flesh. Just as Jesus cried (cf. *Jn* 11:35), so too Mary certainly cried over the tortured body of her Son. Her self-restraint, however, prevents us from plumbing the depths of her grief; the full extent of her suffering is merely suggested by the traditional symbol of the seven swords. As in the case of her Son Jesus, one might say that she too was led to perfection through this suffering (cf. *Heb* 2:10), so as to make her capable of receiving the new spiritual mission that her Son entrusts to her immediately before "giving up his spirit" (cf. *Jn* 19:30): that of becoming the mother of Christ in his members. In that hour, through the figure of the beloved disciple, Jesus presents each of his disciples to his Mother when he says to her: Behold your Son (cf. *Jn* 19:26-27).

Today Mary dwells in the joy and the glory of the Resurrection. The tears shed at the foot of the Cross have been transformed into a smile which nothing can wipe away, even as her maternal compassion towards us remains unchanged. The intervention of the Virgin Mary in offering succour throughout history testifies to this, and does not cease to call forth, in the people of God, an unshakable confidence in her: the *Memorare* prayer expresses this sentiment very well. Mary loves each of her children, giving particular attention to those who, like her Son at the hour of his Passion, are prey to suffering; she loves them quite simply because they are her children, according to the will of Christ on the Cross.

The psalmist, seeing from afar this maternal bond which unites the Mother of Christ with the people of faith, prophesies regarding the Virgin Mary that "the richest of the people … will seek your smile" (*Ps* 44:13). In this way, prompted by the inspired word of Scripture, Christians have always sought the smile of Our Lady, this smile which medieval artists were able to represent with such marvellous skill and to show to advantage. This smile of Mary is for all; but it is directed quite particularly to those who suffer, so that they can find comfort and solace therein. To seek Mary's smile is not an act of devotional or outmoded sentimentality, but rather the proper expression of the living and profoundly human relationship which binds us to her whom Christ gave us as our Mother.

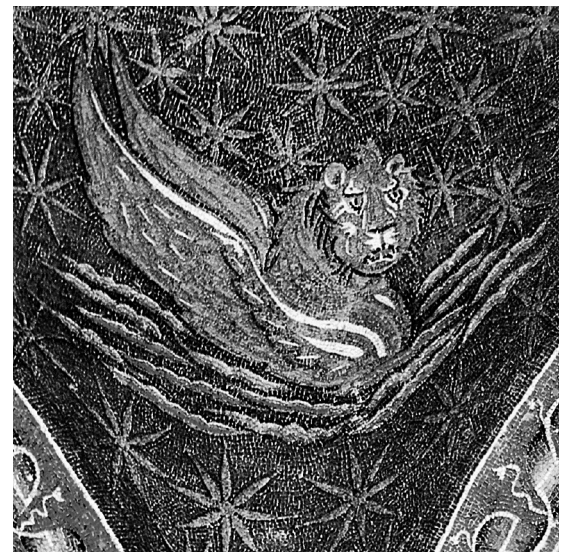
To wish to contemplate this smile of the Virgin, does not mean letting oneself be led by an uncontrolled imagination. Scripture itself discloses it to us through the lips of Mary when she sings the Magnificat: "My soul glorifies the Lord, my spirit exults in God my Saviour" (*Lk* 1:46-47). When the Virgin Mary gives thanks to the Lord, she calls us to witness. Mary shares, as if by anticipation, with us, her future children, the joy that dwells in her heart,

so that it can become ours. Every time we recite the Magnificat, we become witnesses of her smile. Here in Lourdes, in the course of the apparition of Wednesday 3 March 1858, Bernadette contemplated this smile of Mary in a most particular way. It was the first response that the Beautiful Lady gave to the young visionary who wanted to know who she was. Before introducing herself, some days later, as "the Immaculate Conception", Mary first taught Bernadette to know her smile, this being the most appropriate point of entry into the revelation of her mystery.

In the smile of the most eminent of all creatures, looking down on us, is reflected our dignity as children of God, that dignity which never abandons the sick person. This smile, a true reflection of God's tenderness, is the source of an invincible hope. Unfortunately we know only too well: the endurance of suffering can upset life's most stable equilibrium; it can shake the firmest foundations of confidence, and sometimes even leads people to despair of the meaning and value of life. There are struggles that we cannot sustain alone, without the help of divine grace. When speech can no longer find the right words, the need arises for a loving presence: we seek then the closeness not only of those who share the same blood or are linked to us by friendship, but also the closeness of those who are intimately bound to us by faith. Who could be more intimate to us than Christ and his holy Mother, the Immaculate One? More than any others, they are capable of understanding us and grasping how hard we have to fight against evil and suffering. The Letter to the Hebrews says of Christ that he "is not unable to sympathize with our weaknesses; for in every respect he has been tempted as we are" (cf. *Heb* 4:15). I would like to say, humbly, to those who suffer and to those who struggle and are tempted to turn their backs on life: turn towards Mary! Within the smile of the Virgin lies mysteriously hidden the strength to fight against sickness and for life. With her, equally, is found the grace to accept without fear or bitterness to leave this world at the hour chosen by God.

How true was the insight of that great French spiritual writer, Dom Jean-Baptiste Chautard, who in *L' âme de tout apostolat*, proposed to the devout Christian to gaze frequently "into the eyes of the Virgin Mary"! Yes, to seek the smile of the Virgin Mary is not a pious infantilism, it is the aspiration, as Psalm 44 says, of those who are "the richest of the people" (verse 13). "The richest", that is to say, in the order of faith, those who have attained the highest degree of spiritual maturity and know precisely how to acknowledge their weakness and their poverty before God. In the very simple manifestation of tenderness that we call a smile, we grasp that our sole wealth is the love God bears us, which passes through the heart of her who became our Mother. To seek this smile, is first of all to have grasped the gratuitousness of love; it is also to be able to elicit this smile through our efforts to live according to the word of her Beloved Son, just as a child seeks to elicit its mother's smile by doing what pleases her. And we know what pleases Mary, thanks to the words she spoke to the servants at Cana: "Do whatever he tells you" (cf. *Jn* 2:5).

Mary's smile is a spring of living water. "He who believes in me", says Jesus, "out of his heart shall flow rivers of living water" (*Jn* 7:38). Mary is the one who believed and, from her womb, rivers of living water have flowed forth to irrigate human history. The spring that Mary pointed out to Bernadette here in Lourdes is the humble sign of this spiritual reality. From her believing heart, from her maternal heart, flows living water which purifies and heals. By immersing themselves in the baths at Lourdes, so many people have discovered and experienced the gentle maternal love of the Virgin Mary, becoming attached to her in order to bind themselves more closely to the Lord! In the liturgical sequence of this feast of Our Lady of Sorrows, Mary is honoured with the title of *Fons amoris*, "fount of love". From Mary's heart, there springs up a gratuitous love which calls forth a response of filial love, called to ever greater refinement. Like every mother, and better than every mother, Mary is the teacher of love. That is why so many sick people come here to Lourdes, to quench their thirst at the *"spring of love"* and to let themselves be led to the sole source of salvation, her son Jesus the Saviour.



Christ imparts his salvation by means of the sacraments, and especially in the case of those suffering from sickness or disability, by means of the grace of the sacrament of the sick. For each individual, suffering is always something alien. It can never be tamed. That is why it is hard to bear, and harder still – as certain great witnesses of Christ's holiness have done – to welcome it as a significant element in our vocation, or to accept, as Bernadette expressed it, to "suffer everything in silence in order to please Jesus". To be able to say that, it is necessary to have travelled a long way already in union with Jesus. Here and now, though, it is possible to entrust oneself to God's mercy, as manifested through the grace of the sacrament of the sick. Bernadette herself, in the course of a life that was often marked by sickness, received this sacrament four times. The grace of this sacrament consists in welcoming Christ the healer into ourselves. However, Christ is not a healer in the manner of the world. In order to heal us, he does not remain outside the suffering that is experienced; he eases it by coming to dwell within the one stricken by illness, to bear it and live it with him. Christ's presence comes to break the isolation which pain induces. Man no longer bears his burden alone: as a suffering member of Christ, he is conformed to Christ in his self-offering to the Father, and he participates, in him, in the coming to birth of the new creation.

Without the Lord's help, the yoke of sickness and suffering weighs down on us cruelly. By receiving the sacrament of the sick, we seek to carry no other yoke that that of Christ, strengthened through his promise to us that his yoke will be easy to carry and his burden light (cf. *Mt* 11:30). I invite those who are to receive the sacrament of the sick during this Mass to enter into a hope of this kind.

The Second Vatican Council presented Mary as the figure in whom the entire mystery of the Church is typified (cf. *Lumen Gentium*, 63-65). Her personal journey outlines the profile of the Church, which is called to be just as attentive to those who suffer as she herself was. I extend an affectionate greeting to those working in the areas of public health and nursing, as well as those who, in different ways, in hospitals and other institutions, are contributing to the care of the sick with competence and generosity. Equally, I should like to say to all the *hospitaliers*, the *brancardiers* and the carers who come from every diocese in France and from further afield, and who throughout the year attend the sick who come on pilgrimage to Lourdes, how much their service is appreciated. They are the arms of the servant Church. Finally, I wish to encourage those who, in the name of their faith, receive and visit the sick, especially in hospital infirmaries, in parishes or, as here, at shrines. May you always sense in this important and delicate mission the effective and fraternal support of your communities! In this regard, I particularly greet and thank my brothers in the Episcopate, the French Bishops, Bishops and priests from afar, and all who serve the sick and suffering throughout the world. Thank you for your ministry close to our suffering Lord.

The service of charity that you offer is a Marian service. Mary entrusts her smile to you, so that you yourselves may become, in faithfulness to her son, springs of living water. Whatever you do, you do in the name of the Church, of which Mary is the purest image. May you carry her smile to everyone!

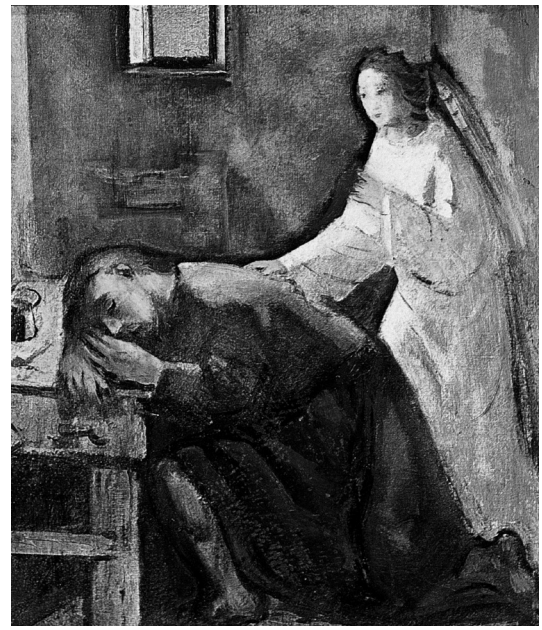
To conclude, I wish to join in the prayer of the pilgrims and the sick, and to pray with you a passage from the prayer to Mary that has been proposed for this Jubilee celebration:

"Because you are the smile of God, the reflection of the light of Christ, the dwelling place of the Holy Spirit,

Because you chose Bernadette in her lowliness, because you are the morning star, the gate of heaven and the first creature to experience the resurrection,

Our Lady of Lourdes", with our brothers and sisters whose hearts and bodies are in pain, we pray to you!

Topics



Making Oneself a Neighbour

The Post-modern Context of Euthanasia

Euthanasia and the Mentally Ill

Care for Mental Health in Childhood and Catholic Health Care

The Increasing Influence of the Economic Factor in Health-Care Policies: Reflections on the Need for Ethical Guidance

The Precursors, Roots and Historical Evolution of Hospitals from the Perspective of Pastoral Care in Health

Making Oneself a Neighbour

The central point of this analysis is the parable of the Good Samaritan which is narrated by Luke 10:29-37. In this analysis we will encounter certain specific themes: who is my neighbour; the God of compassion and mercy in the Old Testament and the New Testament; Christ as the Good Samaritan; and we will finish with the invitation to be Good Samaritans and witnesses to love.

1. THE CONTEXT OF THE PARABLE OF THE GOOD SAMARITAN: THE PERSPECTIVE OF FAITH

1.1 Who is my neighbour?[1]

The parable of the Good Samaritan seeks to answer a question which was anything but trivial for an Israelite believer for whom Leviticus prescribed loving one's neighbour as oneself (Lv 19:18). The question posed to Jesus is made in an existential context of faith. The subject had been discussed for a long time without agreement being reached upon it. Indeed, the parable of the Good Samaritan is placed in St. Luke within the discussion on the greatest of the commandments (Mt 22:34-40; Mk 12: 28-31).

This debate sought to provide an answer to the existential question that assailed not only specialists in the law of Moses but also the simple faithful person, the heir to the covenant of Zion: what must I do to inherit eternal life? In this sense the position of Jesus on the question was indifferent to no one, not even to the lawyer. Whatever the case, in the perspective of Luke, the Scriptures spoke clearly and the lawyer could not be in the dark about it: to inherit eternal life it was necessary to love God above all things and to love one's neighbour as oneself (Dt 6:4-5; Lv 19:18). Whereas in relation to unconditional and all-embracing love for God there were no particular problems, there did not fail to be doubts and reservations about love for one's neighbour, or better, who one's neighbour was who was to be loved as oneself. This is testified to by the interminable discussions that were held in the rabbinical schools of the epoch.

However, even though at an ideal level, and certainly not uniform down history, an answer to the question of the lawyer about who one's neighbour is that one must love as oneself was given in the Old Testament: one's neighbour is above all one's brother, that is to say a member of the chosen people. As regards the concept of neighbour in the Old Testament, A. Vanhoye observes: 'Love for neighbour in it... is understood as an approach of solidarity with one's compatriots, a very narrow limit. One notices, however, that a few verses later Leviticus extends the precept to strangers (*gèr* in Hebrew): 'The stranger who sojourns with you shall be to you as the native among you, *and you shall love him as yourself*; for you were strangers in the land of Egypt" (Lv 19:34).[2]

In the same fashion, and after observing the distinction between the terms 'neighbour' and 'brother', which are contiguous and at times confused in the Old Testament, X. Léon-Dufour observes: 'In the ancient codes questions did not arise about 'brothers' but about 'others' (for example Ex 20:16s): despite this virtual openness to universalism, the horizon of the law did not go beyond the people of Israel'.[3]

This oscillation would continue even though, subsequently, an increased awareness of the divine choice meant that in Deuteronomy and in the code of holiness 'others' and 'brother' were confused (Lv, 19:16), with the reducing of everyone to Israelites (Lv 17:3). In this approach, at least, strangers resident amongst the Israelites were assimilated to them and thus became the subject of love for neighbour (Lv 17:8,10,13; 19:34). Only after exile would the dual approach emerge: on the one hand there was a narrowing which confined love for neighbour to Israelites alone or to circumcised converts; on the other hand, with the translation of the Bible into Greek by the seventy, 'others' were distinguished from 'brothers', thereby indicating that the neighbour to be loved was other people.[4] Despite these indications, the question of the lawyer allows us to understand that the debate was still an open one.

1.2 The parable: the protagonists and their various forms of behaviour

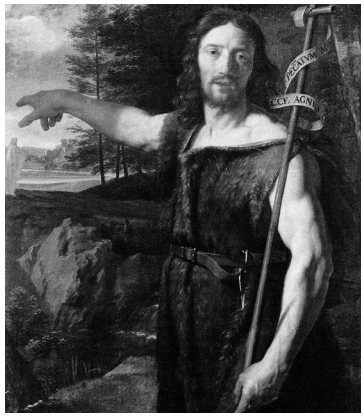
1.2.1 A beaten man

The man who fell amongst robbers does not have a precise identity. Is he the symbol of suffering humanity, as Michel Gourgues suggests? He may be! What is clear in this tale is that the man who has been beaten and robbed does not have a name, he does not have a specific characteristic: he is a man, and matters stop there. Michel Gourgues observes how St. Luke very often begins his parables with the same formula: a man gave a supper (14:16), a man had two sons (15:11), a rich man (16:1,19), a man of noble family (19:12)…[5] Although in the parable we are considering the circumstances of the place are plausible, the identity of the unfortunate man has a relative if not non-existent importance. He is a man who needs help. For Vanhoye, it is specifically this lack of specific importance that makes the anonymity of that man highly significant *tout court*. This authoritative scholar of the Bible observes that the Greek word *an-*

thropos used by the Evangelist does not even allow us to determine the sex of the person involved.[6] This enables us to understand how much in the account of the Good Samaritan emphasis is placed on the existential dimension alone – being a person in vital need.

1.2.2 The priest and the Levite

These two men of religious worship share the same reaction to a man who has been abandoned half dead at the side of the road: they look at him and pass by. The account provides no justification for their behaviour. Some commentators, invoking the prescriptions that governed their behaviour (Nm 19:11-13 and Lv 21:1-4.11), have ventured to read in this cultural reasons, even though this interpretation is contested by others. M. Gourgues points out that when St. Luke wants to object



against a 'close and rigorous observance of the law he does not bring in priests but the scribes and Pharisees'. But above all, in a decisive way, the account is not interested in the motives that led them both not to come to the help of a man who lay at the side of the road.[7]

Why, then, this resort to the priest and the Levite? M. Gourgues attempts an explanation with reference to rabbinical texts. In his view one is dealing with a way that had been current since the post-exile period of orally expressing the socio-religious make-up of the Jewish people: priests, Levites and the people (or the children of Israel),[8] just as in Rome one used the phrase 'the Senate and People of Rome'. In our case, rather than bringing into play the representative of the people, a 'secular person', Luke calls on a 'foreign' neighbour, from whom an Israelite could expect very little., to show that nobody is far from the eyes of God if he has not deliberately hardened his heart, and thus that the love of God is a gift and not a privilege (cf. *GS* n. 34).

1.3 Jews and Samaritans: relations that were not totally friendly[9]

It appears that Luke was favourably inclined towards the Samaritans! One would say that he has immediately forgotten the emblematic episode of the not very friendly relations that existed between the Jews and the Samaritans and that he himself refers to a few passages prior to relating the parable of the Good Samaritan. The inhabitants of a Samaritan village deny hospitality to Jesus only because he was going to Jerusalem (Lk 9:52-53). The question was not new (cf. Jn 4:7-9) and thus their refusal was not very surprising. Various passages in the Old Testament, indeed, bring out how much the Jews despised the Samaritans (cf. 2K 17:24-41; Si 50:25-26). In exchange the Samaritans molested the Jewish pilgrims on their way towards Jerusalem, according to the testimony of the Jewish historian Flavius Joseph (Ant. 20:6,1). Jesus thus showed himself very generous towards Samaritans in proposing one of them as a model for an individual who makes himself a neighbour, that is to say one who faithfully carries out the Law of God. Thus Jesus makes us understand how much the love of God is a freely-given gift that is offered to all without exceptions or conditions, if not that of a total and welcoming openness of the heart.[10]

1.3.1 The compassionate Samaritan

The tale of the Samaritan who allows himself to be moved by compassion is built upon an fundamental antithesis, a mirror of sincere and honest love: the antithesis of 'nothing/everything'. The priest and the Levite pass, see, and go on their way without asking too many questions or having too many scruples. The Samaritan passes there as well, see and reacts differently from the two men who had come before him: moved by compassion, he draws near and takes care of the unfortunate man. The first two see and do *nothing* whereas the Samaritan stops and takes responsibility for this man who is in a state of extreme need: he does *everything* to save his life.

Some scholars have seen in the flow of verbs that describe the principal protagonist of the parable the symbolism of perfection (the number 7): the Good Samaritan sees (1), feels compassion (2), draws near (3), takes care of the wounded man (4), takes him to a safe place (5), pays for him (6) and entrusts him to an innkeeper (7) before leaving again on the next day.[11] Symbolism or not, the parable reaches its high point in those passages that describe the Samaritan striving to serve the man who has been found half dead at the side of the road, in this way placing him in open contrast with the nothing of the priest and the Levite who passed by. What matters here is not so much the identity of individuals, which can without doubt provide a certain colouring, but their approach to a situation of extreme necessity which specifically requires the exercise and the immediate practice of love for neighbour.

1.3.2 Who was a neighbour?

In the Gospel of Luke, contrarily to what is narrated in the Gospels of Mark and Matthew, Jesus does not himself answer the question that is posed to him by the lawyer. He refers it back in elegant fashion to the sender with whom he agrees, prior to asking him to carry out the dictates of the Holy Scripture which he himself has referred to. At this

point the interlocutor of Jesus, the Evangelist tells us, feels the need to justify himself and asks a new question, almost with the intention of clarifying the meaning of the first: 'And who is my neighbour?' (Lk 10:29).

In his answer Jesus overturns the perspectives of the initial question. One is not dealing, it appears, with an intellectual exercise such as that of defining to begin with who a neighbour is so as to then exclude those who do not belong to the criteria that have been previously established. A neighbour is a concrete person, in flesh and blood, and thus comes before any conceptual definition. Thus from a defining perspective that is passive and static, Jesus suggests a more dynamic perspective, one that is more open, more concrete and active: 'make yourself a neighbour'! In ending the parable, Jesus, in his turn, poses a question that corrects the previous one: 'Which of these three, do you think, proved neighbour to the man who fell among the robbers?' In response to the satisfactory reply of his interlocutor he replies: 'Go and do likewise' (Lk 10:37). It is though he had said: it is not enough to know who my neighbour is to treat him as such. One has to allow oneself to be permeated by compassion, like God Himself, and act in line with this.

1.4 The Good Samaritan as the Concrete Embodiment of the Compassion and Mercy of God[12]

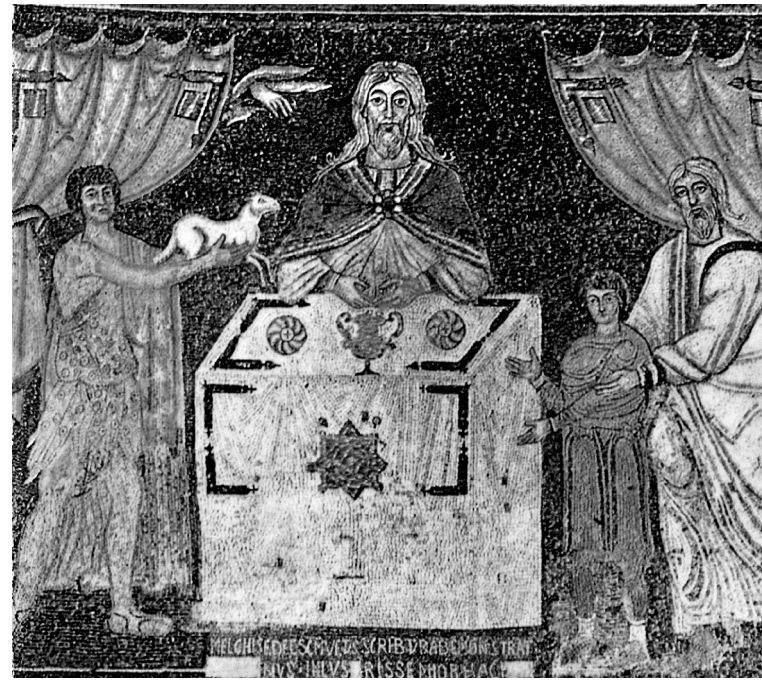
Rev. Vanhoye, in his abovementioned article, emphasises how much the Good Samaritan, differently from what occurs in other parables, is the model that is given by Jesus for imitation: 'This model is the Good Samaritan who allowed himself to be moved on seeing a half-dead man and who expressed his own compassion with a generous action'.[13]

He also observes that the Greek phrase (*poiein eleos*) is applied by Luke to the action of God Himself (Lk 1:72): 'In being moved (Lk 10:33) and in practicing mercy (Lk 10:37), the Samaritan made himself resemble God Himself'.[14]

Here we are at the sources of the Christian moral and spiritual life: we have to allow God have grow inside us His image and likeness, with which we were created, and allows ourselves to be transformed by His mercy. At this point it becomes inevitable to consider, even if only quickly, the mercy of God as it was perceived and experienced in Holy Scripture.

1.4.1 The Old Testament: Yahweh, the God of mercies

In Jewish literature the term translated by the Italian word '*misericordia*' (mercy) is much richer than its translations into modern languages. It is at the confluence of two currents of thought directed towards compassion, on the one hand, and faithfulness, on the other. The various translations oscillate from mercy to love, passing by way of tenderness, pity, compassion, clemency, goodness and even grace, even though this last has a broader meaning.



In the Old Testament Biblical tradition, God reveals Himself as the God of mercies who listens to an unceasing flow of cries, supplications and requests for help that rise up from the souls and the lips of the miserable (Ps 4:2; 6:3; 9:14; 25:16). For this reason, in the songs of thanksgiving, the greatness and the eternity of the merciful love of God are proclaimed (Ps 107:1,23).

Surprisingly, the mercy of God is manifested at the highest level in forgiveness of the sinner, whether the sinner is an individual or a people. It is specifically in forgiveness that God reveals His merciful being, affirming His total freedom to use mercy for whomsoever He wishes and to proclaim His triumph over sin without injuring His dignity. Thus the mercy of God cannot be interpreted as encouragement to sin or even less as a sign of weakness. It seeks to make the sinner go back over his steps, that is to say: conversion and salvation.

Both prophetic reflection (Os 11:9; Jo 4:2) and the reflection of wisdom react against human baseness and the obtuseness of those who want to confine such a benefit to the people of the Covenant. They also uphold forcefully the universality of the mercy of God: 'The compassion of man is for his neighbour, but the compassion of the Lord is for all living things (Sir 18:13). A strongly rooted Biblical tradition upheld this advance without reservations. Yahweh

is tenderness and grace, he is long in becoming angry and rich in mercy: 'The Lord is merciful and gracious, slow in anger and abounding in steadfast love. He will not always chide, nor will he keep his anger for ever; He does not deal with us according to our sins…As a father pities his children, so the Lord pities those who fear him; For he knows our frame; he remembers that we our dust (Ps 103:8-10,13-14). 'For the Lord is a God of justice, blessed are all those who wait for him' (Is 30,18) Because 'his steadfast love endures for ever (Ps 136), For with the Lord there is steadfast love' (Ps 130:7)

The God of mercies wants mercy (Os 4.2; 6:6) and He requires it of man who by now shows that he is clearly unable to live it naturally. Yahweh educates His people in mercy, condemns those who suffocate it and refuse to practice it (Am 1:11); He requires observation of the commandment to fraternal love (Ex 22:26), which is far more preferable to holocausts and sacrifices (Os 4:2; 6:6), as well as the practice of justice destined to blossom into tender love (Mi 6:8). In the same way, fasting itself must bend to the needs of mercy towards widows, orphans or strangers (Is 58:6-11; Jb 31:16-23). To summarise, although the horizon of tenderness and compassion in Israel is still limited to race or faith, the plan of God is to extend it to the whole of mankind: hence the prohibition on vendetta or on nursing rancour in one's heart. In this sense the literature of wisdom constitutes almost a draft version of the message of Jesus (Sir 27:30-28,7).

1.4.2 The New Testament: Jesus, the face of divine mercy

In the New Testament the face of the mercy of God is a person, it is Jesus of Nazareth, a 'merciful high priest' (Heb 2:17). To carry out the divine plan of saving everyone, he chose to become similar to men although he was without sin; he experienced their misery and he healed them first through his actions and then through his passion, death and resurrection. Better than all the others Evangelists, the Evangelist John emphasised this dimension of the ministry of the Lord: the favourites of Jesus are the poor (Lk 4:18; 7:22); sinners find in him a friend (Lk 7:34), who is free of any fear of being with them or sharing their joys and worries (Lk 5:27.30; 15:11; 17:7). The compassion of Jesus touches the multitudes (Mt 9:36; 14:14; 15:32) or takes on a more personal face as in the cases of the widow who had lost her only son (Lk 7:13) or the weeping father (Lk 8:42; 9:38,42). Lastly, the welcoming approach of Jesus to social categories that were held in low esteem, namely women, children and strangers, should also be remembered. With Jesus, the salvation of God reaches all men in a complete way: 'and all flesh shall see the salvation of God' (Lk 3:6).

The compassion of Jesus reveals to mankind the 'heart of God the Father'. Indeed, through his merciful acts Jesus depicts the features of the face of the mercy of God. To sinners who were excluded from salvation by the human baseness of the Pharisees, Jesus proclaimed the Gospel of the infinite mercy of God for whom one converts and one returns to the righteous path. Above all else he brought to everyone a very important doctrinal and spiritual clarification: those who most gladden the heart of God are not those who see themselves as righteous but all those who repent and return to the house of the Father (Lk 15:7,10,20). The God revealed by Jesus in the New Testament is the 'God of mercies' (2Co 1:3; Jm 5:11). Paul, who experienced this in the first person, is a witness to this (1Co 7:25; 2Co 4:1; 1Tim 1:13); but in a free way the great abundance of the mercy of God was promised to all believers (Mt 5:7; 1Tim 1:2; Tit 1:4; 2Jn 3). In his writings, Paul strongly and clearly exhorts people to be aware of the great abundance and breadth of the mercy of God – not even the chosen people can achieve salvation on its own merits. Thus the Jews as well are sinners and thus they, too, need the mercy of God through faith, thanks to which the 'nations' are inserted into the salvific plan of God (Rom 11:32).

The great abundance of the mercy of God expressed in His creative and redemptive work requires man, in return, to have a life based on mercy: 'Be merciful, even as your Father is merciful' (Lk 6:36). In St. Luke this is the perfection that is the essential pre-condition requested by Jesus of his disciples to enter the kingdom of God (Mt 5:7). This is concrete and essential terms means that a disciple of Christ will be judged by his sensitivity towards, and care for, the poor person that he encounters on his path (Lk 10:30-37), for the expression of pity for those who offend him (Mt 6:12; 18:21-35), and for the mercy practiced even unconsciously towards Jesus through our brothers and sisters who are in a state of need (Mt 25:31-46).

In poor words, one could say that, differently from the horizon of paganism, the horizon of Christian action must in a fundamental and marked way be that of love and good sympathy (Ph 2:1), of compassion (Eph 4:32; 1Pt 3:8), and of help for one's brother in a state of need, because the love of God only remains in those who practice mercy (1Jn 3:17).

1.4.3 God faced with human suffering[15]

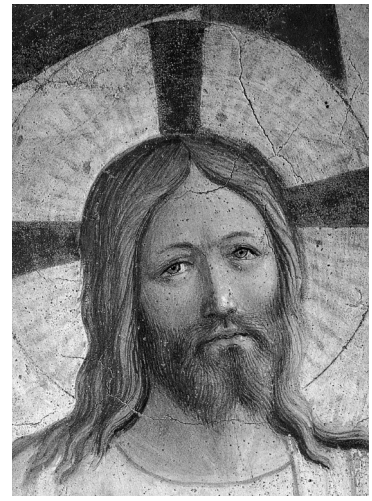
The tale of the Good Samaritan does not deal prevalently with suffering but, rather, with the debated question of knowing who your neighbour is. Why has this tale been ascribed to the 'Gospel of Suffering'? (*Salvifici Doloris*, n. 30). The parable told by Jesus presents a limit case of a man in a state of extreme need. The Lord could very well have enlightened the person he was speaking to with a different case. However, the help that was given to the wounded man, who had been robbed and left in that inhospitable

and terrible place, must have brought to the minds of those who were listening not only a reality that was known to them but also, and above all else, the actions of Yahweh for his suffering people down history (Ex 16-17). And this indicates that human suffering has been to the utmost a place of the revelation of the mercy of God. Holy Scripture is singular testimony to this truth. The teaching of the Bible on suffering is not uniform. There exists, in fact, a multiplicity of conceptions which have their own historical evolution. The idea of suffering in the Bible is not in the least static.[16]

In the Old Testament, suffering is taken seriously as an expression of human frailty when faced with illnesses, natural disasters, mourning due to wars and devastating conflicts. The spontaneous and immediate reaction was always to raise one's eyes to heaven to cry out to the Lord and to ask for His help. Whatever the case, for the Old Testament suffering is an evil that should not exist. And of it exists, in its various (physical, psychological and spiritual) aspects, it remains a profound mystery that cannot be explained with simple recourse to the struggle between the gods or to whim, as happened in the ancient East.

From the perspective of the covenant of Yahweh with the people of Israel, a certain reading connects illness and suffering to man's faithless behaviour in relation to God, that is to say to sin. Its role in this approach is to raise man's awareness of sin (Ps 38:2-6). When addressing the objective difficulty of knowing whether every illness is a divine scourge or not, the Old Testament proposes two solutions: in some cases it is a trial of the righteous and the faithful to emphasise the steadfastness of their faithfulness (Job and Tobit), whereas in others we are dealing with expiating the sins of others (the servant of God: Is 53, 4s).

The prophets and the wise men of Israel, subject to the trial of innumerable and various sufferings but also at the same time supported by their steadfast faith in God, gradually entered the great mystery of the meaning of suffering (Ps 73:17) and experienced the suffered and progressive discovery of the purifying value of suffering (Jer 9:6; Ps 65:10), of its educational value in line with the model of paternal correction (Dt 8,5; Prov 3,11). Lastly, they came to see in the immediacy of punishment an effect of divine benevolence (2 Mac 6,12,17; 7:31-38). The figure of Job, and in particular of the servant of Yaweh, are well known for the terrible story of their unjust sufferings which, in a redemptive key, prefigured the passion of Christ on the cross.



In the New Testament Jesus is presented not only as a man of pain but also and above all else as a man who is sensitive to all human pain, and who is profoundly moved by it (Mt 9:36; 14:14; 15:32; Jn 11:21,32). He shows that he defeats suffering by healing the sick and raising the dead. (Mt 11:4; Lk 4:18).

Despite this, neither suffering nor physical death were eliminated by him. However, he showed that he was able to change them into joy; he did not eliminate suffering but he did comfort it (Mt 5:5). Suffering can become a beatitude because it prepares us to receive the Kingdom and allows a revealing of the works of God (Jn 11:4). It is also known that the Son of God was not spared suffering of all kinds, from the most banal incomprehension at a family level (e.g. Mt 12:46-50) to death on the cross, pierced by the deep worry of Gethsemane where he felt that he was abandoned by God (Mk 15:36). The redemptive passion revealed in the end the glory of the Son of God: 'Jesus of Nazareth… delivered up… you crucified and killed by the hands of lawless men. But God raised him up, having loosed the pangs of death, because it was not possible for him to be held by it (Acts 2:22.23).

For the disciples of Jesus, the resurrection of the Lord should have speeded up the final judgement. One could expect that after such a grandiose event there would no longer be either suffering or death. The risk in this case was of being shaken by the continuation of the tragic realities of existence (1Th 4:13). It should, however, be remembered that the resurrection did not abolish the teachings of the Gospel but, on the contrary, confirmed them entirely (Mt 5:17-18). The message of the beatitudes and the requirement of the daily cross (Lk 9:23) take on all their meaning in the light of the destiny of the Lord. As a consequence, the disciples had to be ready to bear tribulations in imitation of their teacher and for his glory.

St. Paul, who personally experienced various tribulations, writes that the sufferings of the Christians are the same sufferings of Christ (2 Co 1:15) because whether we live or whether we die we do everything for Christ who loved us and gave his life for us (Rom 8:36). Christ expressed solidarity towards the suffering and left his followers the same law (1Co 12:26; Rom 15; 2Co 1:7). Participation in the sufferings of Christ is a guarantee of the more exalting participation of taking part in his glory as well (2Tm 2:11-13).

Thus faced with illness and all forms of suffering, the Bible exhorts believers to engage in prayer so as to ask God for the grace of healing. He is the master of life (Sir 38:9); He is the total physician (Ex 15:26). Thus illness, suffering, pain and death are placed within the order of salvation. As a consequence, service to

the sick, visiting those who suffer to bring them comfort, all of this is Christian charity because it is service to the suffering Christ who is in them and with them (Mt 25:36). Our technologicalised world, perhaps, also has need of this comforting presence. Thus malady and suffering cannot be interpreted as negligence or indifference or even less as abandonment of the creation by God.

2. THE PARABLE OF THE GOOD SAMARITAN: DIFFERENT READINGS, THE SAME PERSPECTIVE OF CONCRETE LOVE FOR NEIGHBOUR

The teaching of Christ that has been given to us in the parable of the Good Samaritan is far from being sporadic, occasional, or, even less, out of date. Providing care to those in need and care for the sick has always been an integral part of the mission that Jesus entrusted to the Church (Mt 10:8; Mk 16:18; Lk 10:9). All of this, however, would have been of little import had it not been for the direction and the paradigmatic example of the Lord: it is his style of life, *his ethos*, if we may express it thus, that marked the life of the Apostles to begin with, and then of the first Christian communities, to the point of leading them to see Christ as the true Good Samaritan. Even though there is a diversity of readings of this parable, albeit in the same perspective of love for neighbour, it would not be ill placed to ask whether Christ is the Good Samaritan. In what sense is Christ the true Samaritan?

2.1 'The Good Samaritan is Christ'[17]

'The interpretation of the Bible begins with the Bible itself', observes Prosper Grech.[18] The most characteristic element of the teaching of Jesus,[19] the parables have monopolised great attention in the study of the Gospels ever since the beginning of the mission of the Church, even though with different results according to the kind of interpretation that was adopted. As regards the parable of the Good Samaritan, a specific allegorical and Christological interpretation has read in it the whole history both of mankind and the Church, with the man who fell amongst robbers corresponding to Adam or mankind, the priest and the Levite corresponding to the various stages of the history of the New Testament, and the Samaritan corresponding to Jesus. The oil and the wine are the sacraments, the inn is the Church…[20] Thus was created and handed down an interpretative tradition that reads the figure of the Good Samaritan as Christ in the first person, if not God Himself. Avoiding a historical-theological excursus on the subject, I will confine myself in what follows to certain examples of authors who champion the approach that has just been mentioned.

In his *Quis dives* Clement of Alexandria wrote: 'And who is that Samaritan if not the Saviour himself? Or who shows greater mercy towards us, who are almost killed by the powers of darkness with wounds, fears and wishes, anger, sadness, fraud and pleasures? Jesus alone is the physician of these wounds; he eradicates vices at their roots'.[21] In the same sense and no less, Severus of Antioch declares in his homilies: 'Lastly, a Samaritan passes. Christ deliberately calls himself the Samaritan. Addressing who knows the Law, who knows how to speak perfectly about the Law, he wants in this way to demonstrate that neither the priest nor the Levite nor in general any of those who presumably follow the prescriptions of the Law of Moses but he alone has come to fulfil the Law and demonstrate with deeds who a neighbour is and what 'loving your neighbour as yourself' means.[22]

François Bovon shows that the oldest allegorical exegesis of the parable of the Good Samaritan that we know about is a Gnostic one, even though this kind of hermeneutics was greatly developed by patristic thought.[23] Thus the parables 'for centuries…were taught and explained by the Church as though they were allegories in which every term was a cryptogram of an idea and everything could be interpreted solely by those who possessed the key to the code'.[24]

This kind of understanding of Holy Scripture is at the base of the rooted theological and pastoral tradition that has come down the centuries until today, with various modulations but always a surprising continuity despite the dominion of the critical-historical method over the last two centuries. Conde writes: 'Christ is the pure embodiment of the Good Samaritan in this initial approach of placing himself next to the suffering, The gospels show with clarity how Jesus could not be a witness to suffering without being profoundly moved by it'.[25]

Next to these texts that state without any indirectness that the true Samaritan is Christ himself, there are others that see the Good Samaritan as the faithful follower of Christ who has well learnt the lesson of his teacher about love for neighbour and has adopted it as his own.

2.2 Whoever dedicates himself to service to the poorest is a Good Samaritan

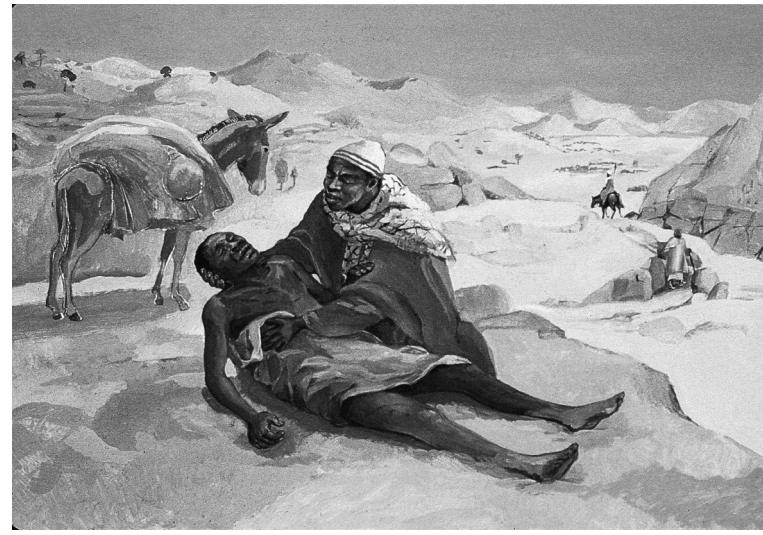
The examples given above enable us to see how the account provided by St. Luke, inserted into the corpus of teachings of the Lord on love for God and neighbour, had a strong impact on the thought and the action of the Church. Thus the first Christians also tried to translate love for neighbour into their lives through service to those most in need (Acts 6:1-7). During the first centuries, beginning with nothing, the Christian communities had already progressively organised a stable service to take in and help the poor and the sick in the name of Jesus and following his example. This was a requirement that was so felt that concrete

love for the poor was required for the election to a bishopric as it was at baptism, as is borne witness to in the Apostolic Constitutions. As regards the election of a bishop, 'he should love the poor', and the Didascalia observed 'remember the poor, extend your hands to them and feed them', and as regards baptism the following questions were made: 'have they honoured widows. Have they visited the sick? Have they done all kinds of good works?'[26] The activities and the initiatives directed towards 'embodying' the love of God in history were diversified and institutionalised through specialisation directed towards achieving a better service and better care for those most in need. One need only think here of the religious Orders and Congregations who were dedicated to care for the sick in hospitals, in rest homes and other health-care structures, and of the religious Congregations whose charism was the education of very poor children and young people, etc.

Closer in time to us, John Paul II, during the course of his long pontificate, extended the model of the Good Samaritan to all those human activities that have a certain social relevance. He indistinctly applied this model of the Good Samaritan to hairdressers[27] as to men and women religious involved in service to sick people with very grave illnesses;[28] to the pastors of the Church[29] as to students of the schools for firemen[30] or those at Cottolengo. For John Paul II, the Good Samaritan was a universal model: 'The Good Samaritan is the Church! The Good Samaritan is each one of us! By vocation! By duty! The Good Samaritan lives charity'[31]

However, one should recognise that the deepest and most enlightening summary of the teaching of Pope John Paul II on the subject remains the one that he expounded in his Apostolic Letter *Salvifici Doloris* on the Christian meaning of human suffering (11 Feb. 1984), where the seventh and final chapter is dedicated specifically to the figure of the Good Samaritan (nn. 28-30). In this document the Good Samaritan is no longer Christ but the man touched by the grace of redemption, who has become a faithful witness to the Gospel and imitator of Christ, the living icon of the mercy of God.

After addressing the great question of human suffering by placing it with a broader context, that is to say the experience of the mystery of evil with the innumerable questions that it raises, the Holy Father presents the answer of Christ, which is overcoming suffering through love and the conferral upon it of meaning and purpose: releasing love in man (nn. 29 and 30). Armed with these reflections, the Holy Father outlines the characteristic features of the Good Samaritan in the following terms: 'Everyone who stops beside the suffering of another person, whatever form it may take, is a Good Samaritan… The name "Good Samaritan" fits every individual who is sensitive to the sufferings of others, who "is moved" by the misfortune of another…in a word, then, a Good Samaritan is one who brings help in suffering'. (n. 28).



To summarise, John Paul II could immediately point out the behaviour that is coherent with such teaching – a Good Samaritan is a man able to give of himself, able to be daily in the arena of human suffering.

During its two-thousand-year history the Church, in the footsteps and name of Christ its Founder and guide, has been able to translate into the world of health and health care the final recommendation of St. Luke, 'Go and do likewise', with the creation of lasting organised and institutional forms of action (n. 29). To conclude, a Good Samaritan is a true imitator of Christ who 'taught man to do good by his suffering and to do good to those who suffer' (n. 30).

In simple words, good service to the suffering, in the name of Jesus, is a particular, high and meaningful expression of the mercy of God who never leaves unheard the supplicant voice of man afflicted by pain and suffering (Ps 69:30; 70:6).

3. WITNESSES TO LOVE: GO AND DO TODAY LIKEWISE

The parable of the Good Samaritan should be told today by ourselves with our lives and in places of suffering, in our work, in our mission, especially if it is directed towards receiving people. We must tell it with the same enthusiasm, imaginativeness, creativity, faith and charity as was practiced by our founders and by so many of our brothers and sisters religious and by so many secular people.

Jesus left to us a testament: the needy, the poor and the sick. Today we are responsible for this heritage. We are responsible not only for the sick

and those in need who come to us in our structures; we are responsible for everyone: drug addicts, those afflicted by AIDS, those with cancer, the homeless, the hungry, exploited women and children, the sick who pass through hospitals, and the sick who are in their homes. All of these people are waiting for paraclytes, concrete answers to their crying out, to their need. Our world needs Samaritans: it needs new St. John of Gods, new Camillus de Lellises, new Vincent de Pauls, new Teresa of Calcuttas, new Ildebrand Gregoris and very many new men and women founders, who are courageous and who love man; our world needs many paraclytes who respond to people's cries, who welcome, who protect, and who love.

Yes, indeed! History is sown, following the example of Jesus, of Good Samaritans – yesterday, today – and it will have them tomorrow. But today these models are more urgent because there are many robbers, priests and Levites, acolytes who pass by in a distracted way, very hurriedly, without soul, without sensitivity, they pass by on the other side. I would say even more: they pass by with indifference.

Our men and women founders are an injection of courage for all of us. Courage to discover our name in the parable of St. Luke: is our name priest, is our name Levite? Is our name Samaritan, Good Samaritan, because we stop, because we are moved by compassion, because we dress wounds?

A Samaritan is not satisfied with seeing; he is called upon and accepts the challenge of improvisation, first aid, spontaneity; yes, he has little ability, a lack of training, but he has a large heart, a wide heart that is capable of welcoming, of making gestures suddenly and not ones that are repeated, prepared and cold. 'Moved by compassion', his insides are moved, he has a full heart that is not afraid to love. A love that does not stop at doing but which is presence, a look, listening, a tone of voice, a way of taking care. *Go and do likewise is what the parable pushes us towards*.

We are sent to do the same, to do what the Good Samaritan did: to stop, to have time, to have readiness to help, compassion, dedication and love. Love for the poor is what speaks best about God in the Church. God is love. Charity is the path where everyone can meet. The example of the Good Samaritan applies to all men and religions. In Somalia dialogue is engaged in with works, says the Bishop of Mogadishu. 'The ecumenism of works', says Cardinal F. Angelini.

'Stake everything on charity' was the cry of Pope John Paul II at the end of the year 2000 when presenting the document *Nuovo Millenio Ineunte*. In this the Pope called us to a great hope: to contemplate in the cross the cry of love, a face of resurrection, a face of life and this to express it a risen people in daily life, in our families, in our professions, and for very many of us through religious consecration to serve the sick and those in need. Those who live – and we live – in the health-care field will find more than others in this field fine opportunities to stake everything on charity (nn. 49-50), that is to say to ensure that our love is active. This is the thinking of Pope Benedict XVI when he says in *Deus caritas est* that charity must be effective, independent of parties and ideologies, professional, and that it is not an instrument to engage in proselytising activity.

The icon of Jesus, the Good Samaritan, is always present in the prayer of the Church. The Church prays in the following way in the Eucharist: 'Merciful father, you gave us Your Son, Jesus Christ. In him you expressed you love for the least and the poor, for the sick and the excluded. He never closed himself to the needs and the sufferings of his brothers. Through his life and his words he proclaimed to the world that you are the Father and that you care for all your sons'.

Encouragement to do good has always been present in the saints as well; they have sought the face of God through man and they experienced it. Benedict XVI said this at the sanctuary of the Holy Face in Manoppello (1 September 2006): 'This is the experience of the true friends of God, the saints, who saw and loved in their brothers and sisters, and especially the poor and those in need, the face of that God contemplated for a long time in prayer. For us they are encouraging examples to be imitated'.

Encouragement, therefore, with their lives and with their phrases, the synthesis of their philosophy, their spirituality and their way of doing things, full of charity. Here are some examples:

'Walk towards man and you will reach God', says St. Augustine.

St. Augustine also said 'In loving our neighbour we purify our hearts so as to see God' (In Io. Ev. tra.17,8).

'The Church has a heart burnt by love. Only love pushes to action. My vocation is love' – St. Teresa of the Child Jesus.

St. John of God said: 'Brothers, do good to yourselves', and St. Vincent de Paul said: 'Do good well; do even more: the sick are our lords and masters'.

'More heart in your hands', said St. Camillus.

'Have charity because where there is no charity there is no God, even though it is true that God is everywhere' (St. John of God).

'How much glory will we have in heaven for every sick person that we have welcomed, cleaned, and cared for' (St. Benedict Menni).

'My son' – says the Book of Proverbs (3:27) – 'do not withhold good from those to whom it is due, when it is in your power to do it'.

'I was hungry, thirsty, I was sick and you visited me', we will be reminded by the Lord in the Final Judgement (Mt 25).

'Go, and do likewise' (Lk 10) is the message of the parable of the Good Samaritan addressed to us all.

And so that this may be reality for all of us, let us finish with the prayer of the Church, once again in the Eucharist: 'Father of mercy, give us eyes to see the needs and the sufferings of our brethren, infuse in us the light of your word to comfort the heavy laden and the oppressed: make us commit ourselves loyally to service to the poor and the suffering'.

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

Select Bibliography

A. *Dictionaries*

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

CINÀ Giuseppe, LOCCI Efisio, ROCCHETTA Carlo, SANDRIN Luciano (eds.), *Dizionario di teologia pastorale sanitaria* (Ed. Camilliane, Turin, 1997).

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

RUSSO Giovanni (ed.), *Enciclopedia di bioetica e di sessuologia* (LDC, Leumann (Turin), 2004).

ROSSANO Pietro, RAVASI Gianfranco, GIRLANDA Antonio (ed.), *Nuovo Dizionario di teologia biblica* (San Paolo, Cinisello Balsamo (MI), 1988).

B. *Documents of the Magisterium*

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

JOHN PAUL II, *Encyclical Letter Redemptor Hominis* (4 March 1979), in *ASS*, 71 (1979), pp. 257-324.

JOHN PAUL II, *Encyclical Letter Evangelium Vitae*, 25 March, Vatican City, 1995.

JOHN PAUL II, *Apostolic Letter Salvifici Doloris*, Vatican City, 1984.

JOHN PAUL II, 'La Quaresima è un tempo di verità' (Lenten Message 1981), in *Insegnamenti* 1981, IV/1, pp. 595-597.

JOHN PAUL II, 'Il saluto agli Acconciatori di Roma', 16 June 1980, in *Insegnamenti 1980*, III/1, pp. 1768-1769.

JOHN PAUL II, 'Lo spirito del buon Samaritano nell'opera di Giovanni Paolo I', Angelus of 22 August 1980, in *Insegnamenti 1980*, III/2, p. 431.

JOHN PAUL II, 'Agli allievi delle Scuole Centrali Antincendi', 15 March 1980, in *Insegnamenti 1980*, III/1, pp. 554-555.

PAUL VI, *Evangelii Nuntiandi* ,in *ASS,* 68 (1975), pp. 5-76.

PAUL VI, *Catechesi Tradendae*, in *ASS*, 71 (1979), pp. 1277-1340.

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.

C. *Works*

AUGUSTIN , Confessions (Seuil, Paris, 1982).

ANGELINI Fiorenzo, *Quel soffio sulla creta* (Vatican City, 1990).

ANGELINI Fiorenzo, *L'uomo delle beatitudini* (Vatican City, 1986).

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).

BUZY Denis, *Les Paraboles* (Beauchesne & ses Fils, Paris, 1932).

CARRIER Hervé, *Évangélisation et développement des cultures* (Ed. Pontificia Università Gregoriana, Rome, 1990).

CHIAVACCI Enrico, *La Costituzione pastorale sulla Chiesa nel mondo contemporaneo Gaudium et Spes* (Ed. Studium, Rome, 1967).

CLEMENTE ALESSANDRINO, *Il ricco e la salvezza (Quis dives salvetur?)* (San Paolo, Cinisello Balsamo (MI), 2003).

COSTE René, *Les dimensions sociales de la foi* (Cerf, Paris, 2000).

DODD Charles Harold, *Le Parabole del Regno* (Paidea, Brescia 1976[2]).

DUPONT Jacques, *Le message des béatitudes, Cahiers Évangile*, 24 (Éd. du Cerf, Paris, 1978).

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 Francio, *L'uomo oltre l'uomo. Le conseguenze della rivoluzione biotecnologica* (Mondadori, Milan, 2002).

GRECH Prosper, *Ermeneutica* (Ed. Pontificio Istituto Biblico, Rome, 1991).

GRELOT Pierre, *Espérance, liberté, engagement chrétien* (Médiaspaul/Éd. Paulines, Paris-Montréal, 1982).

GUARDINI Romano,*La fine dell'epoca moderna* (Morcelliana, Brescia, 2004[10]).

GUARDINI Romano, *Lettere dal lago di Como. L'uomo e la tecnica* (Morcelliana, Brescia, 2001[3]).

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

HABERMANS Jûrgen, *Il futuro della natura umana. I rischi d'una genetica liberale* (Einaudi, Turin, 2002).

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).

KASPER Walter, *Il Dio di Gesù Cristo* (Queriniana, Brescia, 2003[7]).

KEMMER Alfons, *Le Parabole di Gesù. Come leggerle, come comprenderle* (Paidea, Brescia, 1990).

LAPORTE Jean, *I Padri della Chiesa* (San Paolo, Cinisello Balsamo (MI) 2003).

LUCAS LUCAS Ramón, *Commento interdisciplinare alla 'Evangelium Vitae'* (LEV, Vatican City, 1997).

MARITAIN Jacques, *Christianisme et démocratie* (Desclée de Brouwer, Paris, 1989).

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

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).

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

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).

D. *Articles and Essays*

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

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), pp. 12-14.

CARRASCO DE PAULA Ignacio, 'Il buon Samaritano come categoria antropologica', *Dolentium Hominum*, 31 (1996/1), pp. 203-205.

CINÀ Giuseppe, "Antropologia nel mondo della salute", in CINÀ Giuseppe, LOCCI Efisio, ROCCHETTA Carlo, 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', in Giovanni TANGORA - Domenico POMPILI (ed.), *Il male e i suoi volti* (Edizioni San Lorenzo, Reggio Emilia, n.d), pp. 153-174.

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

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

DUFOUR Xavier-Léon, 'Prossimo', in Id. (ed.), *Dizionario di teologia biblica* (Marietti, Genoa, 1976[5]), coll. 1015-1017.

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

FASSIN Didier, 'Une chronique sud-africaine du sida', in *Études*, 6 [4036] (2005), pp. 617627.

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

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, MONTICELLI Italo, *Manuale di Pastorale sanitaria* (Ed. Camilliane, Turin, 1999), pp. 117-123.

MIRANDA Gonzalo, ''Cultura della morte'. Analisi d'un concetto e di un dramma', in LUCAS LUCAS Ramón, *Commento interdisciplinare alla' Evangelium Vitae'* (*LEV, Vatican City,*1997), pp. 225-243.

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

POUPARD Paul, ''Un uomo scendeva da Gerusalemme a Gerico'', *Dolentium Hominum*, 31 (1996/1) pp. 15-20.

RAMLOT Marie-Léon, GUILLET Jacques, 'Sofferenza', in Xavier-Léon DUFOUR (ed.), *Dizionario di teologia biblica* (Marietti, Genoa,1976[5]), coll. 1208-1210.

REDRADO José L., 'Essere un professionista sanitario in un mondo che cambia: chiavi evangeliche', *Dolentium Hominum*, 53 (2003/2), pp. 22-31.

SANNA Ignazio, 'Mysterium Iniquitatis. Il male e i suoi volti', in TANGORA Giovanni, POMPILI Domenico (eds.), *Il male e i suoi volti* (Ed. S. Lorenzo, Reggio Emilia, n.d.), pp. 123-150.

SAVAGNONE Giuseppe, 'Antropologia e bioetica', in RUSSO Giovanni (ed.) *Enciclopedia di bioetica e sessuologia* (LDC, Leumann (Tu), 2004), pp. 212-236.

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

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

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

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

Notes

[1] Denis BUZY, *Les Paraboles* (Beauchesne et ses Fils, Paris, 1932), pp. 622-628; Joachim JEREMIAS, *Le parabole di Gesù* (Paidea, Brescia 1973[2]), p. 246; *François BOVON, L'Évangile selon Saint Luc 9,51-14,35* (Labor et Fides, Geneva 1996), pp. 80-96.

[2] Albert VANHOYE, 'Il Buon Samaritano (Lc 10,29-37). Ermeneutica biblica della parabola', in *Dolentium Hominum,* 31 (1996/1), p. 199.

[3] Xavier LÉON-DUFOUR, 'Prossimo', in ID., *Dizionario di teologia biblica* (Marietti, Genoa ,1976[5]), col 1016.

[4] Ibid.; CLEMENTE ALESSANDRINO, *Quis dives*, 28,2.

[5] Michel GOURGUES, *Le parabole di Luca. Dalla sorgente alla foce* (LDC, Turin), p. 14.

[6] Albert VANHOYE, *loc. cit*., p. 200.

[7] Michel GOURGUES, *op. cit*., p. 15.

[8] *Ibid*., *op. cit*., pp. 16-18.

[9] Arland J. HULTREN, *Le parabole di Gesù*, (Paidea, Brescia 2004), pp. 104-113; Joachim JEREMIAS, *op. cit*., p. 249.

[10] 'Like the priest and the Levite the Samaritan, too, was subject to the law of Moses (Num 5:2; 19:11-13) relating to contact with a corpse and could have passed by in the same way'', Arland J. HUTGRÈN, *op. cit*., pp. 109-110.

[11] Michel GOURGUES, *Le parabole di Luca*, p. 20.

[12] Jules CAMBIER - Xavier-Léon DUFOUR, 'Misericordia', in X.-L. DUFOUR (ed.), *Dizionario di teologia biblica* (Marietti, Genva, 1976[5]), coll. 699-705; Adalberto SISTI, 'Misericordia', P. ROSSANO, G. RAVASI, A. GIRLANDA, *Nuovo Dizionario di teologia biblica* (San Paolo, Cinisello Balsamo (MI), 1988), pp. 978-984.

[13] Albert VANHOYE, 'Il Buon Samaritano', *loc. cit*., p. 202.

[14] *IBIDEM*.

[15] Marie-Léon RAMLOT - Jacques GUILLET, 'Sofferenza', in Xavier-Léon DUFOUR (ed.), *Dizionario di teologia biblic*a, coll. 1208-1210.

[16] Gianfranco RAVASI, *Fino a quando Signore? Un itinerario nel mistero della sofferenza e del dolore* (San Paolo, Cinisello Balsamo (MI), 2002), pp. 35-63.

[17] JOHN PAUL II, *La Quaresima è un tempo di verità*. Messaggio di Quaresima 1981, (Vatican City, 1981).

[18] Prosper GRECH, *Ermeneutica* (Ed. Pontificio Istituto Biblico, Rome, 1991), p. 1.

[19] Cf. Charles Harold DODD, *Le Parabole del Regno*, (Paidea, Brescia, 1976[2]), p. 15.

[20] St. AUGUSTINE, *Quaestiones evangeliorum*, 11,19, quoted in Alfons KEMMER, *Le parabole di Gesù. Come leggerle, come comprenderle* (Paidea, Brescia, 1990), pp. 64-65. The author observes that the intention of the parable is clearly another: to demonsrrate what is the right approach and what is the wrong approach to one's neighbour; Charles Harold DODD, *Le Parabole del Regno*, pp.15-16; François BOVON, *L'Évangile selon Luc 9,51-1435*, (Labor et Fides, 1996), pp. 80-96.

[21] Cf CLEMENT OF ALEXANDRIA, *Quis dives*, 27-29.

[22] Cf SEVERO OF ANTIOCH, *Homelies*, 89 and *passim*.

[23] François BOVON, *L'Évangile selon Saint Luc 9,51-14,35*, p. 91. This author provides a brief account of the history of how this parable had been received (pp. 91-95).

[24] Charles H. DODD, *Le Parabole del Regno*, p. 15. Dodd attributes to Adolf Jùlicher in his book *Die Gleichnisreden Jesu* the demonstration of the limits to such allegorical interpretation (p. 17); Cf. François BOVON, *op. cit*., p. 95.

[25] Jesús CONDE, 'La sofferenza e il Significato della vita', *Dolentium Hominum*, 31 (1996/1), p. 129.

[26] Jesús Alvarez GÓMEZ, 'L'assistenza ai malati nella storia della Chiesa', *Dolentium Hominum,* 31 (1996/1), p. 45.

[27] JOHN PAUL II, 'Il saluto agli acconciatori italiani', 16 June 1980, in *Insegnamenti 1980*, vol. III/1, pp. 1768-1769.

[28] JOHN PAUL II, 'Alle religiose della Diocesi di Roma', 10 November 1978, in *Insegnamenti 1978*, vol. I, pp. 126-131.

[29] JOHN PAUL II, 'Lo spirito del buon Samaritano nell'opera di Giovanni Paolo I', Angelus of 22 August 1980, in *Insegnamenti 1980*, vol. III/2, p. 431.

[30] JOHN PAUL II, 'Agli allievi delle Scuole Centrali Antincendi', 15 March 1980, in *Insegnamenti 1980*, vol. III/1, pp. 554-555.

[31] JOHN PAUL II, 'La Quaresima è un tempo di verità. Messaggio di Quaresima 1981', in *Insegnamenti 1981*, Vol. IV/1, pp. 595-597.

The Post-modern Context of Euthanasia

In particular in the countries of the first world we are witnessing a prolongation of human life and this is seen as a great advantage of modern times. According to recent statistics, reference is made to a life expectancy for people of eighty-one years in Japan (78.5 in Italy), compared to the life expectancy of thirty-nine years in Sierra Leone. Life is getting longer and there are various causes for this; amongst these there is in particular the advance of medicine.

Side by side with the advantages that the lengthening of life certainly involves, people are beginning to reflect on the costs that this implies. Let us list some of these: the economic costs of drugs and medicines, the costs that are involved in looking after the lives of elderly people and the terminally ill, the emotional costs for families who see the fulfilment of their ordinary lives obstructed by the long presence of an elderly or sick relative, especially if they are bed-ridden at home or in hospital, and then there are health-care costs, costs for the health policies of states and so forth. And then there are also the pains that the terminally ill or the sick elderly often suffer and which, in the views of some, make them want death; as well as the costs of palliative care, exaggerated treatment, and all the rest.

Unfortunately, in some circumstances attention is not paid to scruples in making a distinction between exaggerated treatment and euthanasia and people proceed immediately to bring about the death of elderly people and the terminally ill, thinking that in the final analysis the life of an elderly person or of a terminally-ill patient is no longer productive.

The position of the Catholic Church on euthanasia is well known. In no case is euthanasia morally licit. The reason for this is because human life is the most valuable gift that God has given to man for his stewardship and not for his absolute dominion: it is the very foundation of human dignity. Thus it is beyond human competence and cannot be disposed of, To take away the life of an innocent person is seen as one of the greatest crimes there is. Man can certainly do such a thing and in fact often does do this, but murder can never be legitimated.

In contrast with the clear position of the Church as regards the sacredness of life, as I have observed above, on very many occasions contemporary society in some countries comes to legitimate euthanasia at a public level.

The purpose of my paper is to dwell rapidly on certain anthropological points of the context of post-modern thought which at the level of its vision fosters an openness to euthanasia.

I. BASIC ANTHROPOLOGY

In basic terms the anthropological points comes from the thought of F. Nietzsche expounded in his work *Thus Spoke Zarathustra*: 'Man is something that must be surpassed. What have you done to surpass him?[1] Nietzsche mentions a kind of creature who surpasses man – the superman.

1. The Fourth Man, 'Radical Man'

G. Morra explains the thought of Nietzsche to us by saying that one is dealing with a fourth man who subsists after the three men who have preceded him in history have disappeared. The first man was the man of rationality, the man of Greek philosophy, directed by the order of the cosmos and secure in the eternal return of his cyclical mentality. The second man was the man of faith, produced by Christian-Jewish revelation, dominated by religion, oriented towards providence and directed towards an eschatological goal.

The first and second men had a feature in common: a balanced synthesis of faith and reason, of history and meta-history. This synthesis was destroyed by a third man who privileged scientific knowledge and rejected philosophical and religious knowledge. The third man subordinated philosophy and religion to science. He is the bourgeois who overvalued progress, secularised Providence, saw the 'new' and change as positive in themselves, and in this way developed the project of modernity. With the passing of time the third man as well was weakened, he entered his death throes (especially after Auschwitz) and his place was taken by another man, the fourth man: a man without religion, without philosophy, without history; technologised, secularised and contemporarised man.

This is the man of the post-modern epoch who is by now not capable of substitutive atheism but who has capacities with his technological instruments and his mass media, in which science and magic coincide. The fourth man does not live in history, which is largely buried. It is certainly the case that for him many histories exist but there is not history in itself. He is a man without tradition and without a future. The future, in fact, is already over because every 'afterwards' is nothing else but a necessity to maintain the system of doing or consuming, the perennial ideology of the new and the better.[2]

2. The Characteristics of 'Radical Man'

The characteristics of this radical man are the following: he is individual, good, autonomous, pleasure-based, contract-based, and ahistorical.

1. *Individual*

In himself he is not a person, he is only an individual that could become a person because he is sensorial, carries out mental operations, is conscious of

himself, and can engage in relationships with other people and express himself through symbolic representations.

2. *Good*

His will, his reason, his instincts and his senses, and his passions, are absolutely good. There is no moral evil; he is the measure of all things.

3. *Autonomous*

For the autonomous individual, as a consequence, there is no law that constrains him; he is a law unto himself.

4. *Pleasure-based*

He is an individual who looks for happiness only in the extension of every kind of pleasure, and in a special way in the satisfaction of all his desires. One goes from the culture of needs to the culture of desires and from man to consumption. One cannot need anything but one desires everything.

5. *Contract-based*

Because an individual necessarily enters into a total war of everyone against everyone, he looks for a rule for life, and this can only be the contract. A contract, always favourable to the individual, which obliges other people as long as this individual has the strength to oblige other people to implement it; when he does not have this strength he must submit himself to the rules of the strongest.

6. *Ahistorical*

This individual fully rejects the past: everything is surpassed, aged, and is of no use; only the new, the better, is what counts today. [3]

II. APPLICATIONS TO EUTHANASIA

From the first characteristic of this man it is evident that all 'scruples' vanish when faced with euthanasia. If an elderly person or if a terminally-ill person is not totally capable of developing conscious actions, especially in a permanent way, then he is not a person, he is only an individual, and nothing prevents him from being killed. The same applies, for example, to a mentally defective person or to embryos and foetuses, indeed to children.

1. Five Categories of 'Person'

Hugo Tristran Engelhard refers to three categories of persons: *person 1*, the moral agent; *person 2*, little children who have almost the same rights as the person; *person 3*, persons who were once persons 1 and are still capable of some minimal interactions: *person 4*, gravely handicapped or demented people who have not had and never will have the possibility of being persons 1; and *person 5*, human individuals who are gravely disabled, for example in a vegetative state, and who are not capable of interacting, not even in minimal social roles. Only person 1 in a strict sense is a person and the others are persons only in a social sense.[4]

2. Rules of Morality

On other hand, if a conscious person is himself the rule for everybody and for everything, what he wants to do to others he can do in full liberty because there is no morality or moral responsibility. This radical man is also called a 'moral stranger', that is to say he is a stranger in relation to those people who are still in the ancient stages and have by now been surpassed by the three previous men. For this individual to kill or not to kill does not involve any moral responsibility. He must only, as Peter Singer would say, follow the consequences of his actions.

1. *Contracts by Majorities*

Given that by the previous principle a war of everyone against everyone is installed, in order to avoid bad consequences for the 'person' individual, absolutely subjective contracts are signed in which justice has no meaning. Force alone has meaning and in this case it is given to the majority. Thus in a country the majority votes for euthanasia, this will be applied and everyone will have to accept this law without discussion. Any objection that is made in the name of objectivity is surpassed because it does not belong to contemporary man but is a question of the previous stages, which are by now retrogressive, a matter of bigotry, not valid, derived above all else from the religious stage.

2. *Pathways by which to Arrive at a Majority*

The pathway to arrive at a majority, on the whole, follows the following stages: 1. at the first stage a limit case is presented in the mass media, for example in the case of euthanasia the Terry Schiavo case or the Welby case. 2. Round tables are then organised, with the mass media as well, where an attempt is made to have radical portrayals of the 'fourth man' and also of his three predecessors; in these discussions an attempt is made to involve 'philosophical man' and 'scientific man' with 'radical man'. 'Religious man' is also brought into play, but with the intention of ridiculing him and accusing him of being retrogressive. 3. Then, or simultaneously, a survey is made of public opinion. This survey is more truthfully an opinion poll prepared beforehand where people are chosen who think like 'radical man', or where the approach of the opinion poll is such that answers are envisaged that are directed towards generating support for what is sought. 4. The terrain has already been

prepared to move on to the political level and be able to emanate a law that expresses the 'support' of the 'majority'.

By now these stages are ignored where there is dictatorial power and where there are people with this ideology who maintain that they represent the people and simply force other people to follow what they prescribe.

3. *International Agreement*

When one is dealing with agreement that requires an international majority, as for example at the United Nations, the NGOS which profess these ideas are of primary importance. These organisations infiltrate governments and the structures of the United Nations, one may think here of the WHO, and struggle from these position to obtain support. They have no inhibition in proclaiming their rules, especially before the idea of privacy of the religious beliefs of many of the representatives of so-called Christian countries; they are involved in lobbies and these lobbies reach the point of buying the votes of poor countries in a whole host of ways.

At the United Nations on the whole 'Recommendations' are issued, not laws. But these recommendations easily become laws in individual countries, as can be demonstrated from a survey of the world of health and health care.

Thus it happens that one passes from the thesis of the sacredness of life to the true dignity of life and one is here in line with the contemporary stage, in which, indeed, one must live in a civilised country.

Conclusion

Perhaps this modest paper can help to explain certain points that help us to understand better why, and especially over the last fifty years, this overturning of the 'natural' rejection of euthanasia has taken place, leading to its clear acceptance in the political world and also by public opinion.

There are many reasons why this has taken place: there is the whole context of the Malthusian mentality and also, if we want to go beyond this, the whole subjectivist and relativist mentality, which easily reaches nihilism.

Furthermore, it seems to me that this approach is also a characteristic of many epochal changes. We may think here of the Greek sophists after the great masters of philosophical thought, we may also think of the question of nominalism at the end of the Middle Ages or of the Enlightenment during modernity.

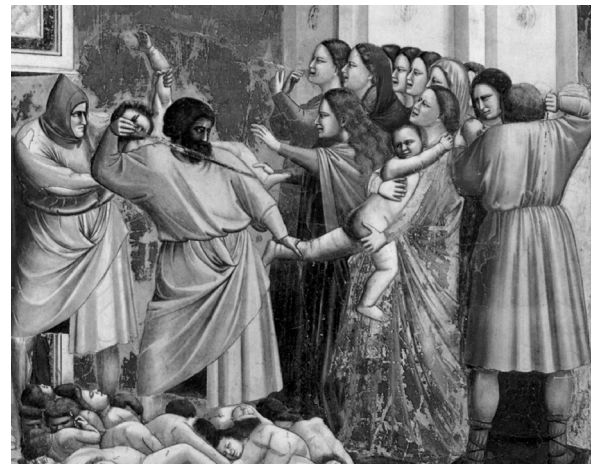
What the history of human thought makes clear is that this crisis of intelligence is a prelude to a strong and vigorous emergence of great geniuses who lead mankind back to truthful paths. For that matter, it is God who guides history and the Augustinian categories of the '*Uti*' and the '*Frui*' which guide the flow of the ages are absolutely valid, that is to say '*Amor Dei usque ad contemptum sui*' as the right way to construct man and '*Amor sui usque ad contemptum Dei* as the bad way by which to destroy man. The legitimation of euthanasia is the crowning point of this poisonous pathway, a climax of the culture of death. If total life is not the end of man, death and euthanasia establish their dominion. But if Christ is truly risen and we rise again in him, culture has a very clear finality which marks it out: death has been definitively vanquished and the total Kingdom of life has been installed.

For technologised man secularisation is no solution in the sense of full autonomy. All of us cannot be at the same time an end and a project. We are not 'moral strangers' because we have a pathway that is ours and one that is not strange and alien. This pathway, for this epoch and for all epochs of mankind, can only be Christ, our Creator and Redeemer and the Creator and Redeemer of every culture. To deny the ability to know the objective truth and to deny history necessarily means death, and this clearly explains why and how we have reached such frequent proposals for euthanasia.

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

Notes

[1] F. NIETZSCHE, *Thus Spoke Zarathustra*, n.5
[2] Cf. G. MORRA, *Il quarto uomo*, pp. 94-95.
[3] Cf. JÁN DACOK, "La postmodernità nel dibattito bioetica", p. 156
[4] H.T.ENGELHARD, *Manuale di Bioetica*, pp. 172-174



Euthanasia and the Mentally Ill? A Few Critical Points from a Christian-ethical Vision!

In Belgium on 28 May 2002 the law on euthanasia was passed. Request for, and implementation of, a 'gentle death' became legal, that is to say under certain conditions it was no longer punishable. The cornerstone of this law was autonomous decision which was seen in the light of the sick person 'being a creature'. In the Christian vision, the dignity of human life occupies the primary position. From this point of view, medical doctors and other health-care workers, as well as people who are involved in pastoral care, can find themselves in a field of tension. Indeed, they find themselves faced with very concrete requests by patients which in certain circumstances are totally legitimate. Were it not for the fact, and here lies the 'problem', that these requests are unacceptable both from the Christian point of view and from the point of view of the Catholic Church or the context itself of care. Thus in the discussion of the legalisation of euthanasia this field of tension was heavily present. Ethical reflection related above all to people who, because of their somatic suffering, found themselves from a medical point of view in a practically terminal situation. Even without an action of euthanasia, after a short period of time they would have died a natural death. Euthanasia would have only shortened (sic!) their natural death for a few days or a few weeks. Such is the background to the article on which I will strive to make a number of critical points.[1] First of all, I will dwell upon the well documented and from this point of view very interesting doctrinal reflection of the author. Secondly I will examine certain practical-ethical advice of the Brothers of Charity. And thirdly I will refer to my critical points.

1. Doctrinal Reflection

Ethical reflection concerns above all non-terminal mentally ill people who, however, suffer in a truly unbearable way and without any prospects. Even a long treatment, however appropriate it may be, changes nothing in their situations of suffering. One is dealing, therefore, with people in society who have no hope of being able to live a somewhat normal life. Their suffering concerns the situation of their lives as a result of which, differently from the terminally ill, this suffering does not lead to a natural death. In this case, euthanasia is said to shorten their lives, at the least for many years.[2]

1. Some fundamental points of view

According to the Belgian law, euthanasia is 'premeditated action by a person who is different from the person who has asked to terminate his life'.[3] In this sense euthanasia is *a* form of active medical accompanying with the intention of *making* that person *die*. This law thus authorises health-care workers, with the prior informed consent of those who ask for it, to terminate those people's lives. One is not dealing, therefore, with help to be given in cases of suicide and to end a life without there being a request to do so. These forms are, and remain, in legal terms punishable. Thus however much in psychiatry the distinction between euthanasia in a non-terminal situation and providing help to engage in suicide is small, from a juridical point of view the judgement is different.[4]

2. The Juridical Point of View

The law covers physical suffering in a terminal situation and mental suffering in a non-terminal situation, making euthanasia possible for non-terminal mental patients as well. However, these patients cannot ask for euthanasia on the basis of a previous voluntary declaration but only on the base of a contemporary request. A mental patient, however grave his situation, will not find himself, in fact, in a possible situation of decisional incapacity, as can be the case in a physical patient.[5] For a contemporary request there are three conditions: the patient must be an adult and be able to want euthanasia; his will must be free, repeated and lasting and not imposed from outside; and the state of the illness must be from a medical point of view without any hope and from both a physical and mental point of view unbearable. On the part of the medical doctor as well there are certain conditions: he must speak with the patient and propose to him forms of palliative care; in addition, he must speak to him about possible alternatives; and lastly he must consult a colleague and speak with the health-care personnel of the patient as well as with those whom the patient has indicated. The medical doctor must write down everything in a dossier and declare the execution of euthanasia. The patient must present his request in written form, date it and sign it. It should be noted that when a patient, as is the case with a mental patient, is not terminal the medical doctor must consult a psychiatrist or specialist or at least wait for a month before carrying out euthanasia.

From what has been observed hitherto, the complexity and delicacy of the situation is already evident. First of all, because certain conditions seem rather paradoxical. On the one hand, the mental patient must take his decisions in an absolutely free way, and, on the other, the situation of his illness must from a medical point of view be truly 'desperate'. Now to what extent can this patient reflect serenely on his request or otherwise as regards euthanasia? And therefore? In addition, given that one is dealing with a grave psychiatric patient, the re-

quest for euthanasia could be a sign of a 'desperate' illness. Thus one should not share this '*forma mentis*' of the patient and one should, rather, hold up some ray of light and a possible hope, above all as regards the possibility of combating the pain. Thus the health-care personnel must be very careful before applying the euthanasia law.[6]

3. The Point of View of the Magisterium of the Catholic Church[7]

Human life is 'the foundation of all goods and at the same time the necessary spring and the condition of every human activity and activity of the social community'[8]. Two theological arguments concretise and explore this humanitarian and philosophical foundation. Life is also a 'gift the love of the God which must be preserved and made fertile'.[9] God is the Lord of life and created man in His image and likeness. To kill someone, therefore, means that man touches the creation of God. Hence one goes to the second theological argument: the divine law that lays down that one should not kill. *Evangelium vitae* condemns euthanasia as 'morally unacceptable pre-meditated killing'.[10] This is a grave transgression of the law of God and more specifically of the fifth commandment: 'thou shalt not kill'. In the documents of the Belgian bishops we find, in addition to this principal argument, arguments that come from medical deontology. 'Medical doctors have 'the responsibility to treat and care for men, to promote their lives and not to end them'.[11] For that matter, the request for euthanasia made by patients is most of the time a cry against their pain, fear and loneliness, and also against the possibility of exaggerated treatment.

Another, very strong, argument against euthanasia is the limit of autonomy, against the right to decide on the end of a life, from the social point of view, that is to say reciprocal relations in deciding about the value of the patient for other people.[12] Lastly, the bishops lay stress on the possible alternatives that by now are offered by the various forms of palliative care.[13]

4. The Point of View of Caritas Vlaanderen

The ethical committee begins with two fundamental options: respect for the human person and the value of autonomy. However, its point of departure, for Catholic hospitals, is not autonomy but 'the unconditional confirmation of the dignity of the human person'.[14] Autonomy is not an 'individual self-decision' but a 'relational autonomy' because the human person is a relational being. Thus 'autonomy' cannot be separated from a tie with other people and from responsibility. From this option the committee requires that every terminal patient can ask for appropriate palliative care 'at home' or in a nursing home.[15]

However, 'there can be exceptions when, despite palliative care, suffering and the request for euthanasia do not disappear. In such cases we respect the decision of conscience by the medical doctor and the members of the team to move on to euthanasia'.[16] In addition to the conditions laid down by the law, Caritas requires that all forms of palliative care are implemented and above all that the patient is already in a stage of death, that is to say that his natural death will take place in a few hours, a few days or a few weeks.[17] Lastly, one must be dealing with physical suffering that is truly unbearable or mental suffering at the base of which there a progressive and grave physical deterioration. For this reason, in the case of non-terminal mental suffering the conditions do not exist to apply euthanasia. For that matter, the decision about palliative care or euthanasia must be accompanied with the greatest openness possible and communication between the interested parties, the patient and the relatives included.[18]

5. The Point of View of the Brothers of Charity

In Belgium the Brothers of Charity are responsible for fifteen psychiatric hospitals. They are confronted with the problems and issues relating to the request for euthanasia by some of their non-terminal mental patients. Their point of view is decidedly that of the Magisterium of the Church. In their programmes of care they do not allow euthanasia and in this way they are more radical than Caritas.[19] For their point of view against euthanasia the Brothers draw upon two arguments: unconditional respect for every man and the responsibility to provide care to patients. Every human being is a person and remains such in all the stages of his life as a person: this person-being of his is linked to his nature and not to the approval of society or the rights that are attributed to him.[20] When a psychiatric patient asks to terminate his own life, this request implies, rather, a cry for greater human solidarity and greater professionalism in the treatment of mental pain.[21]

From various points of view it emerges that the acceptance of a request for euthanasia made by those who suffer from unbearable but not terminal mental pain is irresponsible. Respect for life is so fundamental that it cannot be subjected to the autonomous decision of the patient in questions. However, the author of the article observes, with this valid point of view, at the level of 'principle', all the practical problems are not solved. Indeed, patients can ask for euthanasia in order to be freed from their suffering. At times, given their situation, this request is completely understandable and corresponds to legal requirements. Hence the tension for the health-care personnel: on the one hand the request by the patient and on the other the law on euthanasia and the Christian vision. The points of view at the outset provide an insufficient answer to the practical problem of the accompanying of patients who ask for euthanasia.

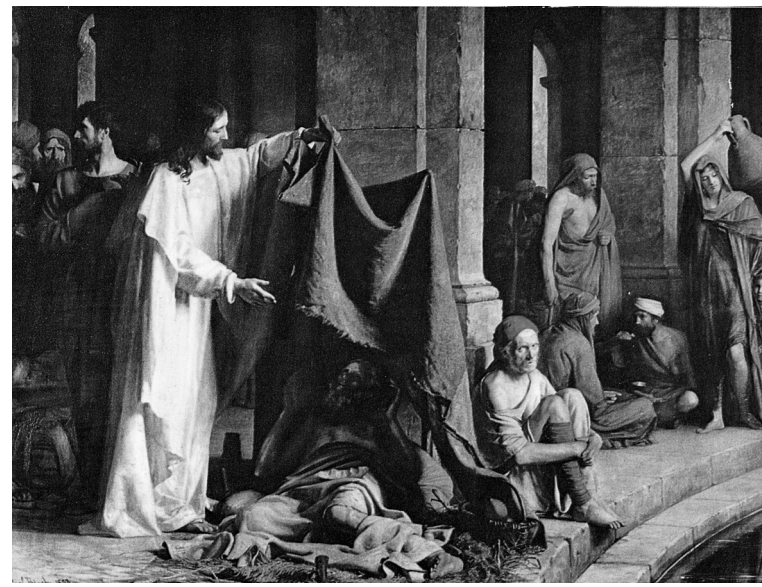
2. A Practical-Ethical Proposal

A workgroup of the Brothers of Charity formulated a proposal for the accompanying of patients who ask for euthanasia in their situations of non-terminal

illness.[22] Beginning with ethical insights and the practice of the twenty-five members of the group, their relevance is brought out because one is dealing with an ethical reflection addressed to practice. Clarified and compared in a critical way with other points of view taken from the literature in the field, a kind of concluding 'draft' was drawn up to be compared once again with the points of view of the literature in the field. After other discussions an agreement on a practical-ethical proposal was reached in which each member of the group, free from any pressure of authority or function, could express his thought.[23]

1. Fundamental values

There are three fundamental values: the right to the protection of life (*de beschermingswaardigheid*); the autonomy of the patient; and the relationship between the person who treats and the patient. The protection for life is the value *par excellence* because it is fundamental and a condition for all other values. It is based upon human life itself and not on its quality. For this reason, every life is worthy of protection and it is so according to the fundamental principles of the law, human rights and the various world *Weltanschauungen* and religions. In addition, Judaism, Christianity and Islam base the dignity of life on the creation of God as a result of which its protection is absolute. Certain people, although they recognise such protection as a foundation of life, confer a relative value on it, that is to say they see it in relation to other values. In the society of our time this autonomy is a very much emphasised fundamental value. Each man is his own legislator, that is to say he can decide, as along as he does not damage someone else. It is emphasised that respect for this autonomy is an essential element in the movement for the emancipation of patients. It is a reaction against the paternalism of the person who treats and the law gives the patient the right to informed consent. Before consenting, the patient can freely decide to accept or not to accept the medical intervention. For some people when the patient is not of sound mind this autonomy is even absolute because he has the right to dispose of his own life and his own death. Others, instead, argue that this autonomy means a relative-fundamental value, that is to say that it has still to be compared in a concrete situation with other values. One of the most important elements is the relationship between the personnel that treat



and the patient; its quality is an essential ethical and deontological element and in the view of some of absolute importance when one is dealing with transferring the patient to another health-care institute.[24]

2. The process of accompanying

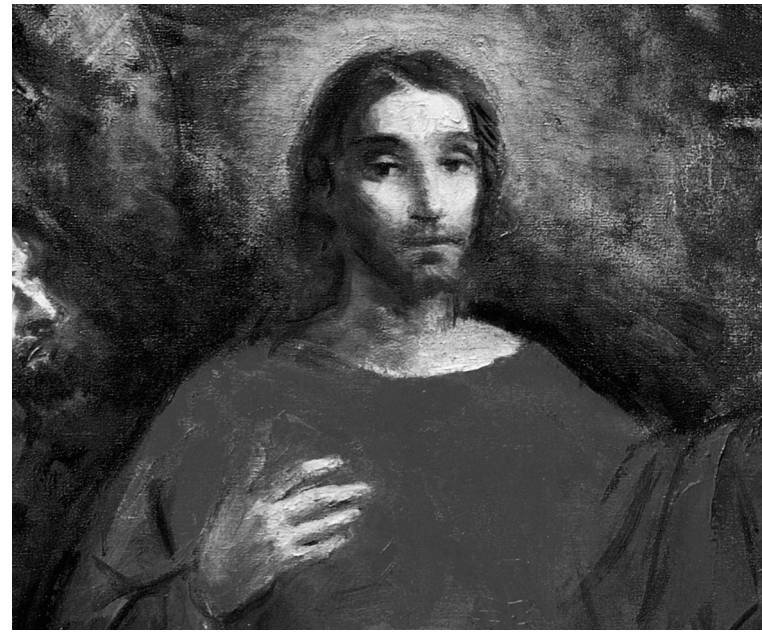
The three fundamental values constitute criteria when patients ask for euthanasia. The right to the protection of life from a Christian point of view is higher than the right to autonomy and thus the request for euthanasia cannot be practiced. However, the request must be taken very seriously and should be discussed with the patient and his relatives. A possible solution is a kind of psychiatric palliative care in which one is dealing with choosing life and a commitment to care. But how should one behave when the patient continues with his request for euthanasia? One must see if the request is in conformity with legal requirements in the field. If the request does not meet the requirements of the law, the personnel engaged in the provision of treatment will continue its use of treatment in the best way possible; if the patient continues with his request and this meets the requirements of the law, in 'Christian' institutes the application of the law is not allowed because of the policy in favour of life. However, the personnel responsible for treatment can inform the patient about the possibility of committing itself to sending him to a consenting medical doctor so as to transfer him to another nursing home or hospital. For this reason, it is emphasised, euthanasia takes place outside (sic) the 'Christian' institute. However it is rightly perceived that this referral requires a justification. From the Christian point of view, the referral is on the only exist path from the conflict between the primacy of the protection of life and the autonomous request for the carrying our of euthanasia. As regards the commitment of the personnel responsible for treatment, the referral is justified because curative continuity acts as a bridge between the autonomy of the patient and the protection of life. From this bridge there follows a therapeutic argument that is common in the health-care sector: the referral of a patient from one health-care institution to another, such as takes place, for example, with a patient being moved from an intensive care unity to a cardiological unit. Lastly, this very law justifies this referral because it does not oblige any

medical doctor to cooperate in the carrying out of a request for euthanasia but also allows a medical doctor to refuse to propose the referral itself. From a juridical point of view, a medical doctor, however, must explain his refusal to the patient, even though, as the author of the article makes clear, the referral is ethically desirable (*wenselijk*).[25]

However our author does not conceal that despite these various arguments that justify such a referral, a number of people find it hypocritical. One is dealing with a tacit approval, of indirect collaboration, of a transfer of the carrying out of euthanasia to other people. The author of the article accuses this criticism of not taking into account the ethical option of referral, that is the non-approval of euthanasia and thus its non-execution. The referral seeks only to respect, as far as this is possible, the autonomy of the patient, all the more so if there are no other courses of action that are practicable and realisable. However, the question is whether there is another solution, as seems possible in the guidelines of the Dutch Psychiatric Association

3. A possible alternative

The Association makes clear that certain guidelines can be found in the Dutch law on euthanasia and assisted suicide for mental patients. First of all, the request must be free of all external pressure and well thought out, that is to say without internal influence of a psychiatric kind. It should be observed that the psychiatrist must judge whether the wish of the patient to terminate his life is lasting. A second guideline concerns whether the pain is truly unbearable and whether there is a situation that holds up no hope for the patient. Given that the unbearable character of the pain to be born and the lack of prospects are of a subjective character, the psychiatrist must be aware, as far as this is possible, of their objectivity and of the possibility of treatment. There thus follows a dialogue between the psychiatrist and the patient when what policy to adopt is decided upon. When, because of a lack of any other solution, it emerges that the only reasonable thing is euthanasia, another psychiatrist has to be consulted. Lastly, after he has expressed in written form his judgement, all the interested parties, the patient, the medical doctor, the personnel responsible for treatment and the patient's relatives agree to accept the request of the patient to terminate his life. The psychiatrist then has the obligation to carry out the act of euthanasia in a very careful medical way. He must announce it and offer assistance to the patient's relatives. This careful commitment on the part of medical doctors which is required by the Dutch law in the field of euthanasia is adjudged by the author of our article as a very worthy thing. However these guidelines neglect the Christian-ethical point of view of the Magisterium of the Catholic Church, of Caritas Vlaanderen and of the Brothers of Charity. Indeed, when the legal requirements are met one can, legally and ethically, meet the request for euthanasia expressed by mental patients. We thus arrive at a point of fracture at the level of the principle of human dignity.[26]



3. Some Critical Points

The key question in the field of euthanasia is said to be this: how should we understand the dignity of human dying and the dignity of human living because, it is said, both those who are in favour of euthanasia and those who are against euthanasia appeal to this dignity. The supporters of the anti-euthanasia line see the dignity of life from the point of view of its protection '*sic et simpliciter*'; the supporters of the pro-euthanasia line see the dignity of human life from the point of view of its quality. The first argue that human life should be protected because, given that it is an intrinsic, primary and fundamental value, every human person has an inalienable divine right to his life. Hence the commandment of the Creator of life: 'thou shalt not kill'. The second argue that because man himself is the judge of the quality or otherwise of his own life he has the right to decide upon the dignity of his life and this to dispose autonomously of his life.[27] Here, with all clarity, it is said, is the point of fracture between *those who are in favour and those who are against euthanasia*.

My critical point concerns first of all the statement that one is dealing with a point of fracture expressed in a 'yes' and a 'no' on the basis of a different conception of the dignity of life. In the field of euthanasia one is not dealing with two opposing opinions: one in favour and the other against. 'No' to direct euthanasia is the official *doctrine* of the Magisterium of the Church which holds that 'What-

ever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick or dying persons. It is morally unacceptable. 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'.[28] To call euthanasia a shortening of life is truly a euphemism, if not an evident falsification of reality. However, and this is what I want to stress, it is the supporters of 'yes' to direct euthanasia who break with the doctrine of the authentic Magisterium of the Church, as a result of which the point of fracture is not a question at issue between two opinions but simply the consequence of an *opinion* that is unacceptable from an ethical point of view. But I would like to also emphasise another critical point concerning above all the conclusion of the author of the article where he adopts a stance in favour of a compromise between the doctrine of the Church and the autonomy of a mental patient. Hitherto, he says, the two opinions (sic!) on the dignity of human life are seen as absolute values, the two points of view (sic!) will always be radically opposed. Thus were the Church, for her part, to relativise somewhat her point of view on the protection of life, and the supporters of euthanasia, for their part, were to relativise their point of view on autonomy, one could reach a compromise. Inspired by a Christian-ethical personalist vision, the protection of life in itself and autonomy in relation to the quality of life are fundamental values. However, *observes our author*, one is dealing with values that in the practical situation of the patient should be dosed proportionately.[29] The aim of this dosing is specifically to aim at the greatest possible human dignity in which life itself is protected as much as possible and the autonomy of the patient is respected as much as possible. Our author says that he is convinced that as regards the tension between protection of life in itself and the autonomy of the patient, when it comes to the quality of his life we can only approach things well when we place emphasis on the relationship and the balance between the personnel responsible for treatment, the patient and his family relatives. Once again we come to the three fundamental values: the right to the protection of life; the autonomy of the sick person; and the relationship between the personnel responsible for treatment and the patient. Now in the compromise the third fundamental value becomes the binding force between the protection of life in itself and the autonomy of the patient as regards the quality of his life. Here, observes our author, from the practical point of view, is the sufficient answer that the theoretical principle of the Magisterium of the protection of life in itself was not able to give.[30]

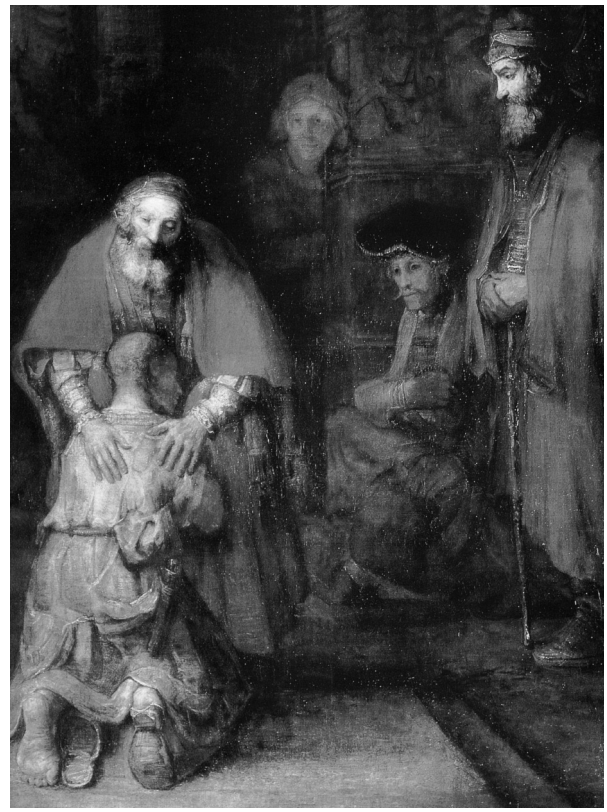
On this point I will formulate my most critical points. There is an underestimation of the fact that the principle of the doctrine of the Magisterium of the Church concerns the *sacredness* of human life, that is to say its intrinsic value and thus the moral obligation of its unconditional protection. This 'moral' intrinsicness' means that direct euthanasia is always an *intrinsic wrong* and thus never allows a situation that would allow an exception. The *Catechism of the Catholic Church* teaches: '*Human life is sacred* because from its beginning it involves the creative action of God and it remains for ever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can under any circumstance claim for himself the right directly to destroy an innocent human being'.[31] In the vision of compromise, and I repeat the point, one does not take into account this absoluteness of obligation: nobody in any circumstance can directly put an end to the life not only of an innocent person but also of that of a terminal or non-terminal sick person. This supporter of compromise forgets that *moral autonomy is a prerogative of the conscience*, on the condition, however, that it conforms to *teonomia*. Thus the conscience of the mental patient as well not only cannot depart from this but to be true and upright and certain it must conform to the fifth divine commandment: only God is the Lord of life from its beginning to its end. The fathers of the Second Vatican Council teach with great authority on this point: 'Deep within his conscience man discovers a law which he has not laid upon himself but which he must obey. Its voice, ever calling him to love and to do what is good and to avoid evil, sounds in his heart at the right moment…For man has in his heart a law inscribed by God…His conscience is man's most secret core and his sanctuary. There he is alone with God whose voice echoes in his depths'.[32] Cardinal Newman, who was a specialist in the field of the conscience, clarified further: 'Conscience is a law of the mind; yet [Christians] would not grant that it is nothing more; I mean that it was not a dictate, nor conveyed the notion of responsibility, of duty, of a threat and a promise…[Conscience] is a messenger of him, who, both in nature and in grace, speaks to us behind a veil, and teaches and rules us by his representatives. Conscience is the original Vicar of Christ'.[33] The same commandment applies to the conscience of the personnel responsible for treatment and to the family relatives. To summarise, the Christian-ethical vision, as proposed by the author of the article, does not only not solve the tension between the *teonoma* of the protection of human life in itself and autonomous conscience of the mental patient as regards the quality of his life, but this vision is also absolutely illicit. Indeed, the decision to terminate life does not depend on the 'autonomous' voice of the patient or on the 'dialogic' voice of the personnel responsible for treatment and the family relatives. In matters relating to life and death, the voice of God alone decides. Given that the Creator united soul and body, no man in any circumstance can directly separate what God has united. 'Man shaped man from the dust of the soil and blew in his nos-

trils a breath of life and man became a living being' (Gen, 2:7). The whole of man is thus willed by God. For this reason, to deny euthanasia in one's own institute and then to act so that the insistent request of the mental patient is met elsewhere is not only a hypocrisy but also signifies a certain illicit collaboration with the intrinsic evil of direct euthanasia. The *Catechism of the Catholic Church* makes clear: 'Whatever its motives and means, direct euthanasia consists in putting an end to the lives of handicapped, sick or dying persons. It is morally unacceptable. 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'.[34] In his address during the audience of 8 March Pope Benedict XVI told the members of the St. Peter's Circle: 'Yours is a silent but more eloquent than ever witness to love for human life, which deserves care and respect until the last moment of its breath'.[35]

Rev. BONIFACIO HONINGS OCD,
Professor Emeritus of Moral Theology at the Pontifical Lateran University and at the Pontifical Urbanian University, Rome, Consultor of the Congregation for the Doctrine of the Faith, Consultor of the Pontifical Council for Health Care Workers, Ordinary Member ad vitam of the Pontifical Academy for Life, the Holy See.

Notes

[1] Cf. AXEL LIÉGEOIS, 'Eutanasie bij psychisch lijden? Een christelijk'ethiscue visie', Collationes, 36 (2006) p. 363; the whole of the artice is to be found on pp. 363-380; hereafter 'Euthanasie'.
[2] Cf. 'Eutanasie', p. 364.
[3] Belgisch Staatsblad, 22 June 2002, art. 2 of the law.
[4] Cf. Eutanasie, p. 364.
[5] Cf. art. 4 § 1.
[6] Cf. 'Eutanasie', pp. 366-367.
[7] The author cites: the Declaration of the CDF of 1980; The Catechism of the Catholic Church of 1993; the encyclical *Evangelium vitae* of 1995; two letters of the Belgian bishops, one of 2001 and one of 2002 (see p. 367, note 14)
[8] CDF, Declaration, n. 2 (quoted on p. 369, note 15).
[9] *Ibidem* (quoted on p. 369, note 16).
[10] *EV,* n. 65 (quoted on p. 369, note 17).
[11] 'Accompagnare gli uomini quando la morte è vicina', n.7 (quoted on p. 369 note 18).
[12] Cf. 'Accompagnare', nn. 8 and 9.
[13] Cf., 'Eutanasia: retrocessione della civiltà umana. Cura palliativa, sí, eutanasia, no'.
[14] C. CASTMANS, *Cura per una morte dignitosa dell'uomo,* p. 228.
[15] Cf. *Ibidem,* pp. 228-235.
[16] *Ibidem,* p. 236 (see article quoted p. 369)
[17] Cf. *Ibidem,* pp.236-237 (see p. 369 at the end).
[18] Cf. 'Eutanasie', pp. 369-370.
[19] This Caritas in exceptional cases accepts the decision for euthanasia, se above 1. 3.
[20] Cf. R. STOCKMAN, *Euthanasie. Het standpunt van de Congrgatie van de Broeders van Liefde* (Gent, 2002); quoted p. 371, note 32.
[21] Cf. STOKMAN, op.cit., p. 23-27; quoted p. 370.
[22] *Werkgroep Ethiek in de Geestelijke Gezondheidszorg, Begeleiding van psychiatrische patiënten met een verzoek tot euthanasie in een niet terminale situatie* (Ghent, 2006); quoted p. 371, note 36; the group was made up of twenty-five people.
[23] See p. 372.
[24] Cf. 'Euthanasie', pp. 371 and 372.
[25] Cf. 'Euthanasie', p. 376 and above all at the end.
[26] Cf. 'Euthanasie', p. 378.
[27] Cf. 'Euthanasie', pp. 379-380.
[28] CCC, n. 2277.
[29] Cf. 'Eutanasie', p. 380; the author refers to his article 'Een personalistiche model voor ethiek in de zorg', in Tijdschrift voor Gezondheidszorg en Ethiek, 15 (2005) nr. 3, 75-80.
[30] Cf. 'Eutanasie', p. 380 at the end.
[31] *CCC,* n. 2258.
[32] GS, 16, quoted in *CCC,* n. 1776.
[33] JOHN HENRY NEWMAN, letter to the Duke of Norfolk, 5 , quoted in CCC .
[34] *CCC,* n. 2277.
[35] *L'Osservatore Romano,* Friday, 9 March 2007, p. 5.



Care for Mental Health in Childhood and Catholic Health Care

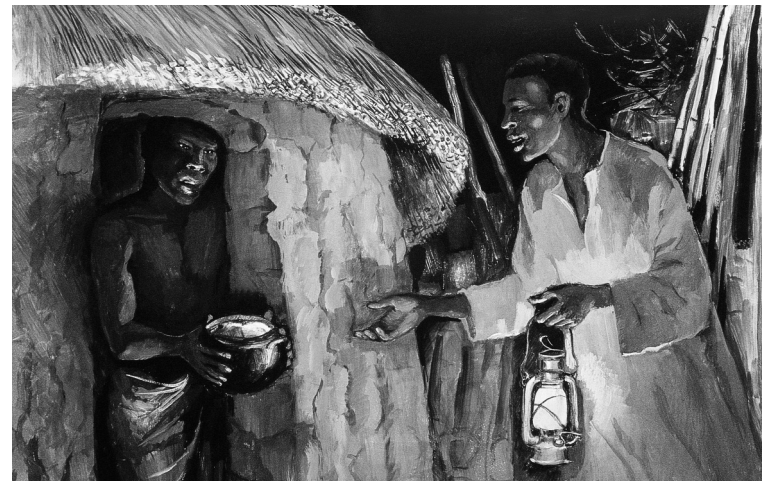
Introduction

The approach of this paper is an ethical approach. To speak about mental health from an ethical angle means to call on the sciences or the practices that deal with mental health to address the human condition in its reality made up of a body, a faculty for relationships, and spiritual competences/abilities that cannot be reduced to the mere neuro-sensory apparatuses. In basic terms, we are proposing anew the question of the religious meaning of the human being, with the ascertainment itself of identity and the meaning of life.

In contrast to certain ideologies which propose a total liberation from rules, we base ourselves on objective values that include the concept of limits and propose an appeal to individual responsibilities as a specific connotation of human freedom. For this reason, it appears to us to be a gratuitous reduction to want to solve the questions of the mental disturbance of childhood, adolescence or adulthood with recourse to pharmaceuticals. We do not believe, with all the advantages that pharmaceuticals offer, that one can accept the idea of transforming all emotions and emotional disturbances into pathologies, with the proposal of corrective pills from early childhood onwards. Our proposal is in harmony with Christian personalism and is based on models of planned care in which needs are analysed and solutions proposed with actions and coordinates of a psycho-social and clinical-care character.[1] On this assumption is based the mission of Catholic hospitals directed towards men of all continents and of all cultures, with special concern for choices at the level of education and prevention to achieve the health of children.

1. A Prosperous Society without a Culture of Life

During the sixty years of prosperity and economic growth that followed the Second World War, the vision of the age of childhood in Western society has changed drastically for a multitude of reasons that are well known to the Catholic community: the decline of numerous families; the increase in the number of divorces and of one-parent families; a concentration on attention being paid to the individual world rather than to the relational world; and changes in lifestyles due to an increase in secularisation, materialism and consumerism. It is certainly the case that a great deal of consumerism today is focused on the wellbeing of childhood, as one can see from changes in diet, which are influenced, for example, by additives to foster the consumption of foods which have more sugars and fats, with the consequent well-known plague of obesity.



Despite this 'prosperity', research reveals an increase in unhappiness, depression, anxious states, aggression, and the abuse of psychotropic dugs by young people for whom there are exaggerated prescription of such drugs. Indeed, there is the risk that the exaggerate administration of psychotropic drugs to young people is an easy and rapid way for adults to reduce their sense of responsibility, their fears and their insecurities. This is a situation that raises serious questions for the consciences of Catholic health-care professionals but above all for institutions that want to maintain their own identity out of a faithfulness to the Catholic Magisterium.

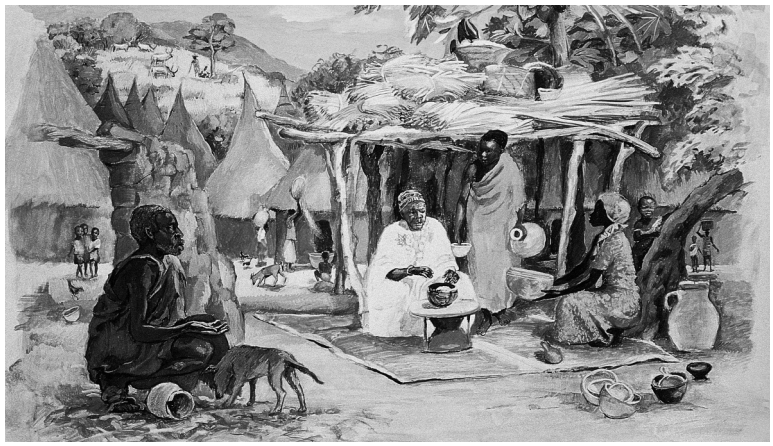
In the United States of America millions of children (including the very young) are prescribed anti-depressants, stimulants, anti-psychotics and anti-convulsives with side effects that can even be lethal. Most of these pharmaceuticals, as is known, have still not been fundamentally studied as regards their paediatric use.

This practice of treating the behaviour and the emotional state of children is in expansion globally and has been observed in more than fifty nations.

In the United States of America the diagnosis of mental disturbance has increased by 4,000% over the last ten years.[2] *In the United Kingdom the prescriptions for stimulants increased by 7,000% between 1994 and 2004.*[3]

In the West, the relations between families, communities and society have changed. The same may be said of lifestyles, which have been influenced by materialism secularisation and an increase in depression, drug abuse, aggression and anxiety.

Instead, the prevalent biomedical model locates the 'problem' inside the child and treats behaviour as an illness. The suffering of children is reduced to genetic and biochemical imbalances which have to be treated with pharmaceuticals that bear directly on the development of the brain of the child. At the present time there is no scientifically proven study that demonstrates that there is a gene, or an imbalance in an chemical process, which is the real cause of a mental disturbance:[4] nobody knows what a normal level of serotonin (the neurotransmitter often connected with mood) actually is.



However, medical journals, daily newspapers, TV and academic institutions continue to argue that a dysfunction in the brain is the cause of mental disorder, despite a lack of scientific evidence to sustain this thesis. The reductionist approach prevails, according to which there is a pill for every illness. This is in opposition to the holistic vision of Catholic personalism which welcomes, listens and accompanies.

2. The Abuse of Pharmaceuticals and the Illnesses of Childhood: What is the Primary Interest?

Various authors have emphasised how many psychoactive drugs cause a chemical imbalance by disturbing the levels of the neurotransmitters. In addition, there is still no long term research on the toxicity of these pharmaceuticals for the development of the brain and the nervous system in children. For this reason, it is not clear whether the brain of a person who interrupts this pharmacological therapy begins once again to produce its normal levels of neurotransmitters.

The collateral effects of stimulants fosters a delay in physical growth (and also in brain growth) and the risk of sudden death because of heart problems or suicide. Stimulants provoke addiction and are known for their capacity to cause obsessions and psychoses. The paediatric use of these pharmaceuticals has demonstrated the generation of alcohol, nicotine and drug abuse later on in the lives of these children.[5]

The new generation of antidepressants is, in addition, connectable to the risks of neonatal deficits, including brain damage, congenital malformations and pulmonary hypertension.

Anti-psychotic pharmaceuticals are connected with obesity and diabetes, late dyscinesia and other permanent neurological damage, suicide, and early death with a reduction in life expectancy of ten to twenty years. As Dr. B. Duncan, the author of *What's Right With You*,[6] says: 'a risks/benefits analysis does not support the use of psychotropic drugs as the first line of treatment for youth problems'.

An alarming trend is the increase of poly-pharmacological therapies, especially in children who are administered anti-depressants (SSRI: selective serotonin recaptation inhibitors) and who begin to manifest obsessions. Some experts have claimed that SSRI reveal profound bipolar disorders and have no intention of recognising obsession as a collateral effect of SSRI. The response to treatment is the addition of a more powerful (and potentially dangerous) anti-psychotic to counter an aggravation of the cerebral illness.

To complete this information, it should be said that after the official communiqué of the British Health Agency the FDA of the USA also expressed worry about the increase in cases of suicide or cases of violence in children and adolescents being treated by anti-depressants. The increase in the registration of suicides and aggressive behaviour in these children, treated in particular with SSRI-class drugs, also led the EMEA,[7] the European Medicines Agency, to reassess the data on the use of these pharmaceuticals during the paediatric and adolescent age with the goal of clarifying their safety profile in these age bands.

What has not been demonstrated in any in-depth study is the safety or effectiveness of these forms of treatment.

*Indeed all of the three most important studies, CATIE (Clinical Antipsychotic Trials of Intervention Effectiveness) , STAR*D (Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study), and STEP-BD (Systematic Treatment Enhancement Programme for Bipolar Disorder) of the National Institute of Mental Health (NIMH), have defects either of methodology or of design (in all of them placebo groups are absent) and have exaggerated success rates.*

Cost: 100 million US$.

These studies cannot be seen as valid and correct studies because of an absence of empirical data.

If there is no evidence of safe and long-term effectiveness of these pharmaceuticals in paediatrics, there can be no scientific justification for their use. Is this not a violation of the Hippocratic oath which at the outset imposes not causing injury? To go on treating children with these pharmaceuticals may be seen as pure and simple experimentation. Many producers of cosmetics avoid testing their products on animals. How can

we then justify experimentation with pharmaceuticals that modify the brains of our children?

As Dr. Grace Jackson MD, the author of *Rethinking Psychiatric Drugs*,[8] declares: 'in disturbing the endocrinal and immunological system, the so-called 'psychotropic' agents weaken the ability of the human species to produce healthy progeny; they compromise the capacity of caregivers to provide adequate protection and educational roles in relation to young people and reduce the wellbeing of all age groups as regards their capacity to manage stress and frustration. And even more important, in altering the function and integrity of the brain, psychoactive drugs destroy the essential qualities of mankind as a reflection of the Divine Creator. In destroying the seat of consciousness, they damage the foundations of our humanity such as compassion, morality and spirituality'.

Despite the fact that it was informed about the dangers of these pharmaceuticals, the American Congress approved more than 20 million US$ for a general screening of mental health beginning with infancy. This inquiry was outlined and financed by the largest pharmaceutical companies, thereby favouring recommendations of treatment with their products, which are also more expensive.

This screening programme, which was little publicised, was implemented in schools throughout the United States, and in Great Britain, France and Italy the tendency is to implement a similar programme. However there have been protests by many professionals.

Many American States find themselves in a bankrupt state as regards their Medicaid projects (which support those in need of care who are most in need), whose budget has been reduced by the high costs of certain forms of treatment that arose as a result of the screening applied to thousands of young people.

It should be stressed that even when the pharmaceutical companies agues that screening can identify young people who run the risk of suicide, there is no evident proof that this instrument is appropriate as regards the obtaining of such results. Opponents see these screenings as a way by which the pharmaceutical companies obtain long-term consumers of psychoactive drugs in such a fragile part of the population and one dependent on adults.

The subject of psychoactive drugs and the lack of in-depth research to demonstrate their safety and effectiveness, including certain manipulated or suppressed negative data in order to influence the market, has moral and ethical implications for the whole of mankind and above all for health-care workers, pastoral workers and families with children.

3. Ethics and Mental Health in Childhood

In this context 'of the West is not the best', globalisation promotes the biomedical model of mental health in developed countries and in developing countries. Even though this is not a contemporary and urgent problem in developing countries where other emergencies exist, we may ask whether the errors committed in the West could not be avoided.

For health-care workers, pastoral workers and families, a careful basic information is required. It is certainly the case that access to truth is a human right.

As the Holy Father Benedict XVI said at the Holy Mass at the sanctuary of Mariazell in Austria on 9 September 2007: 'this resignation faced with the truth is, in my view, the core of the crisis of the West, of Europe'. And he went on: 'If truth does not exist for man, he, in basic terms, cannot even distinguish between good and evil. And then the great and wonderful forms of knowledge of science become ambiguous: they can open up important prospects for good, for the salvation of man, but they can also – and this is something that we can see – become a terrible threat, the destruction of man and the world'.

The scientific world has ethical obligations and its responsibility is required in demonstrating that research reflects respect for truth.

Pope Benedict XVI gave a direction for the aspects of modern science of 'predictability and 'ethical responsibilities' for scientists in November 2006 in his address to the members of the Pontifical Academy of Sciences when he stated: 'Scientific predictability also raises the question of the ethical responsibilities of the scientist. His conclusions must be guided by respect for the truth and by an honest recognition both of the accuracy and of the inevitable limits of the scientific method. Certainly this means avoiding uselessly alarming predictions when these are not supported by sufficient data or go beyond the effective capacities of science to predict. However it also means avoiding the contrary, i.e. silence, born of fear, in the face of authentic problems. The influence of scientists in shaping public opinion on the basis of their knowledge is too important to be undermined by inopportune hurry or by the search for shallow publicity'.

The essential purpose of health care is to protect, care for and safeguard human life from its beginning until its natural end. We ask ourselves whether it is right for a child, who has managed miraculously to come into this world, to be subjected to prescriptions for psychoactive drugs as early as the age of six months.

Let us try to avoid the silence of fear. In contrary fashion, let is begin to give this subject our vigilant attention and study, starting together, and honouring the words of the Holy Father Benedict XVI, realising our role as witnesses to the truth. Together let us try to work to protect and safeguard the whole of human life.

Thus, interpreting disturbance means finding appropriate research tools, opening a dialogue, providing support and entering into discussion in order to construct an educational project. Care for mental health in childhood should be proposed with the taking on of ethical responsibility for a life project that is not limited to solving a disturbance temporarily but in giving answers to the

question of 'how we should live' and bearing fruit for the wonderful gift of God that every human life is.

Mrs. MARCIA BARBACKI
Occupational Therapist, Registered, Florida, West Palm Beach.

Mrs. ISABELLE BIONDI
Secretary of the AISAC, (International Association of Catholic Health-Care Institutions), Pontifical Council for Health Care Workers, Vatican City.

Prof. PIETRO QUATTROCCHI, O.H.
Lecturer in Bioethics, University of Tor Vergata, Rome, Ufficio Studi AISAC, Ufficio Studi ARIS (Religious Association of Socio-Health-Care Institutions), Rome.

Notes

[1] Cf. P. QUATTROCCHI, 'La dimensione etica della salute mentale', *Nuntium* , Rivista della Pontificia Università Lateranense, 2007/3 n. 33 *Pianeta Giovani: la realtà , le attese*, pp. 101 – 107.

[2] MORENO, C., LAJE, G., BLANCO, C., HUIPING, G., SCHMIDT, A. B., AND OLFSEN, M., (2007). 'National trends in the outpatient diagnosis and treatment of bipolar disorder in youth', *Archives of General Psychiatry*, 64, 1032-1039.

[3] Department of Health (2005), *Prescription Cost Analysis England 2004*. Available at *http://www.dh.gov.uk/ PublicationsAndStatistics/Publications/PublicationsStatistics/PublicationsStatisticsArticle/fs/en?CONTENT_ID=4107504&chk=nsvFE0*

[4] LACASSE, JEFFREY R. AND LEO, JONATHAN, 'The Media and the Chemical Imbalance Theory of Depression', published online: 28 November, 2007, *Society*, 45, 35-45. *http://www.springerlink.com/content/u37j12152n826q60/fulltext.pdf*

LACASSE, JEFFREY R. AND LEO, JONATHAN, 'Serotonin and Depression: A Disconnect between the Advertisements and the Scientific Literature', *PLOS Medicine*, Vol. 2, Issue 12, December, 2005 *http://doi.org/10.1371/journal.pmed.0020392*

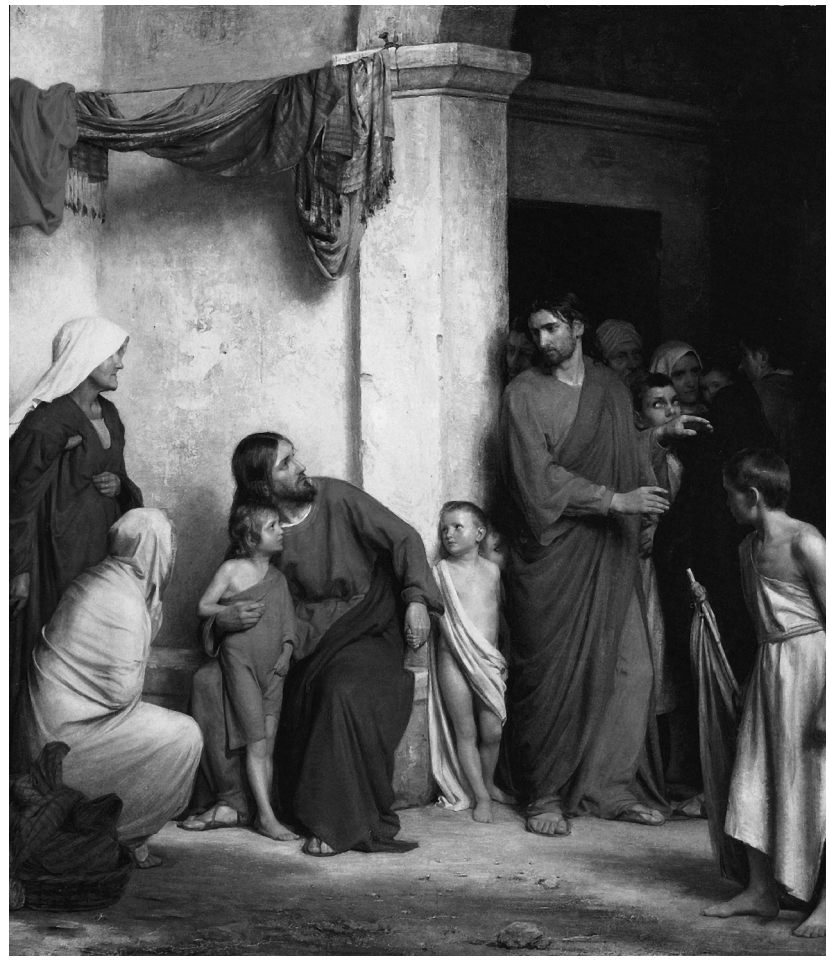
[5] LAMBERT, N.M., 'Contribution of Childhood ADHD, conduct problems, and stimuland treatment to adolescent and adult tobacco and psychoactive substance abuse', *Ethical Human Psychology and Psychiatry*, 7, 2005, 197-221.

LAMBERT, N., AND HARTSOUGH, C.S., 'Prospective Study of Tobacco Smoking and Substance Dependence among Samples of ADHD and non-ADHD Participants', *Journal of Learning Disabilities*, 31, 1998, 533-544.

[6] DUNCAN B., *What's Right With You: Debunking dysfunction and changing your life*. Health Communications Inc. , (2005)

[7] European Medicines Agency, *Press office,* 7 Westferry Circus, Canary Wharf, London, E14 4HB, UK, *http://www.emea.eu.int*; London, 25 April 2005 - Doc. Ref. EMEA/CHMP/128918/2005 corr

[8] JACKSON G., *Rethinking Psychiatric Drugs – A Guide for Informed Consent* (Bloomington, IN: Author House, 2005).



The Increasing Influence of the Economic Factor in Health-Care Policies: Reflections on the Need for Ethical Guidance

1. Health-Care Services and the Philosophy of the Control of Expenditure: Analysis of the Scenario

The development of health-care systems in industrialised countries has been characterised in recent years by an increasing gap between demand for services and the availability of resources. This phenomenon is explained by two categories of causes:

1.1. On the one hand, the conspicuous expansion of the demand for services, which can be directly attributed to the spread of the health-care culture in the population and the increasing conscious and induced attention that has been directed towards mental/physical wellbeing and quality of life.

1.2. On the other, the increase in health-care expenditure which can be correlated with multiple and heterogeneous causal factors: a modification in the demographic structure of the population with a current and projected increase in the percentage of elderly people, who are in need of increasing basic and specialised health-care services; the current and projected increase in chronic-degenerative illnesses (in particular cancer, cardiovascular diseases and illnesses with a prevalent pain component which has a major impact on the *quoad valetudinem*) and the correlated situations of psycho-physical handicap and of reduced self-sufficiency; the increase in the young and adult population of traumatic pathologies, with a correlated increase in intensive treatment and a very high absorption of resources; the introduction and diffusion of biomedical technologies which have high costs; the increase in the number and cost of health-care workers; the socialisation of health-care expenditure: the costs of health care in many countries are paid for by the so-termed 'paying third party' (a national health service, a private or social health insurance, private parties) as a result of which 'the price of the product' (in this case a health-care service) cannot bear upon the choices of the consumer – in this case the enjoyment of health-care services).

In a scenario of limited resources and faced with a demand for health care that is in constant expansion, the idea has increasingly grown that it is necessary to make responsible choices as regards the primary needs that have to be met and the measures that are required to achieve this objective. Economic assessment in public health care, together with clinical studies, are said to provide the bases at the level of knowledge and the criteria required to direct choices at various decision-making levels (this is the theory of the priorities of resource location).

It directly follows from this that 'in the process of the conversion of health-care structures into companies is to be found the most effective instrument by which to achieve the control of health-care expenditure'. This process is to be identified and organised in the adoption of specific managerial instruments of companies such as strategic planning, accounts in terms of centres of costs, and budgeting. But the element that is seen as most defining of this reform is said to be making personnel responsible, and most specifically the managerial personnel, for the results of their own activities, expressed as levels of 'productivity (the number of admissions, the number of services), the absorption of resources (costs), the efficacy of services, and the satisfaction of patients, who for the first time are called 'customers''.

This new organisational system attributes to medical doctors responsibility for the employment of resources, which previously did not exist, and *pre-supposes* the acquisition of a managerial mentality and culture which completes and supplements those of a strictly professional character.

In order to encourage the adoption of company-style organisational approaches the system by which hospitals are financed has been modified. Whereas previously public hospitals received a refund for the costs that had been met (a refund in line with a list) and private hospitals were paid on the basis of the number of days of a patient in hospital, at the present time all hospitals are financed on the basis of the typology and the number of treatment cycles carried out, classified by a system termed 'diagnosis related groups' (DRG).

The objectives of the new system of funding can be outlined as follows: to assure greater fairness in the distribution of funds to hospitals in relation no longer to the resources present and the costs undergone but to the activity that is engaged in; to promote responsibility in relation to management and the rationalisation of the processes involving the provision of care; to encourage a full utilisation of resources and thus to increase operational efficiency in the production and distribution of resources; and to activate an improvement in the quality of the services that are provided with the aim of acquiring a competitive advantage in relation to other providers and thus to attract a greater number of patients/users/customers.

A first reflection on what has been described hitherto in this paper relates to the intrinsic

limits to the DRG system which lie in a weak definition of the level of seriousness of an illness, *the trend towards an excessively early discharge from hospital and a selection of incoming patients on the basis of the potential remuneration*, and the penalisation of high-technology hospitals. This has led people who are most critical to refer to 'health-care accounting', thereby implicitly expressing a dissenting judgement, rather than to health-care economics.

Within the framework of the new system of funding, the management objectives of hospital structures thus become: the provision of services of an adequate qualitative level and the maintenance of a balanced budget which is an indispensable pre-condition for the very survival of the company.

2. The Principles of the Revolution in the Health-care System

The basic principles of this sort of Copernican revolution can be objectively identified in the dizzy increase in the increase in health-care expenditure in the countries of the Western world. This has led to various beliefs and situations which in summarising form can be described as follows:

– A vision of the state where essential services such as instruction, health care and others are the responsibility of the state which has to provide them free and in a way that ensures easy access to everyone. From this came, in the face of a strongly to be appreciated idealistic dimension, an inevitable increase in health-care expenditure to the point that it was no longer sustainable other than by recourse to the deformation of some other sector of equal importance of the welfare state.

– The demographic and epidemiological change of the population in large part attributable to socio-economic progress after the Second World War and to progress of a strictly medical character which was 'responsible' for the progressive ageing of the population with a consequent increase in the incidence of chronic-degenerative illnesses.

– A cultural change with the appearance of new lifestyles and ways of thinking with the development of an almost absolute 'intolerance' towards situations of malaise, even transient ones, which led to a further notable increase in the demand for treatment, for that matter not always justified from a strictly therapeutic point of view.

– The technological revolution in medicine with the appearance, and the induced employment/misuse of, equipment, which meant that in the face of extreme sophistication and very high costs equally high levels of therapeutic efficacy were not always obtained, with a resultant disproportion between expected advantages and real advantages.

– Health and life as a harmonious physical, mental, social and spiritual process: in this context it is very important to emphasise how the vision of the Church in this sphere goes well beyond the definition of the World Health Organisation (WHO). *Indeed, if we can share the aspiration to the achievement of the best mental-physical condition achievable by man, we should identify in the spiritual aspect the fundamental component and that aspect which ennobles man, which elevates him and draws him near to God*.

Medical science, ever since Hippocratic times, has displayed interest in this component. At the present time it is sufficient for all of us to cite how the psychological aspect, which derives directly from the spiritual one, is determining in defining the level of perception and working through of a painful stimulus for a person. There is also a close interacting link between the person in himself and the social context to which he belongs and of which he is, we might say, a constitutive brick. Man, therefore, as the centre of the universe, in constant symbiosis and interchange with a flow of afferent/efferent messages that govern the whole of his existence in a continual search for a homeostasis that is not only physical, not only psychological and not only social, but above all spiritual because it is of a higher level.

3. The Search for Ethical Guidance

The contemporary *status quo*, therefore, raises for us pressing and troubling questions to which we have to provide answers illuminated by ethical guidance that is able to retrieve the right priorities between man as a person and economic doctrines that increasingly often it would be appropriate to define as economistic.

– Is it right and ethical to accept the rationing of resources for health-care expenditure beginning with a moral vision near to the human person and his dignity?

– Is the tandem efficiency /productivity acceptable for ethics based upon the value of the person and the principle of benefit to the patient (the good of the patient)

– How is it possible to find a balance, a harmonisation and an integration between economic and ethical needs in a context directed towards the rationing of health-care expenditure?

– In the light of new trends what should be the role of medical doctors and what should be their spheres and their limits of influence as regards economic matters?

– Is the profound modification of the health-care field and the aim of overcoming the concept of free health care for everyone compatible with the model of fairness and social justice?

An aspect of a prejudicial character is to be identified in the concept of the *company* applied to a national health service. This implies the concept of *health as a product*, offered by a company in a '*competitive*' way or rather following the maximum assessment of the resources available and the reduction of costs, seeing, lastly, the *patient as a customer* rather than as a sick person.

Taking into account the limits connected with terminology, one cannot, nonetheless, ignore that the new system in fact brings with it many misunderstandings, where, indeed, it does not actually foster them:

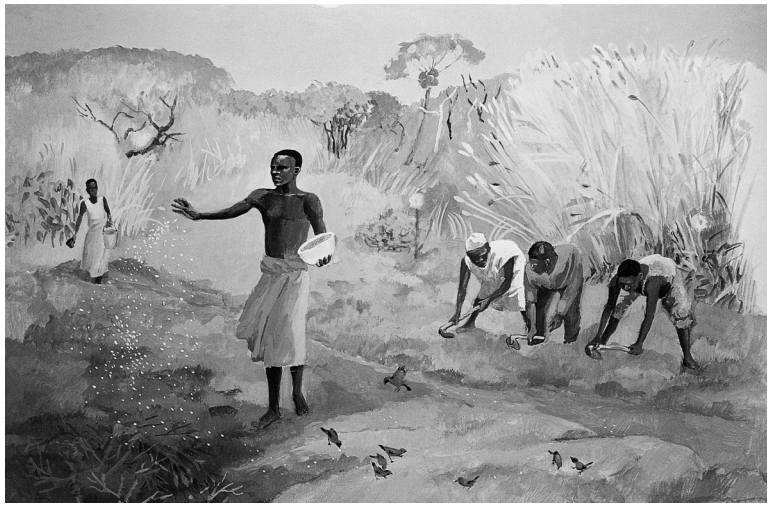
– In the health-care field *it is not possible to posit* the existence of market saturation.

– To define health as a 'product' is *absolutely offensive* to the concept of overall health which includes the physical, mental and spiritual aspects of man.

– Lastly, to define a sick person as a 'customer' who is looking for the best buy, without taking into account the disadvantaged condition in which he finds himself, *for me is something that cannot in the least be subscribed to*.

To complete the picture, it is incumbent to extend the analysis to developing countries where the situation is even more worrying and thereby to produce a further reflection. In this large geographical area, indeed, because of the economic weakness and dependency of governments, there is a mortification of the most elementary rights of man and there is a dramatic manifestation of the negative consequences of the free market if it does not have mechanisms of control and regulation at a central level. In these countries expenditure on health ranges between $2 and $7 per person each year, the death rate oscillates between 20% and 45%, and every year six million children die every year because of enteritis-related illnesses because of a lack of drinking water. The basic health-care conditions and the socio-cultural sub-stratum, which are much graver than in the Western world, justify the priority importance of important structural intervention directed towards the prevention rather than the treatment of illness. Implicitly, therefore, it is of urgent and compelling importance to intervene with suitable training and education programmes in order to bring about a good fertilisation of the cultural and social terrain so as to make it suited to accepting and developing planning, programming and strategies of a primary kind. *Only after* this indispensable stage will it be possible to address the question of the health-care market.

We should also ask ourselves whether the so-termed 'health-care market' does not run the risk of introducing elements that are in contrast with the specific values of health-care treatment and the professional code of ethics. *The logic of the health-care market is in itself abhorrent and brings with it the denial of the essential values of the person and of society*.



In agreement with the doctrine of the encyclical *Centesimus Annus*, I believe that *the logic of the market, left to itself, cannot be reconciled with the requirements of justice, above all because it does not take responsibility for the fundamental needs of the weakest. That sense of justice, which cannot be expressed in money, which forces us to ask whether economising on human needs because of the need to balance budget does not mean the denial of respect for the values that connected to it*.

4. The Relationship between Doctors and their Patients

As is written in the *Charter for Health Care Workers*, I believe the relationship between a medical doctor and his patient is 'a meeting between… the trust of one who is ill and suffering and hence in need, who entrusts himself to the 'conscience' of another who can help him in his need and who comes to his assistance to care for him and cure him' (n. 2).

In the present-day situation, there is a high risk that the medical doctor who has provided the service, because he is deprived of all room for decision-making, is forced by economic dynamics which are not those of his own training to abandon the patient, following a purported increase in efficiency matched, however, by a diminished efficacy and quality in the care provided and a drastic reduction in the time dedicated to an interpersonal relationship with the patient. In other terms, there is present the very strong possibility of a *problematic falling away of ethical principles centred around the value of the person* who is no longer to be identified, therefore, as being the centre of health care.

In agreement with what is argued by those who study health-care systems, including those who are Catholic, I see it is incumbent to stress *the risk of a purely mercantilist application* of fees directed solely towards budget criteria and *totally without that inalienable attention* that must be devoted totally to the patient. A medical action, in fact, should be seen first and foremost with reference to its clinical efficacy and not primarily in terms of remunerations or mere costs. *The value of the person is defended, instead, only by upholding that where there is greater need there is a greater justification of the employment of re-*

sources even though these will not be economically productive.

On this point it is important to remember that the *Pontifical Council for Health Care Workers* understands and identifies improvement i*n quality of care and treatment* as being the *primary objective* of this new organisational model. From this implicitly derives the role to be attributed to so-termed health-care economics. Indeed, it is my belief that a detailed study of the costs connected with pathologies must unfailingly constitute the means and not the ends of all medical procedures. These must, instead, be directed towards *the search for the pursuit of the return of personal and social dignity to the sick person*.

Searching for the logic of profit for its own sake in such a very delicate context as that of health and health care can be seen as being neither ethical nor as corresponding to the duties of the modern physician nor, even less, as corresponding to the needs of those who suffer. I believe, instead, that of great utility is the application and employment of time and study where they *are directed towards* identifying methods and systems by which to retrieve resources that are badly used and distributed, so as to obtain for them a more directed and rewarding use for the *true recipient of the whole process – the patient*.

Beginning with this assumption it is possible to bring out the true core of the present-day situation as regards the rationing of resources available for expenditure on health care. Although it is true that *the right* to health constitutes an inalienable right of man as such, it is very difficult to find a point of convergence with the contemporary economistic axiom which holds that the need for health has to be established beforehand and in a rigid way. This affirmation has to be *rejected and avoided because of the intrinsic possibility that the weakest and the marginalised will be abandoned*.

Historically, the Church has always proposed a socialised model of medicine where the sick person, the true centre of health care and the universe, has been seen in his physical, mental and spiritual entirety, albeit, also historically, in situations involving much scarcer resources.

It follows from this that the economic techniques applied to health care and the containing of expenditure remain objectives that are subordinate to the primary objective of the overall wellbeing of man.

As does the need to make clear that the most ethically acceptable criterion is the criterion of therapeutic proportionality and not the criterion of the cost/benefit ratio.

It is my profound belief that the *concept of access to care and treatment pre-supposes the concept of the centrality of man, the concept of his dignity understood as an inalienable characteristic of his very nature*. There follows from this *the right to the best care possible, independently of religious, political and philosophical beliefs, race, and social and economic roles*.

The concept of access to care and treatment finds a guarantee in the Constitutions of nearly all countries but first of all it must find this guarantee in the philosophy of each one of us.

To complete the picture, I would like to make clear that where the concept of fairness constitutes the point of encounter and balance between the requirements of the individual and the requirements of the social fabric of which he is the central and structural point, the concepts of efficacy and efficiency must be seen as referring solely and exclusively to the specific operative processes of any health-care action, with the objective of rationalisation and the result of a freeing up of human and economic resources that were allocated in a wrong way.

The criterion of a company-style kind should not interfere in the least with the sacred duty of due care for the patient in line with the criterion, upheld by deontology, of the autonomy of the health-care worker in care work imbued with the principle of doing good.

The safeguarding of this ethical criterion is a duty of medical doctors, or, to put it better, of all health-care workers who must align their behaviour and the behaviour of the scientific associations to which they belong with to the greatest *responsibility* and the greatest and most rigorous training possible, not only of a professional kind but also of a human and Hippocratic one.

What has been expressed hitherto implies that the present-day situation involves and will involve a redefinition of a series of roles that are worthy of attention.

It is by now a widespread opinion that a medical doctor cannot delegate, as was done in a not so distant future, responsibility for economic aspects which previously in the best of hypotheses were ignored at various levels to the point of not existing. A move to extremes of this approach led to a clash between *the culture of 'health without a price' and the culture of the binding need for a 'balanced budget'*, with the risks, on the one hand, of health-care consumerism, and, on the other, of profit for its own sake. These aspects should be rapidly dealt with without worrying about external organisation but always bearing in mind the conception of man and his destiny which underlies this new approach.

5. Conclusion

In this conclusion I will offer a number of reflections on the role of medical doctors. Possessing the instruments to be able to assess beforehand the economic and social consequences of a pathway of diagnosis and therapy, the prerogative and exclusive task of a medical doctor, is not as was erroneously believed a factor working for distraction in the practice of medicine. It could become this only if the economic criterion is the end and not the means.

If, *vice versa*, the health-care system and the policies connected with it conserve, defend and pursue the anthropocentric criterion, a complementing and

integrating of economics and health will instead constitute the most modern and most responsible method for drawing near to a sick person.

The medical doctor, because of his cultural, scientific and human endowment, must not and cannot, in the name of ethics and his deontology, shut himself off from the changes in scenarios that contemporary society rapidly proposes.

He can and must, instead, constitute the indispensable *ring of connection and harmonisation between two needs*. But in order to perform to the best this evolved role that the contemporary epoch asks of him he must enrich his professionalism with a new knowledge that is by now indispensable, he must address and assimilate new disciplines so that in the final analysis he can draw from them the best that they offer and place that at the *service of his patient*, fully taking upon himself the exclusiveness and autonomy of his relationship with those who suffer and their defence.

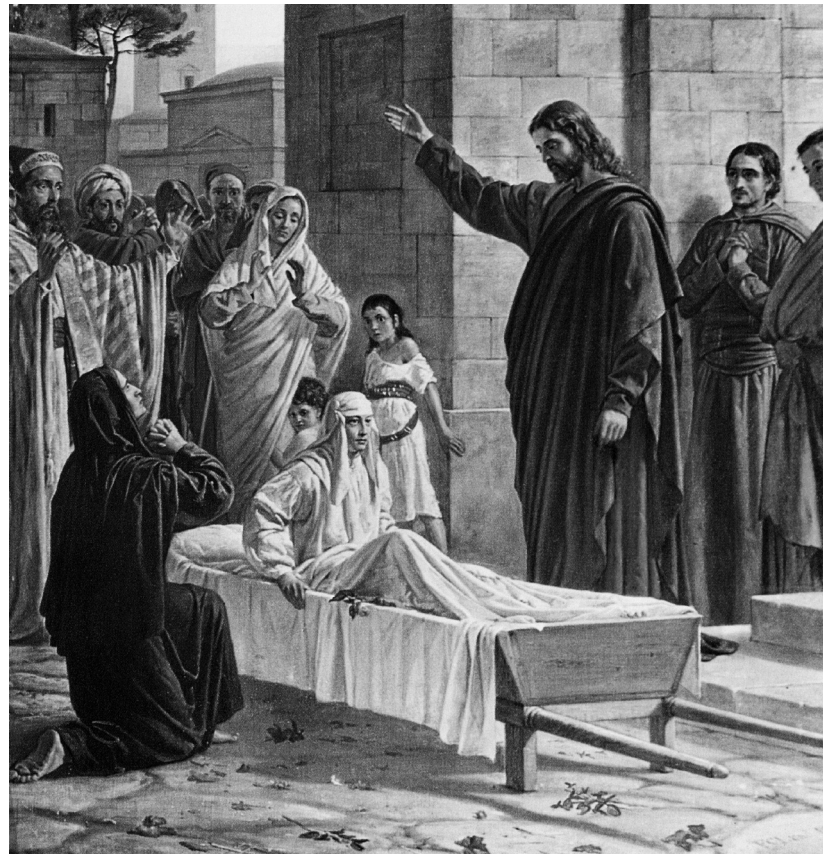
It is certainly the case that this is the most intelligent but above all the most effective way of participating in a correctly directed restructuring of the world of health care. But this is also the most ethically based method that the modern medical doctor has available to be able to go on being, as the *Charter for Health Care Workers* has it, a '*servant of life*', treating, and assuring, as he has done for millennia, the best possible service for the sick.

Scientific associations, because of their endowment of authoritativeness and scientific representativeness, which marks out each of their members, could, in my view, constitute a strategic factor of decisive importance in the upholding of the rights of man. For this to take place, however, the commitment of everyone is required and an awareness of the responsibility *to transmit not only scientific values but also ethical and deontological principles that should be implemented in daily practice*. This, unfailingly, must be matched by methodological and scientific rigour which, conjoined with intellectual honesty, constitute indispensable elements if we want to achieve the safeguarding of the symbolic function of being guarantors and defenders of the right to medical care and the therapeutic alliance, which, indeed, has always been a prerogative of medical doctors.

But ethics and deontology must therefore become a formidable instrument of all health-care workers if they are employed in sensitising both public opinion and political leaders about the strategies to be adopted in terms of the obtaining and employment of resources for health and health care, not fearing to affirm that to achieve good medicine and good economics there must always be good ethics.

Prof. MAURIZIO EVANGELISTA
Consultor of the Pontifical Council for Health Care Workers, Lecturer and researcher in the therapy of pain, the Catholic University of the Sacred Heart Rome, Italy

* I would like to thank Dr. Andrea Benvenuti for his help in the preparation of this paper.



The Precursors, Roots and Historical Evolution of Hospitals from the Perspective of Pastoral Care in Health[1]

PREMISE

This research of a historical character engaged in with a view to pastoral care and carried out by a person who is not a historian but only a *lover of history* involves, first of all, a presentation of a selection of texts by recognised historians so that their knowledge can directly reach the reader. The methodology for this research was conceived in line with the following steps:

– First of all, the *collection of documentation* which was as abundant as possible on the subject that figures in the title of this paper, drawing upon historical sources to which I have had access, and which are listed at the end of this paper.[2]

– This was followed by the drawing up of *certain criteria* for the choice of these texts which within all the material collected illustrated in a clearer and more direct way the aims and the objects that were pursued in the carrying out of this work.

– Then a *selection* of the texts adopted in line with these criteria and their organisation through a *classification by stages* of the historical growth and development of hospitals.

– The inclusion of *brief comments* or illustrative notes in each of the subsequent section of the work in order to clarify the reason for the inclusion of each group of texts and the relationships with the other sections and the contemporary reality of pastoral care in health.

– Lastly, certain conclusions on order to demonstrate the relevance of the subject to the Campaign for the Sick 2007[3] and to outline certain guidelines for action in the present and the immediate future.

The subject to which this paper has been dedicated has not hitherto been addressed directly from the *precise* perspective of: a. looking at the contemporary evolution of hospitals and the probable paths to be taken by them in the near future in the light of their past;[4] (b.) with the express intention of examining well the conclusions that emerge in order to review and decide upon the hospital pastoral care of the Catholic Church in Spain.

However, I would like to observe that this dual aim will be completely implemented only if the outlines of historical evolution that are presented include a detailed description of the processes that have over time been experienced by realities such as, for example, Catholic religious care in hospitals and its successive forms or the kinds of relationship between society and the Church that have influenced at every epoch the evolution of hospitals. Subjects such as these are only alluded to in this paper given the confines of its subject matter.

I believe, however, that the importance of offering a panoramic vision of the historical evolution of hospitals is sufficiently justified. I think that this has already been engaged in by the authors that I cite and quote.

'At the beginning of the twenty-first century... the concept of what a hospital is, is undergoing the greatest change that it has probably ever experienced during the course of the history of hospitals' (AN-HCAD, p. 3).

'The evolution of hospitals over recent centuries raises the central question of whether care and treatment are still the primary function of this institution... its original finality was to admit and comfort all suffering and people in need. To a great extent hospitals now limit their admissions to the gravely ill who require very sophisticated diagnoses and treatment. The movement towards acute episodes of physical illnesses, complex technological operations and the increasing economic cost of admissions, have transformed hospitals into places of episodic and brief stays. Bureaucratisation, financial restrictions and the invasion of every kind of equipment have only increased the essential depersonalisation of institutional care. The losses are clear. Over three centuries of medicalisation hospitals have moved from being centres of care for the poor to machines for the sick who remain without care' (GBR-HMH).

'Nobody so far has sought to seriously describe the evolution and the development of hospitals from their beginnings until the sixteenth century... [However] contemporary hospitals... have their origins in those institutions that are centuries away from us... The customs... that today remain in the most modern structure must be seen as the products of that epoch, and must be examined, and where possible replaced, by something better' (DJ-HUM).

One is dealing, therefore, with examining, by looking at past history, whether the drastic evolution that hospitals are now undergoing will allow these health-care institutions to maintain some of the signs of identity that defined their creation and have defines their historical development until today, or whether the above-mentioned contemporary evolution will lead them *to be something completely different*.

This is not a question of pure erudite curiosity but, rather, it is a matter of capital importance because what is at stake is knowing whether the experience at the level of care accumulated down the numerous centuries of evolution of hospitals can still be fertile in defining the hospitals of the future, or whether, in contrary fashion, we must prepare ourselves for the drawing up a death certifi-

cate for what, over seventeen centuries of health-care history, has been meant by the word 'hospital'.

Before ending this premise, I would like to add that before speaking about the historical evolution of hospitals one should begin with a certain kind of definition of hospitals. However, the dynamic of change of this evolution involves wisdom in proceeding and it will be description itself of the historical development of hospitals that presents the various profiles that this institution of care has demonstrated over time that will enable us at the end of this paper to have observed certain general characteristics common to varying degrees to all epochs.[5]

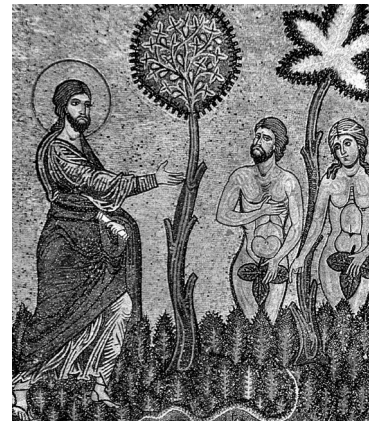
Despite this, A. Navarro in his work *Los hospitales: concepto, alcance y dimensión* offers a concept of what a hospital is from a historical perspective and includes in this the following three general characteristics: '*A hospital means beds*: From the most ancient centres that received this name until the end of the nineteenth century, a hospital meant a centre of hospitality that provided food and accommodation to those who entered it. It was used not only by sick people but also by those in need. *A hospital means technology*. At the end of the nineteenth century various forms of scientific and professional advance were achieved which modified the concept of a hospital. All of these changes remained essentially the same during the twentieth century. At the end of the twentieth century and the beginning of the current century a new revolution in the concept of what a hospital is took place... *A hospital means a solver of clinical cases*. In this concept of the future (and the present) laws are relativised and even technology moves out of the hospital-building (AN-HCAD, p. 3s).

I would only add the hope that a study like this will be of use, at least at the level of the intention, to what the Episcopal Commission for Pastoral Care established as an objective to be reached through the 2007 Campaign for Pastoral Care in Health, and that at a concrete level it will ensure that every diocese in Spain implements this Campaign, and hospital pastoral care within, its sphere of activities.

I. THE HISTORICAL PRECURSORS OF HOSPITALS

Some historians have traced back the origins of hospitals to certain specific institutions that existed before Christianity on the basis of the fact that some documentary sources demonstrate that 'various primitive cultures developed institutions that had as their purpose looking after sick people'.[6] However the evidence of the most reliable authors indicates that these institutions were only antecedents of varying degrees of remoteness of hospitals in the real sense of the term. Of these, the following cultures and institutions should be emphasised:

a. *Ancient India*: 'The evidence on ancient India refer to centres that dispensed medicines and possessed personnel who were trained in caring for the sick'[7] (TSM-H).

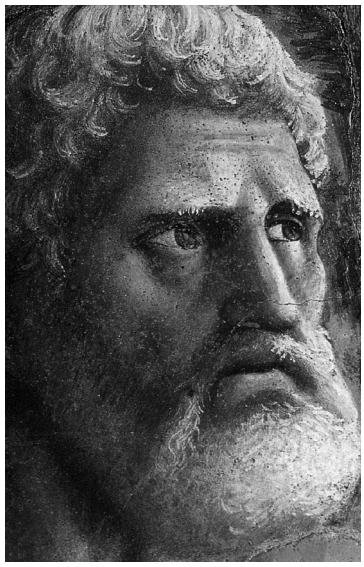


b. *Ancient Egypt*: 'In the Egypt of the pharaohs sanctuaries existed on which we have only vague information in which sick people who reached them looking for help could stay' (DJ-LHEM). 'Imhotep, the high priest (but not a physician) and architect of the layered pyramid of King Zoser, a Saqqarah... was seen as a divinity with curative powers about 2,000 years after his death. Sick people visited his temple looking for curative sleep'(WW-CM, p. 20). 'The training of Egyptian doctors took place in the so-termed 'houses of life' which were a combination of academies, universities and libraries. These were government institutions near to the great temples whose primary task was to protect the pharaoh through the use of magic' (PLE-HM, p. 17).

c. *Ancient Greece*. 'In ancient Greece the ιατρειον (*iatreion*) was only a kind of private clinic of the most eminent physicians who had a habitation with a bed for sick people where they could be examined and could stay' (JMLP-MH).[8] 'Roundabout the year 400 BC on the island of Cos the building of a sanctuary was begun, the ασκλεπιειον (*asclepieion*), which was dedicated to the divine physician Asclepius, the King of Tricca, Thessaly. Sick people went to the temple on Cos so that the physician-god would cure them by giving them advice while they were asleep. In addition to practicing ritual ablutions, they offered sacrifices to the divinity and offerings to the temple. Finally, so-termed therapeutic sleep was induced in them in the *incubatio*, the room where they were taken by the priests and where they were made to lie down on beds, the κλιναι (*clínai*). During this therapeutic sleep Asclepius appeared to the sick people both to heal them and to prescribe a remedy for them (CS-GME, pp. 36-39).[9] 'The *asklepieion* experienced a second period of fame during the second century AD. Those of Pergamum, Epidaurus and Cos were famous. In them, together with the *incubatio*, people bathed, took exercise and followed diets. Treatment with medicines was an exception. In reality, the majority of these temples resembled more places of pilgrimage than places for treatment' (*l. c.* p. 52). 'In total, the sanctuaries of Asclepius survived for almost a millennium, coexisting towards the end with Christianity as it spread... one of these temples was consecrated to St. Cosma and St. Damian [and this] enables us to detect the beginning of the medieval hospital'[10] (DJ-LHEM).

d. *Ancient Rome*. 'In Rome the structures of the Greek *ia-*

treion were called *tabernae*, a term that indicated their lack of prestige. The only organised care that existed was provided in the *valetudinaria*[11] which were created in the large Roman military camps on the frontiers of the empire for wounded or sick soldiers' (JMLP-MH, p. 109). 'Before the year 20 AD one of the first Roman *valetudinarian* created by the legionaries was established in Alexia, near to Haltern in Westphalia. The personnel included medical doctors, pharmacists, scribes and inspectors. In Italy great landowners also ordered the building of these kinds of hospitals in order to keep their slaves in good health, slaves who provided manual labour and who were looked after by physicians who were themselves slaves' (CS-GME, p. 50).



Thus the forms that care for the sick took in a number of ancient cultures can be seen only as *mere antecedents* – and to a rather partial extent – of hospitals in the real sense of the term. These have their real roots in early Christianity, as historians who will now to be quoted in this paper have well understood.

'However, none of these institutions [those mentioned in the above paragraphs] managed to survive the cataclysms that destroyed a large part of ancient civilisation in Eurasia between the years 200 and 600' (TSM-H).

'The search in Athens and Sparta, Alexandria and Rome, for institutions similar to hospitals and which formed a part of the social order of those cities has been in vain' (DJ-LHEM).

'Neither the Egyptians nor the Greeks or Romans had hospitals for the poor and the sick, with the exception of *valetudinaria*' (CS-GME, p. 62).

'In Greco-Roman classical antiquity even hospitals or other equivalent institutions did not exist' (JMLP-MH, p. 109).

'The spirit of antiquity towards the sick and those in need was not one of compassion and the custom of coming to the aid of unfortunate human beings was born to a very great extent with Christianity' (F. H. Garrison, quoted in AN-HCOD, p. 9).

'For hospitals to exist in a society care for a multitude of strangers has to be necessary, useful and socially valid. Thus... during the first centuries of antiquity... there were no ethical or religious values that upheld the maintenance of hospitals for the poor and the sick... In order to build and maintain hospitals what was needed, first of all, was a recognition of the value of the poor and the sick... a strong ethical impulse of a philanthropic character' (MAS-LHH, p. 16s).

II. THE HISTORICAL ROOTS OF HOSPITALS

The texts presented in this section clearly demonstrate that the terrain in which hospitals had their roots – and beginning from which they had their historical journey as well – had characteristics that were not known in history prior to their birth in the Christian era. These characteristics may be summarised as being four in number: *a different approach to the sick* and thus also a different evaluation of illness; *a new rule in human relationships* based upon charity;[12] *the extension of care to the incurably ill*, and even to the dying; *and the appearance of organised care for the whole of the population*.

'Modern hospitals have their origins, and even derive their name, not in and from indigenous centres of treatment, the Greek *asklepieia* or the Roman *valetudinarian,* but the open houses and the hospitals created by the Christian Church at the end of the Roman Empire. From the outset, Christianity asked its faithful to help the sick and those in need. At the beginning of the second century bishops such as Polycarp of Smyrna[13] exhorted the clergy to care for the sick, orphans and widows, and the clergy began to offer them care' (TSM-H).

'The spread of Christianity represented two fundamental changes for medical care: a different view of the sick and a new rule in human relationships based upon charity... In the early Christian communities an equality at the level of care existed; the incurably ill were looked after and disinterested medicine had acquired meaning, even at the risk to one's own life. The principal consequence of this change in values was the appearance of organised care for the whole of the population which led to the creation of the hospital as a specific institution' (JMLP-MH, p. 110).

'The invention of the institution of the hospital was the consequence of this new ethical-operative approach (the approach of Christianity) towards the afflictive character of illness' (PLE-HM, p. 140).

In this context it is helpful to quote as well the theologian Manuel Gestiera when he speaks about the view of the sick that Christianity brought with it and which in the end was translated into the creation of hospitals: 'The most important contribution of ancient Christianity within the sphere of human suffering did not consist so much in expanding the theoretical knowledge of medicine, or in the discovery of new techniques (this was something the Christians had to learn completely from the art of treatment of the Greeks), as in its charitable dedication to the sick and care following the example of the Lord. The sick ceased to be unfortunate poor people whose presence had to be avoided, or sinners who bore in their flesh the stigmata of their sin, punished by the hand of God (or

destiny), and became companions and brothers on the arduous and difficult journey of life' (MG-CM).

A. The driving forces at the roots of hospitals

What Christianity brought with it, in definitive terms, according to the exhortation of St. Paul to the Romans, was the need to walk in a new life.[14] Pedro Laín Entralgo, from his perspective as a historian of medicine, points to this new experience[15] as the deepest cause of the contribution of early Christianity to the history of health care. From this sprung those driving forces which would subsequently gave rise to hospitals and which in very summarising form took the following concrete form:

1. ***The theology of Christ the Physician*****,** which was developed to begin with by Ignatius of Antioch and which starting from him was transformed into a classic theme of Patristic literature: 'There is only one material and spiritual physician, Jesus Christ, our Lord' (Letter to the Ephesians, VII, 2).[16]

2. ***The theology and pastoral care of works of mercy*****.** 'I was sick and you visited me when you did this to my sick brethren' (cf. Mt 25:36.4). One is dealing here with the ethical-pastoral development of this passage in the Gospel which in a simple way and a way that was comprehensible to every member of early Christianity derived practical consequences from the theology of *Christ the Physician*, as happened with the complementary theology of *Christ the Sick Person* who was thus in need of care being present in those who in this passage are seen as constituting his living image.[17]

3. ***The practice of hospitality*****:** 'practice hospitality'[18] (Rom 12:13, and elsewhere). Practiced and held to be a fundamental human duty amongst all the peoples of the ancient world, hospitality in the Old Testament acquired the rank of an express divine mandate. Transformed in the New Testament into a virtue and duty of the faithful followers of Christ, it gave its Latin name – 'hospital' – to those Christian institutions that received and treated the sick and subsequently to a large number of religious Orders and Congregations that founded hospitals.

'Hospitality in its original meaning of sacred reception and care in relation to friends and strangers had been known about and practiced ever since the rise of the religious consciousness of mankind... But neither in the ancient empires of the Middle East nor in Egypt or Greek was hospitality practiced in the more specific sense of public care for the sick... Before the advent of Christ institutional care for sick people was completely unknown' (JAG-YEC, p. 27s).

B. The enabling instruments

1. ***Personal care for the sick in the early communities.*** At the outset the enabling instruments were above all of a personal character. In the early Christian communities the bishop was the first person responsible for care for the sick and entrusted this task more directly to *deacons, deaconesses, virgins and widows*, people who in every church formed the *first teams* of visitors to, and carers of, sick people in their homes.[19] 'Deacons sought out the sick, studied each case to see which one merited greater care, brought them the Eucharist that had been consecrated at the liturgical assembly and helped them in material terms'.[20]

But presbyters were also involved in this task, as was attested to by St. Polycarp of Smyrna at the beginning of the second century: 'The presbyters should be filled inwardly with compassion and should be merciful to everybody... visiting all the sick'[21] (St. Polycarp, *Letter to the Philipessians* VI).

2. ***The creation of care houses*** **(*xenodoquios*).** The deacons, who were more directly in contact with what we would today call *health-care* situations, were very probably the first people to realise that home care for the sick did not meet all needs and that it was necessary to create *special places to take in and care for sick people* who were extremely poor or were homeless. As a consequence, they were the first and most important supporters of these care homes. Indeed, we know that in 'the middle of the third century St. Laurence, the archdeacon of the Church of Rome, established a hospital (*xenodoquio*) where the sick people of the community received care' (cf. JAG-YEC, p. 33). 'The ξενοδοχιον, or *xenodoquio*,[22] was the care home for sick people and poor people that the Christian communities created from the second century onwards... and which were obligatory from the fourth century onwards... In the year 325 the Council of Nyssa ordered (by canon 70) all bishops to create in their own dioceses a ξενοδοχιον a hotel or care home for foreigners, poor people or the sick... This petition was formulated once again by the fourth council of Carthage which was celebrated in the year 398' (CS-CM, p. 60).

III. THE STAGES OF THE HISTORICAL EVOLUTION OF HOSPITALS

A. From the fourth century to the end of the medieval period

Leaving aside the discussions of the theoreticians of history about when the separation of the so-called Dark Ages and Middle Ages took place, it is clear that the last thirty years of the fourth century AD represented a real milestone in the subject that is addressed by this paper because it was at that time that the first hospitals appeared, as is demonstrated by the authors that will now be quoted. In addition, this historical period, which was begun with the foundation of a hospital by St. Basil of Caesarea, offers at the level of its development certain homogenous characteristics which continued with only a few variations until

the appearance of the national European States between the fifteenth and the sixteenth centuries. This does not remove that fact that during this period there were a series of phases, in particular because during this period an enormous number of hospitals arose and the varied character of the people for whom they were intended was notable.

1. ***The beginnings***

'Until the fourth century AD within the ancient world there did not exist a system of care for those in need and for the sick. During that century, however, the Christian Churches of the East... created that charitable institutions which would subsequently be called a 'hospital' (MAS-LHH, p. 21).

a. *The Hospital City of St. Basil of Caesarea*. Although there are those who have deemed[23] the first hospital in history the one that was built in 365 at Sebastes[24] by Bishop Eustace, which was for pilgrims but also for the sick, the most scrupulous authors declare that the first hospital was the work of St. Basil and his *Hospital City*. 'The first evidence about a Christian hospital comes from the year 370 when Basil the Great founded a large building for the sick in front of the gates of the city of Caesarea, now Queisari, in Cappadocia' (JMLP-MH, p. 119). 'In 370 St. Basil founded a hospital in Caesarea in Cappadocia and thus truly began the history of hospitals at the hands of Christianity. Subsequently the hospitals of Edessa (375), Antioch (before 398) and Ephesus were create' (451) (CS-CM, p. 62). 'Roundabout the year 370 St. Basil of Caesarea opened an institution where sick people were looked after by medical doctors and nurses and until 410 the monk Neilos of Ancira regarded the hospital doctor as a habitual figure of the Greek Christian world. These first hospitals evolved from homes of care, including, however, in their services, free medical care to those people who had been admitted to them' (TSM-H). 'With the foundation of a number of major hospital structures by Basil the Great, near to Caesarea in Cappadocia, the history of hospitals in the Christian East began' (PLE-HUM, t 3).

The driving forces to which I referred in section II. A converged with the appearance of the hospital city of St. Basil and his hospital. The theology of *Christ the Physician* took concrete form when Christian medical doctors were incorporated into this hospital and into those that were created afterwards. These were Christians who exercised their Hippocratic-Galenic profession convinced that medicine was the instrument by which they could render operative the charity of Christ in the person of the sick.[25] As regards the practice of hospitality and merciful care for the sick, the foundation of St. Basil was also the convergent result of the experience of early Christian monasticism in the East. This is borne out by the two quotations that now follow.

'It should be borne in mind how much it [the hospital city of St. Basil] resembled the foundations of the monasteries that took place during that epoch... Roundabout the year 320 Pacomius brought together a number of hermits north of Tebas in Egypt for work, prayer and community life. It was from this precise moment onwards that Christian monasteries were born... The few decades (from 320 to 370) between the creation of the first monasteries and the creation of the first hospitals in Christendom obliges us to see these two new institutions as contemporaneous... The most important fact is the relationship that existed between monasteries and hospitals, between life for itself and life for the community' (DJ-LHEM).

'Palladian offers a fine summary of the social care provided by hermits who did wonders in caring for the sick... care in homes and hospitals, and the duties of the most disinterested hospitality for those in need... The Pacomian monasteries did not tarry in organising their social activity through the creation of special houses for strangers and pilgrims, which were run by medical doctors who looked after sick monks and pilgrims... The great importance that monasticism attributed to hospitality meant that next to each monastery linked centres arose to care for the sick people of the environs... The taking over by monasticism of the charitable and social work of the Church was the work of Basil... The great merit of St. Basil was to have definitively linked eastern male monasticism to the daily hospital work of the Church' (JAG-YEC, pp. 49-51).

St. Basil, therefore, was the man who began to unite these two genuinely Christian institutions: monasticism and hospitals. And this union would be consolidated in the West by St. Benedict of Norcia, as we will see below. For the moment I will add the fact that it was specifically St. Basil who was the author of those Rules[26] thanks to which most of the monasteries of the East were made Christian and when adapted to the mentality of the Latin West acted as a basis almost a century later for the Benedictine Rules.

'During the fourth century Christian bishops built hospitals and later on more specialised centres for the sick... During this century the cities of the eastern provinces were subjected to an influx of poor people from the countryside who emigrated to the cities looking for food and work. The classic civil institutions were not able to feed, house and look after these new residents and the local bishops used the growing resources of their churches to build hospitals and care homes for these immigrants, thereby securing the appreciation both of many poor people and the aristocrats of the cities' (TSM-H).

'The first hospitals were funded by the revenues from the lands donated by the local bishops. As a result, rich aristocrats and emperors increased the resources of these hospitals. As Christianity gradually spread, some aspects of classical civilisation were destroyed whereas others were simply redirected. For example, whereas Christianity willingly accepted the classical obligation of

aristocrats to benefit cities, the Christian Church encouraged them to give their donations to institutions such as hospitals rather than to palaces and ornamental colonnades, as had been the practice previously' (*l. c.*).

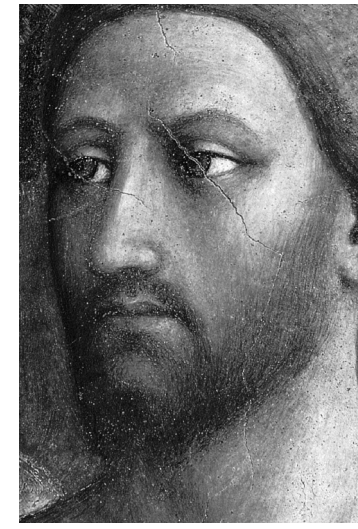
b. *The xenodochi for sick people in Rome, the Merovingian kingdom and the Kingdom of Spain in the Christian West*. The first person to provide information on the birth of real centres for the sick in the West at the end of the fourth century and the beginning of the fifth century was St. Geronimo.[27] 'In the western part of the Roman empire all the processes referred to developed with lesser intensity and much later. In addition, the professional physicians were few in number and held in low esteem.[28] Thus the development of hospitals in western Europe was not at the same level as that of the East until the end of the medieval period'[29] (MAS-LHH, p. 23). 'The first information that we have on Christian hospitals in western Europe goes back, in Italy, to the end of the fourth century, with the foundation in Rome of a hospital by Fabiola,[30] which was followed by that founded by Pammachius, built in Ostia roundabout 395... In Spain it appears that in 580 Masona founded a hospital in the city of Merida, of which he was the bishop... In Merovingian France, Bishop Caesarius of Arles built a hospital roundabout the year 500' (DJ-LHEM).

2. ***The Byzantine hospitals***

These constituted the natural and immediate development of the work of St. Basil and his successors, beginning a trajectory of care that was increasingly marked by the employment of the medical science of the time, that is to say a medical science based on Hippocrates and Galenus. The Byzantine model then passed onto the medieval and modern Islamic world and to the Christian-Roman West from the twelfth century onwards.[31] A number of quotations now follow which illustrate this development. 'The most ancient names and designations that come down to us to describe the hospitals of the medieval period point to the East: πανδοχειον *pandoqueion*, a home for pilgrims; ξενοδοχιον *xenodochio*, a home for strangers; and νοσοκομιον, *nosocomion*, a home for sick people'[32] (JAG-YEC, p. 42). 'Hospitals developed most rapidly where they had first appeared, that is to say in the eastern half of the Roman empire. The major cities of the Mediterranean and the political stability of the eastern Roman, or Byzantine, empires fostered a further evolution in hospitals. Until the end of the fourth century Christian hospitals, such as the Σαμψον Ξηνον (Sampson Xenon) of Constantinople, had special operating theatres for patients and for patients afflicted by eye illness. In addition, the principal physicians αρχιατροι *archiatroi*) of the Byzantine capital were given every month funds to treat the sick in the Sampson hospital and other hospitals in the city. During the course of the twelfth century the hospitals of Constantinople were transformed into relatively sophisticated medical centres. The Παντοχρατορ Ξενον (*Pantocrator Xenon*) (which existed until the fall of the empire) had five specialised theatres, eighteen physicians, thirty-four female nurses, eleven servants and a storeroom with drugs and medicines supervised by six pharmacists. The *Pantocrator* treated patients both inside and outside its walls' (TSM-H). 'From the outset the Christian hospitals of the Byzantine cities were intended for the poor but as these institutions were gradually transformed into sophisticated medical centres, a number of sick people belonging to the middle and upper classes began to ask to be provided with their services' (*l. c.*). 'Mention should be made of the fact that a non-profit-making institution, financed by donations, income and taxes and administered by the Church and by the imperial bureaucracy was able to attain such very high levels of excellence. The scientific level and the level of care was far greater than that of the contemporary hospitals of the Christian West. They were utilised for the teaching of medical science and played an irreplaceable role in the conservation of ancient learning and knowledge' (MAS-LHH, p. 25).

3. ***Islamic hospitals***

Although the appearance and the development of Islamic hospitals does not seem to be directly relevant at first sight to pastoral care in health, the references to them in the quotations that follow clearly demonstrate that Islam – whose historical contribution to medical science was notable, at least between the eighth and thirteenth centuries of the Christian era – received its idea of what a hospital was from Christianity. 'Like Byzantine hospitals, Islamic hospitals evolved started from the Christian philanthrop-



ic institutions of the major cities of the Byzantine empire. When in the year 489 the Emperor Zenon expelled the Nestorian Christians from Syria, many of them sought refuge in Persia where they created hospitals modelled on the hospitals of the Byzantine cities. This was the case, for example, of the hospital in Antioch. When the Muslims conquered Sasanid Persia in the seventh century they entered into contact with the Nestorians and, struck by their medical skills, they adopted many Syrian medical traditions – teaching methods, scientific texts and hospitals – as a model for the corresponding Islamic institutions' (TSM-H). 'Islamic hospitals began to exist after the

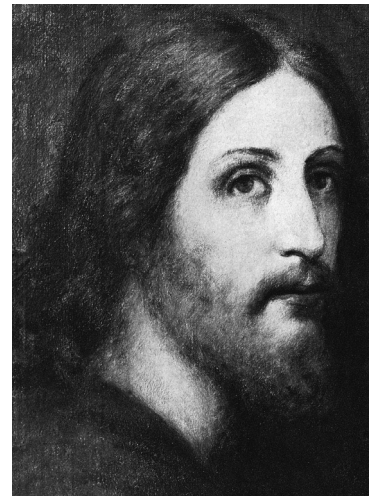
Arab conquest of the territories where hospitals with Byzantine origins and physicians with a classic training existed. Thus the first Muslim hospital seems to have been built in the city of Damascus roundabout the year 707, with the help of Christian Syrians who already had their own charitable institutions' (MAS-LHH, p. 25).

4. *Hospitals in the medieval West*

The hospitals that came into being in this geographical region during this historical period did not achieve the high level of medical care and institutional organisation reached by the Byzantine and Islamic hospitals until developments in Italy during the fourteenth century, perhaps with the exception of the hospital created by the hospital monks/knights of St. John in Jerusalem after the conquest of that city by the crusaders. 'Hospitals developed more slowly in the Roman empire of the West... The invasions by the barbarians from the north and the Muslim advances in Africa hindered political, economic and social life. There were few cities that survived and which in terms of size and complexity could support medical centres similar to the hospitals to be found in Byzantium and the Muslim worlds' (TSM-H).

A rather approximate description of the nature, function and users of most of the kinds of hospitals that will be cited in this chapter is that to be found in the following quotation. 'Although medieval hospitals did not have a directly clinical purpose but, rather, a charitable one, because they dealt with all kinds of people in need (orphans, widows, travellers, pilgrims, the sick and the poor), everyone was offered accommodation and food. The first objective, logically, was to care for all those could be cared for, although at times there was a shortage of therapeutic resources; many people inevitably died but were cared for until their deaths with especial attention being paid to their spiritual healing' (CCPA-HCP).

Some characteristics that should be stressed about the creation of hospitals rather than their evolution in the medieval West are: the variety of supporters who were involved in their foundation, the large number of hospitals that arose during that period in Europe, and the growing diversification of users and the services that were provided in them. This was an epoch which lasted for more than a millennium and it had a number of features that should be mentioned. 'The first *xenodochi* of Syria and Byzantium, the homes for pilgrims in Gaul during the Merovingian epoch, the infirmaries of monasteries prior to and after the reform of Cluny, the hospitals of the Orders of knights in the Holy Land, the foundations of bishops in cathedrals, the leper homes and the homes for plague-victims run by the cities and the homes for the mentally ill: all of this must be must be taken into account if one wants to achieve an overall vision of hospitals during the Middle Ages' (DJ-LHEM).



a. The monastic infirmaries and the *hospitales pauperum*. '*Infirmorum cura ante omnia adhibenda est, ut sicut re vera Christo ita eis serviatur*'[33] (RSB, XXXVI). This succinct phrase from the Rules of St. Benedict perfectly sums up the spirit that gave rise to the development of hospitals in the West from the fifth century onwards. This impulse took place first of all as a result of monastic medicine which developed in shadow of the Benedictine Order depite what certain Enlightenment thinkers later thought. 'At the end of the Enlightenment Kurt Sprenger (1823) discredited the monastic doctors, giving them the appelation of guardians of the sick who were pious and fanatical,[34] unworthy of being defined as doctors. Monastic medicine, however, offers an exemplary vision of the structure and the essence of the art of treating of the High Middle Ages' (DJ-LHEM). 'The spirit of the *Regula Benedicti* [was] a key to spiritual life that led man, fragile and perishable, to *stabilitas*, that is to say to the salvation of his *integritas*... For centuries, ever since in 529 St. Benedict of Norcia (480-543) had founded a monastery in Montecassino, providing it with his Rules, they were seen as the fundamental book of medieval life together... In chapter 36 of the rules one can read [in addition to the quotation at the beginning of this chapter] 'The abbot will watch over with greatest attention to ensure that they are not neglected from any point of view... The sick, however, should be aware that they are served out of love for God and should not oppress with excessive demands the brothers who care for them'. This special concern for the sick – which was different from the way in which they were treated by other cultures – in whom Christ himself was seen, obliged the monks to provide active service and the abbots to organise care for the sick, for whom was required an isolated and suitable place (*cella super se deputata*), an organised medical service, and, lastly, those instruments that were necessary. The regulations of the abbots even covered the bathrooms: 'the sick should be allowed to use the bathrooms whenever necessary'. In addition, the sick were administered a special diet, rich in meat, as well as the drugs and medicines that were necessary, which came from the pharmacy and the herb garden of the monastery... The *Regula Benedicti* also laid down concrete rules for the organisation of hospitals, adding to the pious duties of abbots those of regularly visiting the sick, being concerned with their *status preasens* (their situation at any

moment) and their processes of healing, and watching over the treatment to which they were subjected... They also had to supervise the behaviour of the watchmen, the bursars and the heads of the dispensaries. As a result of these regulations, the medieval monasteries had in addition to a refectory and a dormitory also an infirmary (*infirmarium*), a library, an orchard (*hortulus*) and a *scriptorium*.[35] In the plan that we still have today of the monastery of San Gallo (Switzerland) the idea that governed care for the sick is clearly evident. Together with a hospital it also had a home for the medical doctors (*domus medicorum*), a house for bleeding, a bathroom (*balnearium*), a storeroom for drugs and medicines (*armarium pigmentorum*), a dormitory for the gravely ill (*cubiculum valde infirmorum*), and next to that special accommodation for their medical doctor (*mansio medici ipsius*)' (PLE-HUM, t 3). 'In addition the recommendations of the Rules on the promotion of a scientific programme, together with prayer and work, were decisive for practical medicine... This lifestyle, which was characterised by moderation, discipline and order in daily tasks, and regulated in a rhythmic and reasonable way, was the lifestyle created in the West' (*l. c.*).

'The creation in monasteries of infirmaries not only for the members of the community but also for the poor of their local areas and for pilgrims, and the *early home visits* which according to some documents were made by monks, arose out of this spirit... The interpretation of dietetics as a *regula vitae* or *ordo vitalis*[36] – that is to say the essential connection between the rules for Christian perfection constituted by the statutes for monastic life, on the one hand, and various dietetic prescriptions for healthy and sick people, on the other – was observed and emphasised by H. Schipperges' (PLE-HM, p. 189). 'Care for the sick in the hospitals of monks integrated spiritual care with material care. The sick people who were admitted to these hospitals usually began by receiving the gospel washing of their feet, they then took part in the prayers and divine offices... the principal forms of treatment were rest, warmth, diet, herbs, oils and bleeding. The medical tasks were performed by the monks themselves' (MAS-LHH, p. 28).

b. *The Carolingian renaissance and the appearance of the word 'hospital'*. Charlemagne, whose, reign lasted for forty-seven years, was crowned the first emperor of the Holy Roman Empire by Pope Leo III. Under this ruler, there took place the so-termed Carolingian renaissance which gave a new impulse to the renewal of buildings which from that point onwards would be called 'hospitals'. 'The word 'hospital', from the Latin *hospes* (guest, friend, invited person or foreigner), goes back to *hospitium*. The term 'hospital' appears for the first time in the eighth century when some of the *xenodochi* renewed by Pope Stephen II (752-757) received the name of *hospitalia*, *hospitalarii* or *infirmarii* (CS-CM, p. 62). 'In the decaying western cities of the High Middle Ages it was the bishops who established charitable work, encouraged in this by the Councils which obliged them to allocate a part of their revenues to supporting and housing the poor... It was, however, in the rural monasteries that the most typical form of care of the High Middle Ages was organised... In addition, the monasteries conserved what remained of the writings of ancient knowledge. And some monks acquired medical knowledge. Thus the medieval monasteries organised care for sick monks and all guests who asked for it'[37] (MAS-LHH, p. 28). 'During the High Middle Ages the hospitals were largely the responsibility of the monastic Orders' (JMLP-MH, p. 171).

However monastic medicine decreased in importance from the eleventh century onwards. Various causes lay behind this, such as changes in the lives of monks and the lower level of dedication to the sick, the appearance of the Medical School of Salerno[38] – where only lay medical doctors were trained – and the increases in the contacts with the Byzantine East, above all beginning with the Crusades. All these facts made up the beginning of another stage in the historical evolution of European hospitals, and of care for the sick as well, as the following quotations bear out. 'The Benedictine reform of Cluny of the tenth century argued that care for the sick within the walls of monasteries disturbed the peace of monastic life. This was the reason why numerous European monasteries transferred their hospitals to lay hands and to the military Orders as well'(l. c. p. 86s). 'The era of monastic medicine came to an end during the twelfth century. In 1130 the Council of Clermont decreed the abolition of this practice to clerics and monks, and this decree was supported by the subsequent Council of Tours (1163) and by the fourth Lateran Council (1215)' (FRH-CM, p. 72).

c. *The hospitals of the military Orders*.[39] From the twelfth century onwards new forms of hospital care appeared in Europe which received their first impetus from the new hospital orders that arose with the Crusades (MAS-LHH p. 29).[40] 'A year before [the conquest of Jerusalem by the crusaders in 1099) a number of merchants of the Amalfi had founded in the Holy City, near to the Church of St. John, which was located near to the Holy Sepulchre, a refuge that took in pilgrims. This gave rise to the first hospital of the Order of St. John of Jerusalem, which was approved by the Pope in the year 1120. It was said that this hospital aroused the admiration of Muslims to the point that, according to a legend, Saladin himself had himself treated there in secret.[41] Because of its high level of organisation in the care it provided for the sick, this hospital became a model for those hospitals that were later built in western Europe'(DJ-LHEM). 'The motto of the Order was 'defence of the faith and service to the poor'. The tasks of caring for the sick to be found in the Statutes served as a model for other Orders: for each medical

service four medical doctors had to be provided of proven experience, amongst whom two surgeons. Each ward had to have nine auxiliaries. Sick women had to be cared for by women. The sick were 'lords who had to be looked after with the greatest care'. Within the Order, brothers, who made up the third level, together with knights and clerics, were allocated to caring for the sick' (IM-LMMC, p. 141). 'In 1119 the Order of the Temple was created. Its name came from its first residence, near to the Temple of Salomon in Jerusalem; at the outset its goal was the protection of pilgrims. Another community of knights providing care was the Order of Teutons which was created in a hospital in Jerusalem that had been opened in 1142' (*l. c.* and JLE-HUM). 'The Order of Teutons arose from the Hospital of St. Mary of Jerusalem and the temporary hospital that was created by German merchants in Acri in 1190. Those responsible for the hospital adopted the Rules of the Hospital Orders and were recognised by the Pope in 1191. Shortly afterwards, this charitable Order was transformed with the approval of the Pope into a military Order with the mission of caring for the sick and combating the infidel enemy' (GZ-LCT, p. 97).

d. *The proliferation of hospitals in medieval Europe*. The model of the Hospital of St. John of Jerusalem, imported into Europe where cities acquired new vigour from the thirteenth century onwards, inspired the proliferation of hospitals,[42] whose principal characteristics are described in the quotations that follow and from which one can understand that the ownership, the intended patients and the characteristics of some of them were the same.

Civil hospitals. 'These were founded by charitable associations supported by the middle classes,[43] whose power increased as the medieval period advanced. One of these associations was the Brotherhood or Order of the Holy Spirit[44] which was promoted by a certain Guido and it founded a hospital in Montpellier roundabout the year 1180. Just twenty years after this, this Brotherhood created around Guido administered another nine hospitals and in 1204 Pope Innocent III entrusted the administration of the Hospital of the Holy Spirit, near to the Tiber, a few yards from the Basilica of St. Peter's in Rome, to this Brotherhood. This hospital was the forerunner of many others with the same name in Spain, France and Germany' (DJ-LHEM).

Episcopal hospitals. 'The important contribution of bishops (St. Basil, St. Caesareus, Masona, etc.) to the construction of hospitals during Christian antiquity has already been observed.[45] References to this activity in the medieval West began to appear between the years 800 and 1,000. One model of this kind of hospital was the *Hotel-Dieu*[46] in Paris, Chartres, Amiens and many other cities. They were built near to cathedrals (such as that of Magonza: *hospitale pauperum ante ecclesiam maiorem constructum*)[47] and at times were promoted by the chapters of the cathedrals themselves' (*l. c.*).

Town hospitals. 'These were built in cities that obtained a greater political independence and were endowed with their own municipal sovereignty. They were a sign of the power and the increasing activity of the middle classes. Their management was entrusted to religious bodies because at the time a bourgeois hospital was inconceivable without an altar and clergy or a community providing care that had a semi-monastic life, usually a follower of the Rules of St. Augustine. Many of them became the points of departure for contemporary hospitals' (*l. c.*).

Royal hospitals and hospitals of the nobility. 'From the High Middle Ages onwards the monarchs of the principal Christian kingdoms which arose after the decline of the Carolingian Empire, like the most powerful nobles, took the initiative of founding hospitals both to demonstrate the generosity of their rule and to make the scales of the final judgement lean in their favour. Thus some of the most important medieval hospitals arose, the royal hospitals, whose influence and activities went well beyond the beginning of the age of the Renaissance' (*l. c.*).

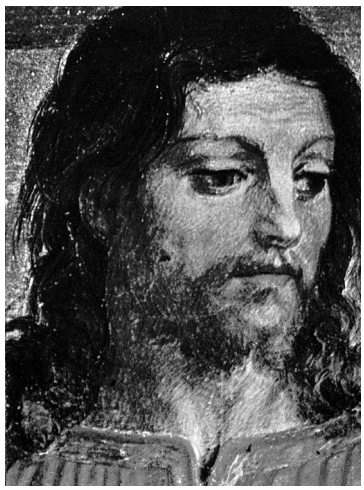
Hospitals for pilgrims. 'With regard to these kinds of buildings it is possible to follow the thread of a tradition which, beginning with the hostels for pilgrims of the East and of Rome during the fifth century, have come down to our days in Loreto, Lourdes and Fatima. But the culminating point of this development was reached roundabout the year 1200 when the pilgrimages to Santiago de Compostela spread out from various places in Europe. In that epoch hospitals for pilgrims offered not only accommodation and food but also health care to sick pilgrims'[48] (*l. c.*).

Cruciform hospitals. 'These hospitals, many of which took the architectural form of a cross – for which reason they were often called hospitals of the Holy Cross, constituted the forerunners of the subsequent general hospitals because they were created out of a fusion of the old leper hospitals and other smaller hospitals, at the outset to unify and give greater efficacy to the hospital care of the time (*l. c.*).

Hospitals for lepers.[49] 'During the medieval period[50] there were a large number of leper hospitals in Europe. It is calculated that in France alone, roundabout the year 1225, there were over two thousand houses for leprosy victims. The typical leper hospital was surrounded by a wall, had a small stone chapel (which in general is the only thing that remains today), a large number of small wooden houses, most of which have been lost, and always a cemetery... From the second half of the fourteenth century onwards the first hospitals for plague victims began to be founded which gradually replaced the leper hospitals' (DJ-LHEM).

Hospitals for the mentally ill. 'A large number of historians have argued that before the French Revolution there only existed chains or cages for the mentally ill, and exorcisms and burnings for witches. This is completely false and laughable for those who even superficial-

ly know about the realities of the hospitals of the medieval period' (PLE-HUM; t. 3). 'The hospitals for the mentally ill began to take shape during the High Middle Ages when those who needed help because of this kind of infirmity visited churches where a male or female saint was buried to whom they prayed. A step forward took place with the appearance of the Order of St. Alex which was dedicated almost exclusively to taking care of these kinds of sick people... At the end of the medieval period special cells existed for mad people in the 'general' hospitals. These structures were important forerunners of the later lunatic asylums' (*l. c.*).



From the medieval period to the Renaissance: hospitals in Italy in the fourteenth and fifteenth centuries. 'Basing themselves on the hospital of Jerusalem, the communes of Tuscany began to build their own hospitals in the thirteenth century. Before the thirteenth century, for example the city of Sienna built one to whose personnel, differently from the *Hotel-Dieu* in Paris, belonged a medical doctor, a surgeon and a pharmacist. In 1288 Folco Portinari, the father of Dante's Beatrix, founded the Hospital of St. Mary in Florence which, towards the fifteenth century, became an experimental centre for medical treatment. A document dated 1500, but which reflects previous arrangements, reveals that the Hospital of St. Mary paid six of the best doctors of Florence to visit the sick every morning. In addition, three young interns lived permanently inside the hospital. In exchange for accommodation, work and the valuable opportunity to acquire experience at the level of medical practice, they attended to the three hundred patients in the hospital, followed what was going on and drew up reports for the appointed doctors' (TSM-H). 'The Hospital of St. Mary was not a death trap, like the less organised hospitals, nor was it a home where only the sick poor were given food. It provided to its patients access to the best doctors in society and an excellent number of recoveries were registered... At Santa Maria Nuova the interns attended to the patients without being paid not only because theirs was a virtuous service but also because it offered them an incomparable opportunity to observe the development of many illnesses' (*l. c.*). 'During the sixteenth century the professors of medicine of Padua, in the territory of Venice, established formal clinical training in the Hospital of St. Francis. Many students from North Europe came to study in Padua because of the excellence of its empirical training' (*l. c.*).

d. *Conclusion on the hospitals of the medieval period*. The most recent studies on the hospitals of that vast period known as the Middle Ages have managed to go beyond the historical prejudices in which the Enlightenment thinkers of eighteenth century and those of scientific and medical positivism fell, as is borne out by the following statements of Timothy S. Miller. 'Modern scholars have not felt inclined to engage in research into medieval hospitals because they thought that these were badly equipped places which offered the sick minimal medical care. the intellectuals of the eighteenth century contrasted the effectiveness of science in treating man's illnesses with the uselessness of Christian charity which at the most provided only relief and not real remedies. However the hospitals of Renaissance Italy like those in medieval Constantinople and Baghdad demonstrated that philanthropic institutions were not necessarily isolated from scientific medicine. Indeed, the hospital service in Italy came to constitute a vital part of medical training, first in Florence and then at the University of Padua. In hospitals such as Santa Maria Nuova the Christian commandment to help the needy was combined with a sense of civic pride and with a concept of professional ethics on the part of medical doctors to create situations which were at one and the same time truly philanthropic and efficient in the art of treating and caring for the sick' (TSM-H).

B. Hospitals during the modern age

After the above description of the direction that the evolution of hospitals in Italy took at the end of the medieval period and the beginning of the Florentine and Paduan Renaissance, one may observe that the new historical period which we commonly designate the 'modern age' clearly demonstrated a further evolution in the idea of the hospital and its features. We should point out here four moments that followed each other.

1. The Renaissance hospitals; the secularisation of hospitals begins

For reasons of brevity, the quotations of this section refer only to the evolution of hospitals during the Spanish Renaissance. There are two important reasons behind this decision: the first is that this evolution was in general representative of that which took place in other European countries; secondly, the transplanting of the Spanish model of Renaissance hospitals into the new world is worthy of especial mention, as is shown in section b.

'During the years of the Renaissance *a greater involvement of public authorities* in the government of hospitals became evident. The municipal and state authorities began to admit that hospitals were their responsibility. And the state began to become responsible for public welfare. In this way the *secularisation* of hospitals was set in motion... Throughout Europe

royal and municipal hospitals began to be founded. In the major cities some religious hospitals came under civil jurisdiction... This does not mean that religion was ignored... Hence the internal working of hospitals continued to adhere to the model of religious and monastic life' (MAS-LHH, p. 32s).

'During the Renaissance, Spanish society contributed to the fight against illness by supporting hospitals that had been created in previous eras and by creating new and more advanced hospital centres. Three fundamental aspects characterised the organisation of hospitals in Spain during the last years of the sixteenth century and during the seventeenth century: *a new architecture for hospitals*, in the form of a Greek cross, with four walkways or cloisters, a rule that was applied for the first time to the Royal Hospital of Santiago and later applied repeatedly by the other Renaissance hospitals of the peninsula' (PLE-HUM, t. 4).

'As regards the architecture of hospitals, the Renaissance introduced a renewal of forms... hospitals stopped having the appearance of churches and had more the appearance of palaces. They could use four halls placed around a patio, and gave rise to a design that took the form of cloisters' (MAS-LHH, p. 33).

'The evident appearance of specialised hospitals, such as hospitals for people with infectious diseases, the incurably ill and the convalescent, hospitals for people suffering from syphilis, military hospitals, hospitals the mentally ill and madhouses etc.' (PLE-HUM, t. 4).

'During the Renaissance there began the process of separating hospitals in the strict sense from nursing homes or accommodation houses for the poor. Amongst the factors that contributed to this process were the ineffectiveness of medieval hospitals in the new socio-economic conditions, the change in the way poverty was seen, and the beginnings of the modern state' (JMLP-MH, p. 282s).

'The *incipient centralisation* of many institutions which took place with the explicit aim of performing their function of providing treatment and care in a better way. Here, for example, Philip II decided to regulate the hospitals of Madrid by placing all the old institutions of St. Lazarus, of Muslim origins, the Hospital of St. John of God (152) and the Hospital of Peace within a single organisation' (PLE-HUM, t. 4).

'During this period various *Orders dedicated to medical care and strictly charitable tasks* came into existence. The Order of the Hospital Brothers of St. John of God, which was approved in 1571 by Pope Pius V and spread rapidly in Spain and America, became very widespread' (PLE-HUM, t. 4).[50]

Reference should be made to a very important characteristic of this period which affected the Renaissance hospitals both in Spain and other European countries and which was to characterise for at least three centuries their way of providing care and treatment and the character of their patients. I am referring here to the change in *the way poverty was seen* that was produced by the humanists of the Renaissance and the consequences that this had for the world of hospitals.

'Another modern feature of the intervention of the Crown... was the promotion of houses for poor people. These were clearly separate from hospitals because they centred around the idea of *providing aid to the poor*... During the Low Middle Ages poverty had had positive connotations based principally upon charity as a central Christian notion of human relationships. Poverty out of choice was a basic element of the mendicant Orders and was seen as a way of drawing near to Christ... [Poverty] freely taken on, if adopted with resignation, was also seen as a propitious condition by which to acquire eternal salvation. The poor were seen as intercessors in relation to God and providing aid to them was seen as a social expression of charity' (*l. c.*).

'The change that was produced during the course of the sixteenth century and which led to a negative assessment of poverty was the result first of all of the transformation in socio-economic structures. Population growth, associated with changes in agrarian production and the appearance of a pre-industrial, pre-capitalist economy led to a sizeable increase in the number of the poor throughout Europe' (*l. c.*).

'Another factor which had a negative effect on the approach to poverty was the exaltation of work by the humanists... this was the context of the current of ideas on 'poor relief', whose *point* of departure was usually to be found in the *De subventione pauperum* (1526) of Luis Vives. As Cavillac has observed, Vives was the first writer of tracts to deal with the problem of the poor in sociological terms and brought out the limits to the medieval concept of charity. The approach of Vives meant, amongst other things, the secularisation of charity... the creation of information on, and lists of, the poor, the non-counting of people who pretended to be poor and the rationalisation of relief that was provided to people who were really poor. All these elements had a great influence in the field of ideas and studies and in the practical field and the sphere of government policy' (JMLP-MH, p. 276s).

2. Hospitals in Hispanic America[52] and Japan.

A very significant feature of Spanish and Portuguese colonial expansion was the mass exportation of the models of what hospitals ought to be in the Iberian peninsula to the territories that were conquered or visited in the West indies or the Far East. This phenomenon, whose rapid and widespread introduction was on a surprising scale and whose consequences remain with us still today in Latin America, was caused fundamentally, once again, by the practice of Christian charity towards both sick Europeans and sick natives.

'The exchange of diseases between the Spaniards and the native Americans found a salvific formula in Christian ideas of charity... In Hispanic America a large number of hospitals were quickly founded. The first American hospitals

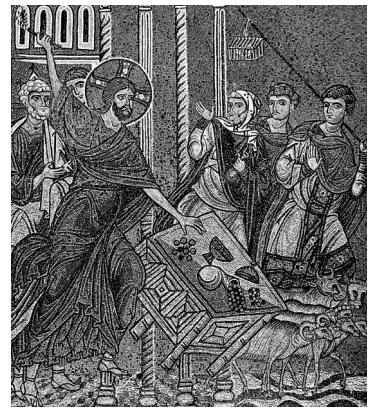
were founded on the island of Santo Domingo when Nicolás de Ovando unveiled the first on 29 November 1503. This was rebuilt in 1519 and extended in 1552. In 1509 Diego Colombo had already subsidised the hospital of San Buenaventura and the Hospital della Concepción. The Hospital of San Andrés was built in 1512, together with the Hospital of San Lázaro for lepers. But the majority of hospitals had religious origins. Those built by the episcopates were attached to cathedrals and those created by the Spanish hospital Orders (the Brothers of St. John of God, the Bethlemites, the Hippolites...) experienced great fame on the continent and were marked out by the excellence of the services that they provided. The statistics published by Santos in 1716 on the hospital Foundations of the Order of St. John of God in the Spanish domains of America and the Philippines give a clear idea of the gigantic efforts at the level of care made by these Orders in the Colonies' (PLE-HUM, t. 4).

'In 1556 a hospital for the poor, the elderly and lepers, under the direction of the Jesuit and medical doctor Luis d'Almeida was founded in the *Japanese* city of Funai (today's Oita) The Franciscans, who reached Japan in 1593 also dedicated themselves first and foremost to care for the sick and the poor and they founded various leper hospitals and numerous structures to provide care in Kyoto' (IM-LMMC, p. 151).

3. The hospitals of the seventeenth century in Baroque France: the general hospitals.

Although Renaissance Spain may be seen as the leader in terms of the evolution of European hospitals during this epoch, given that it was the dominant nation of the time, it was France that had a hegemony in Europe during the baroque period and for this reason France is also a paradigmatic example in the description of the process which involved the transformation of hospitals.

The survey presented by the quotations that illustrate this epoch is highly significant. On the one hand, the secularisation of hospital charitable care continued through an increase in the control by governments of hospitals and their policy of the reduction of numbers and the concentration of centres in areas of greater institutional rationalisation. In this way the reality of the 'general hospital' was strengthened, a reality which continued to be in force until the twentieth century. On the other hand, the quality of the actual services received by patients under this state control was deplorable. Secularised welfare brought with it, indeed, bad health care which as we will see below continued until the first decades of the twentieth century, at least in public hospitals.



'During this period of the history of France, the great number of illnesses, the growth of cities and the prestige of the Crown and the Church lay behind an important growth in hospitals. Some hospitals were extended, others were created, and all were regulated and reorganised. In this way there arose a new kind of hospital which others countries adopted as a model. In Paris the *General Hospital* was founded, to which were assigned the Hospital of Bicêtre and the Hospital of Salpêtrière, this last being for women. How was care provided in these hospitals? We should refer to four elements to answer this question, taking as an example the *Hotel-Dieu* of Paris. *The hospital death rate*. The death rate was very high, especially the death rate of children... Overcrowding and a lack of hygiene in hospitals were responsible for a large number of deaths. During the seventeenth century the plague killed hundreds of people every day; during the eighteenth century it was replaced by scurvy. *The conditions of hospitalisation*. The number of beds was notably insufficient at the level of needs. In 1786 Joseph Townsend was amazed by the presence of 2,547 patients in a hospital with 1,219 beds. Despite the constant instructions that were issued to ensure that the patients were well fed, these often failed to be implemented. The quality of the food was insufficient, and the health-care structures were few in number, badly lit and far from the wards. The patients with contagious diseases were not isolated and those with different affliction were not separated in the basis of their age or the gravity of their condition. Surgical operations were carried out in the wards themselves in the presence of the other patients; the post-operation periods were very dangerous and all the people who were operated on died. However, in almost all the hospitals there were special and better rooms for the privileged. *The medical and health-care personnel*. The number of medical doctors was very low. In the *Hotel-Dieu* in 1626 there was only one, there were three in 1638 and between 1656 and 1714 the number increased to four, six and seven. From 1651 onwards it had a variable number of medical doctors and auxiliaries, between two and seven. The number of surgeons was much greater – in 1726 there were almost a hundred. Although they were mostly students, more than a dozen were qualified. Together with the medical doctors there were a large number of nuns of the Congregation of Augustinian Sisters and Dames. The role of the Church in hospital care continued to be important and to such an extent that immediate medical and spiritual care was provided to the sick by members of various religious Orders and Congregations such as the Daughters of Charity and the Hospital Sisters of St. Joseph. *The funding of hospitals*. The *Hotel-Dieu* of Paris maintained

itself in fundamental terms thanks to donations and legacies, and to rights, exemptions and privileges. The donations made up almost a half of all its resources. The ecclesiastical subventions and alms were decreasingly important and thus the secularisation of care was already a fact' PLE-HUM).

As regards the work of the Church, this was the moment when France brought to the hospital world and home care for the sick the figures of St. Vincent de Paul, St. Louise di Marillas and her *Daughters of Charity*. Until the appearance of Florence Nightingale and as a result of her initiatives the appearance on the scene of qualified nurses at the end of the nineteenth century, it was these figures, as health-care *women religious*, who would become responsible for the greatest number of tasks in providing care to the sick in hospitals, attenuating, with abnegation, a Christian spirit and expertise, the grave defects of these centres. Their Founder said: 'The Daughters of Charity will have the homes of the sick as their convent... their cloister will be the streets of cities and the wards of hospitals' (JAG-YEC, p. 101).[53]

4. From charity to medicine. The hospitals of the Enlightenment

Roundabout the middle of the seventeenth century hospitals entered a new evolutionary stage, where their control by the state grew increasingly and ended up by placing them at the service of political, economic and military ends. This approach involved the gradual replacement of motivations and finalities of a charitable character and the search for greater efficacy in the achievement of those ends. Thus medicine entered in a decisive way into the hospitals of this period, being advanced, in addition, by Enlightenment thinking in the eighteenth century.

The virtue of the Enlightenment was to give a decisive impulse to the medicalisation of hospitals and through this to transform them into places where during the nineteenth century scientific medicine and its academic study would be increasingly developed. However, the dark side of this stage of development lay in the fact that these advances in the organisation of hospitals and medical scientific progress were not accompanied by better care that was more worthy of patients and more attended to. In the section on hospitals during the nineteenth century there is even too much instructive evidence on this.

'Beginning in 1650, the new political policies that were outlined to increase the power and the prosperity of the emergent national States led hospitals towards new functions. Great value was given to human life to the extent that new population policies were established to increase the number of inhabitants to form a base for the power of the State, for economic development and for military strength. Those who championed emergent European mercantilism saw in work the key to wealth and operated to ensure that the workforce of the nation was mobilised and maintained in an excellent state of productivity'.

'At the same time a more optimistic vision of prevention and rehabilitation in the sphere of health drawn up by the thinkers of the Enlightenment argued that illness, rather than being an inevitable burden, the outcome of sin and something that it was not possible to eradicate, could be controlled and eliminated. In addition to their traditional moral and physical goals, from that moment onwards hospitals were seen as institutions that aimed and physical rehabilitation and healing, as places that were the first and not the last resource, in particular those for military personnel and the work force. These measures involved a major commitment on the part of the professions connected with dealing with the health of vast sections of the population which, up to that time, had no contact with them. To implement these new health-care policies, national government, local authorities and professional bodies engaged in major organised efforts to reform the existing medical profession and the profession of surgery. New ways by which to have access to hospitals were guaranteed for doctors and surgeons and new rules were laid down to govern the institutional activities of hospitals. The first models of the process of medicalisation came from military groups and the navy, and were intended for members of the armed forces who were sick or wounded in a Europe that was undergoing expansion. Later, medical professionals which worked in civil hospitals began to demonstrate with success that their way of treating patients constituted a new factor and a factor of notable importance, which was united with the rest and diet that was given to those who were admitted to religious care centres. During the last part of the eighteenth century and the beginning of the nineteenth century, medical goals profoundly reshaped hospital rules as regards the admission of patients until their discharge or death. Preference was given to the treatment of acute illnesses over chronic illnesses, and young patients were admitted more than elderly ones. The objectives were rehabilitation and recovery' (TSM-H).

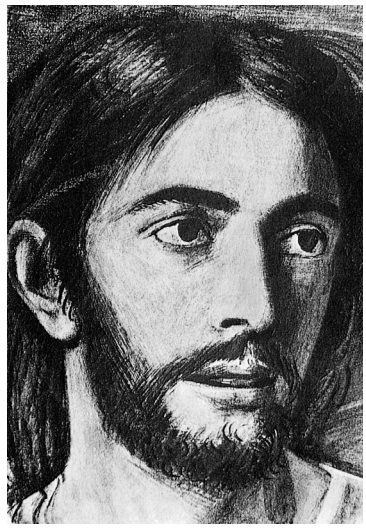
B. Hospitals in the contemporary world

1. Hospitals during the nineteenth century.

The quotations in this section are intended to attest to the paradox presented by the historical evolution of hospitals during the nineteenth century: they admirable at a scientific level but deplorable at the level of care. In these hospitals medical doctors and surgeons more than justified their claim to be seen as authentic scientists and they even transformed medicine into a 'new positive-scientific religion' (Rudolf Wirchow) and hospitals and their laboratories into the 'temples' of this religion (C. Bernard). In these centres, however, patients became the preferential field for scientific observation and this was carried out with the criteria of the crudest enlightened

despotism, and the conditions that were offered by hospitalisation were very often beneath the minimum allowed by elementary human decency and dignity.

'Until the eighteenth century, excluding elements of a religious character, hospitals had one or two infirmaries, a pharmacy and probably a room for treatment. Subsequently an autopsy room was added. During the course of the nineteenth century operating theatres, a chemical laboratory, a microbiological laboratory, wards, one was dealing with a decent hospital, and in some cases a department of physio-pathology and experimental pathology, also came to form a part of hospitals. At the end of this process, by the twentieth century, hospitals constituted a small world all of their own with their own characteristics' (PLE-HM, p. 675).



'As regards what was available at the level of health care during the second half of the century, what clearly emerges is the institution of the hospital even though the creation of public clinics was also important. For this reason, the characteristics that hospitals adopted illustrate the nature of the encounter between medical doctors and patients during this epoch. Intended, to begin with, to deal with the illnesses and the sufferings of the lower classes, institutionalised as charity, they showed themselves to be an increasingly effective instrument. This was the moment when there was an enormous growth in both general and specialised and private hospitals, above all for mental illness. But all of this took place when there was still reliance upon an authoritarian pyramid-style organisation where a patient of low social origins had to adopt a passive approach, of total dependence, with a lack of access to general practitioners and in definitive terms with a lack of a relationship to the needs at the level of care of society as a whole and the organisation of health care. In secularised bourgeois society... the poor in difficulty [were treated] in hospitals; the middle classes were treated in their own homes or in those of their family doctor; the upper classes were treated at home or at the clinic of a specialist or by a high figure in medicine. When a medical doctor reached the rank of one of these two categories he had to divide his clinical activity – and thus his days – into two halves: a hospital morning when he treated the poor and a private afternoon when he treated the less poor and the rich. A sick person went to a hospital... convinced that he was going to receive the medical care given to *poor people*, supplemented by the following three ingredients: an excellent diagnosis given that the medical doctors of the hospital were on the whole the best in the area; a treatment that of necessity was limited to the scarce or precarious economic opportunities (structures, drugs and medicines, auxiliary staff, etc.) offered by the *charitable funds*; and a scrupulous necropsy if the illness was fatal. 'We sick people of Vienna', declared with great resignation the poor of Vienna in about 1860, 'have the great good fortune to have good diagnoses by Skoda and good autopsies by Rokitanski'. To this belief was added in general an approach of resignation and acceptance... The sick had more faith in the doctors than in the hospitals and they entrusted themselves to them with two principal approaches which can be reduced to equally expressive phrases: 'here is my body, do with what you want', and, if the hospital was a teaching hospital 'look how interesting my illness is'. 'In addition to being treated a hospital patient was obliged to offer his living body for the purpose of clinical teaching and his corpse for anatomical teaching. When it fell sick the body of a poor person became *res publica* or at least *res publicanda*... The reality of hospital life... was enough to justify this protest (*the rebellion of the proletarian classes against the division of medical care into medicine for the rich and medicine for the poor*)... Marañón has illustrated in a way that is never demagogic but always sober what the large number of wards of the General Hospital of Madrid was when he began his medical career. Hospital meat our people declared for many years to refer to what had in front of it no other hope than illness and misery' (*l.c.* p. 218-220).

'The heads of the surgical services of the *Hotel-Dieu* of Paris had placed over their mouths and nostrils a sponge impregnated with vinegar in to order to be able enter their respective infirmaries during the morning so great was the fetid odour that they breathed in' (PLE-LMA, p. 93).

'In his book *Society and Medical Progress* (1941), B.J. Stern describes nineteenth-century hospitals in the following way: the patient had to enter them for his death throes. It is not surprising that the admission of a patient to hospital was a sort of announcement of his death... Windows that were always closed, wooden beds with patients who were never washed and sheets that were not changed regularly produced a terrain favourable for lice' (PLE-HUM, t.6).

C. Centeno and P. Arnillas rightly stress the historical utility and the alternative at the level of health care that underlay in the middle of the nineteenth century the creation of the *Maisons du Calvaire* by Mrs. Garnier and her companions. These homes were the immediate precursors of the hospices for the terminally ill of C. Saunders' St. Christopher movement (1967).

'The *Maisons* were founded as alternative institutions to the

hospitals that provided care to the sick poor during the nineteenth century, whose lamentable hygienic and accommodation conditions meant that there was an authentic refusal of people to die inside them' (quoted in JCH-CP, p. 58).

2. A hospital for all social classes (1870-1945).

The third and last part of the nineteenth century may be seen as the moment when the evolution of hospitals acquired a new impulse which, during the course of the first half of the twentieth century, defined these institutions with specific physiognomies which, at the level of by no means a few features, have continued to the present day and which I will illustrate with the following quotations.

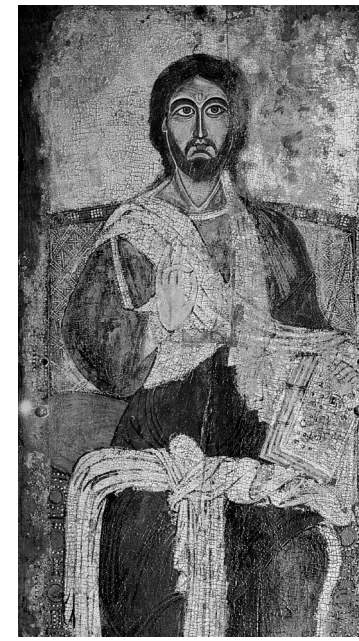
a. *From charity to state-funded health-care*. 'At the end of the nineteenth century many hospitals continued to be buildings where poor people *who had nowhere else to go to die* betook themselves. But in the first decades of the twentieth century this situation changed radically... for the first time in history, indeed, hospitals were used to diagnose and treat sick people of all social classes' (MAS-LHH, p. 52).

'In 1882, with the introduction of social insurance in the case of illness, which over the next decades covered employees and their family relatives, there was a marked broadening of the market of health because it included treatment by a doctor, the costs of drugs and medicines, and, where this arose, the costs of admission to a hospital. At the same time the medical doctors who worked within the state-funded framework found that they had to decide between the patient's need to be treated and their ability to work. This power of decision and of clarification by the medical profession, which had grew gradually and progressively in what until then had been the private sector, was designated the medicalisation of society' (JB-MCPC, p. 285).

b. *Hospitals – centres for the diffusion of the medicalisation of society*. Thanks in part to the advances in medical knowledge and technology, the process involving the medicalisation of western society made notable strides before the Second World War. Prior to 1914 in Europe and the United States of America patients of the upper and middle classes sought to pay for treatment in hospitals and did indeed do this. Endowed with skilled professional doctors and nurses, and equipped with clinical laboratories and other instruments by which to carry out diagnoses, hospitals became the preferred location for acutely ill people who needed medical care and surgery. The new demand for health care, propelled forward by urbanisation and industrialisation, expanded even more and came to include obstetrics and care for infants and mothers after birth' (GBR-HMH).

c. *Hospitals in the new urban and industrial context*. The new mission of hospitals was the result of the convergence of ideologies, political strategies and needs at the level of care, some of which were traditional and some of which were new. Religious values and charitable donations still had an important function at the beginning of the twentieth century and the needs of economic development based on capitalism indicated that the health of workers in the industrial world was of great importance both for the state sector and for the private sector... Urbanisation was generated at an accelerating rhythm, leading a growing number of people towards neighbourhoods in cities that were already highly populated. Amongst these people there was a wave of new immigrants with multiple health-care needs and few funds. In exchange, industrialisation created a new panorama of occupational illnesses and accidents. Without money or a family context from which to obtain the help that was needed, many sick people and many wounded people found themselves forced to look for medical care in hospitals' (*l. c.*).

d. *Hospitals become the first and most important health-care resource*. With their incorporation of scientific medicine, hospitals became primary institutions of reference and no longer a last resort. Thanks to increasingly sophisticated diagnostic and therapeutic procedures, such as radiology, electrocardiograms, and clinical laboratories, the ability of hospital staff to formulate diagnoses improved enormously. In addition to providing rest and a healthier diet, hospitals increasingly concentrated on the treatment of acute illnesses, above all those that involved a high risk to life and required sophisticated technical care. A new generation of vaccines and chemical-therapeutic substances improved the success rate in the battle against certain illnesses. Through the adoption of anaesthetics and antiseptics, hospitals became the most important centres for surgery' (*l. c.*).



e. *The new professional nurses*. 'To care for patients hospitals increasingly turned to new generations of nurses who came from the middle classes and were trained with educational programmes based on the model established by Florence Nightingale (1820-1910).[54] These new hospital nurses came to replace the religious personnel that had traditionally provided these services to patients. The nurses of Nightingale became valuable assistants of the medical profession in the treatment of patients' (*l. c.*).

f. *Hospitals, centres of research, specialisation and the teaching of medicine*. After hospitals had been transformed in the second decade of the twentieth century into the primary laboratory of medical doctors, the medical objectives, including specialisation, education and research, became the priorities of hospitals as institutions... The hospitals of the twentieth century displayed considerable growth in specialised care through the creation of clinical departments, the increase in medical students and the creation of clinical research. These activities were crucial for academic and university needs and conferred prestige and greater professional stature on those who were allowed to work in these pre-eminent institutions' (*l. c.*).

g. *Other aspects of the new hospitals*. After the transformation of hospitals and the special attention that was paid to the application of scientific principles to medicine, *new ethical problems appeared*. The processes that involved the medicalisation of life broadened the level of vital experiences involving medical problems for hospital professionals. *Birth and death*, which previously had been events that took place at home, now took place in hospitals. From the beginning of the nineteenth century a *depersonalised approach to illness*, centred around the organs, replaced the previous holistic notions of illness. And as hospital practice became gradually regulated and technical in character, *patients became mere containers of illnesses*, and these were the primary subject of research and treatment. This approach levelled a blow at the nature of the relationship between medical doctors and patients because the professionals concentrated first and foremost on a positive resolution of the problems of diagnosis and human pathology. The moral authority of medical doctors, based up to that time on personal qualities, was now founded on scientific skill. Clinical experimentation became aggressive and at time abusive when compared to the few guarantees for safeguarding patients that were envisaged' (*l. c.*).

3. The second half of the twentieth century: hospitals, the supreme scenario of biomedicine.

The inherent characteristics of the evolution of hospitals during this period which has continued to this day are in general terms already known about both because of the multitude of studies and monographic research works and because of the information provided by the parts of the various mass media interested in the field of health.

In addition, the objectives of the Campaign for Pastoral Care in Health 2007, which include special studies on the contemporary development of health care taken as a whole, and also of the new and growing socio-health care sector, require that this paper ends here its journey of historical inquiry, leaving to other people the task of describing the contemporary unfolding of this development.[55] I would like only to add two last observations: a simple and summarising of what experts predict hospitals will be in the immediate future; and, to end, some conclusions beginning with pastoral care in health today, looking at past history, at the present and at the foreseeable future of hospitals.

D. Where are hospitals going?

At the beginning of this paper there is a quotation from a historian who calls into question at a deep level the future of hospitals: 'the evolution of hospitals over the last centuries raises the central question of whether health care[56] is still the primary function of these institutions'. I will here direct readers to a reading of this quotation and I will not resist the temptation to quote something similar by way of a prediction. A. Navarro ventures the question: 'what will happen to hospitals in the future?, and then answers: 'one can identify the answer by analysing the evolution of hospitals in recent times. Probably, during our century, hospitals will have increasingly less beds, they will be more problem-solving in character, they will continue to incorporate the knowledge of professionals, new technologies and innovative drugs and medicines, roles will disappear, data information will travel in a fluid way through health-care systems with guarantees about privacy, high quality will be a primary objective, and efficacy will be present in all the textbooks of professionals. Seen in these terms, what will be the size of hospitals during the twenty-first century? The question cannot have a classic answer. Their size cannot be measured in terms of beds or in terms of technology given that these may be inside or outside hospitals. It will be necessary to introduce a new parameter, namely the so-called 'packet of services', which represents the capacity to solve clinical cases... Beds will be inescapable and technology will increasingly lead to a reduction in their number... although in grave case they will be indispensable. Perhaps for this reason we will have to open our minds to some hospitals with beds and some hospitals without beds' (ANHCAD, p. 5).

This prediction is based upon characteristics that directly affect all of us who see hospitals from the perspective of health care as a whole, that is to say from the perspective of all the areas of human society, because health – its promotion, maintenance and recovery – is a universal aspiration. However, the historical inquiry that I am about to finish has had as its constant purpose that of emphasising what *pastoral care in health should adhere to* and what therefore the Catholic Church should adhere to as it establishes its evangelising mission in hospitals.

To answer this question with the greatest lucidity possible, I have thought it necessary to recall what I have considered to be of greatest importance in the history of the relationship between the Church and hospitals, convinced, as I am, that this history is not *merely a matter of the past* and that there are many important aspects of it that are

still alive or which continue to exist openly in the contemporary life of hospitals. What hospitals will be in the future will be the outcome of decisions that will open up, on the one hand, new pathways, but which, on the other, will close others that already exist. To take these decisions a wisdom will be required that is able to discern what is most beneficial between *nova et vetera,* between th*e new and the old*, as is done, for example, will the production of good wine. The following conclusions are only a humble contribution to such a discernment.

E. Conclusion

1. History tells us that the Church created hospitals and has had a decisive influence on their evolution during the course of the last one thousand and seven hundred years.

2. In the modern age hospitals started to shift from being owned and managed by the Church to being owned and governed by various secular institutions, amongst which political authorities and, later, medical culture and science.

3. Hitherto this has not impeded the Church from continuing to dedicate special attention to the institution of hospitals. A very succinct summary bears this out:

a. The large number of religious Orders and Congregation which from the sixteenth century onwards chose for their own charism the service of care and pastoral care in hospitals, and the foundation of their own centres to put this charism into practice.

b. The foundation of hospitals in lands of mission, beginning in the sixteenth century and continuing until the present day as well, as an action inseparable from the work of evangelisation of the Church.[57]

c. The number of hospital foundation which still today have as their owners the diocesan Churches.

d. The number of hospital beds which at the present time the Church makes available in the various sectors of health care, such as the psychiatric sector, without which, with a few exceptions, it would be impossible to provide secular health care in an adequate way.

e. The active and productive contribution made to contemporary hospitals by such new and pioneering initiatives as: ethics committees; palliative care units; and units for patients with brain damage.

f. The agreements with public authorities and private health-care bodies to supplement the services of Catholic religious care in hospitals.

4. For all of this, we must uphold with vigour and clarity the following, and this must be the fundamental objective of the Campaign of the Sick of 2007:

a. The Church, the whole of the Church, must be faithful to her Tradition and for this reason must devote to hospitals the attention, the people and the pastoral instruments that their evolution requires.

b. What is at stake is nothing else but faithfulness to Jesus Christ, the Good Samarian, the sick Healer and Physician of souls and bodies.

c. The same may be said of faithfulness to the Church which in his name made hospitals a fundamental instrument of the encounter with the health-care world, with sick people, with their family relatives, and with health-care workers.

5. Lastly, and as a contribution to the concrete objectives of the Campaign 2007, I venture here to propose:

a. Making all the members of the our local Churches learn about the history of hospitals and their contemporary development so that they can continue to be seen as a fundamental place of evangelisation.

b. Revaluating and implementing services of Catholic religious care so that they can carry out in a satisfactory way the pastoral commitments that are required by the contemporary development of hospitals.

c. Making the dioceses more aware and appreciative of the efforts of Catholic hospitals to respond to the new challenges of hospital care and launch with them closer relationships of pastoral cooperation.

d. Revising and renewing the *Ideario del Hospital Católico* (1981)[58] amongst health-care religious Congregations.

I would like to end this paper with a final quotation which moves me and gives me the strength and which I here have before me for the first time. This is a paragraph taken from the founding document of St. Christopher's Hospice, drawn up by its creator, Dr. Cicely Saunders. For me this is a clear demonstration of the creativity that Christianity is able to continue to have within the historical evolution of hospitals. This is in its entirety an example to follow:

'St. Christopher's Hospice is founded on Christian faith in God, through Christ. Its objective is to express in all ways possible the love of god for all who come: in the skill of nursing and medical treatment, in the use of all scientific knowledge to alleviate suffering and malaise, in sympathy and personal understanding, in respect for the dignity of each individual for the person he is, appreciated by God and men. Without barriers of race, colour, class or creed' (Cicely Saunders).[59]

Rev. JESÚS CONDE HERRANZ
Diocesan Commissioner for the Health Pastoral Care, Madrid, Spain

Bibliography

AB-LGJPI Antonio Borrás, 'Los grandes jalones de la presencia de la Iglesia en el mundo de los enfermos', in *LH*, n. 185 (1982), 145-148.

AC-LOAM Antonio Casera, *L'Ospedale e l'assistenza ai malati nel corso dei secoli* (Salcom, Varese, 1990).

AN-HCAD A. Navarro, 'Los hospitales, concepto, alcance y dimensión', in VA-LHHA, pp. 1-11.

CCPA-HCP Carlos Centeno and Pedro Arnillas, *Historia de los Cuidados Paliativos*; reference and quotations in JCH-CP.

CEP-DPS Comisión Episcopal de Pastoral - Departamento de Pastoral de la Salud, *25 años de Pastoral de la Salud en España* (Edice, 1999).

CGQ-LAMH Constantino González Quintana, 'La asistencia médico-hospitalaria', in *Dos siglos de lucha por la vida: XIII-XIV. Una contribución a la historia de la Bioética* (Publicaciones Universidad Pontificia de Salamanca, 1995), pp. 224-237.

CS-GME Charlotte Schubert, 'Grecia

y la medicina europea' in VA-CM, pp. 34-62.

DC Doménico Casera, *Chiesa e salute. L´azione della Chiesa in favore della salute* (Áncora, Milan, 1991).

DGG Diego Gracia Guillén, '*El Cristianismo y la asistencia a los enfermos',* on *LH* n. 184, 1982, 66-75.

DH *Dolentium Hominum,* Review of the Pontifical Council for Health Care workers, Vatican City.

DJ-LHEM Dieter Jetter, 'Los hospitales en la Edad Media' in PLE-HUM, t. 3.

DPS-LARH Departamento de Pastoral de la Salud, *La asistencia religiosa en el hospital* (Edice, Madrid ,1987).

DRB-PA Daniel Ruíz Bueno: *Padres Apostólicos* (BAC, Madrid, 1965).

EF-THMS Eliot Freidson, *The Hospital in Modern Society* (Free Press, New York, 1963).

FRH-TCMA Friedrun R. Hau, 'Tradición cristiana y medicina árabe' in VA-CM, pp. 63-120.

GBR-HMH Günter B. Risse, 'Historia moderna de los hospitales', in *Encyclopedia of Bioe-thics,* (ed. digitale) (Washington D. C., 1995).

GBR-MBSS G. B. Risse, *Mending Bodies, Saving Souls. A History of Hospitals* (Oxford University Press, New York and London 1999).

GR-TH George Rosen, 'The Hospital: Historical Sociology of a Community Institution', in his *From Medical Police to Social Medicine: Essays on the History of Health Care* (Science History Publications, New York, 1974), pp. 274-303.

GZ-EMM George Zarnecki, 'El mundo monástico' in J. Evans, *Historia de las civilizaciones* 6: *La Baja Edad Media* (Alianza, Madrid 1988), pp. 51-112.

GZ-LCT *Id*., *Los Caballeros Teutónicos,* l.c. pp. 97-99.

IM-LMMC Ingo Müller, 'La medicina entre la magia y el conocimiento', in VA-CM, pp. 121-161.

JAG-YEC Jesús Álvarez Gómez, *"...Y ÉL LOS CURÓ". Historia e identidad evangélica de la acción sanitaria de la Iglesia* (Publicaciones Claretianas, Madrid, 1996).

JB-MCPC Johanna Bleker, 'La medicina como ciencia y la patología celular', in VA-CM, pp. 284-339.

JCH-CP Jesús Conde Herranz, 'Los Cuidados Paliativos: sus raíces, antecedentes e historia desde la perspectiva cristiana in *DH*, 58, 2005-1, 54-63.

JCH-AIS Jesús Conde Herranz, 'El Cristianismo Primitivo: una sanidad comunitaria que surge de la base; en La aportación de la Iglesia a la Sanidad desde el Evangelio y su propia Tradición', *LH*, n. 223, 69-77.

JCH-IPS Jesús Conde Herranz, *Introducción a la Pastoral de la Salud* (San Pablo, Madrid, 2004).

JCH-LPH Jesús Conde Herranz, 'La Pastoral Hospitalaria', in JCH-IPS, pp. 250-55.

JCH-PPS Jesús Conde Herranz, *La Pastoral y la Pastoral de la Salud,* pp. 7-40.

JDTGG-HSAH J. D. Thompson and G. Goldin, *The Hospital: A Social and Architectural History*, (Yale University Press, New Haven and London 1975).

JL-HI Joseph Lortz, *Historia de la Iglesia,* vols. 1 and 2; digital ed.

JLB-PSI Javier Lozano Barragán, 'Pastoral de la Salud en la Iglesia', in *DH*, n.62, XXI, 2006 n. 2. 29-34.

JMLP-ACM José María López Piñero, *Antología de clásicos médicos* (Triacastela, Madrid, 1998).

JMLP-MH José María López Piñero, *La Medicina en la Historia* (La Esfera de los Libros, Madrid, 2002).

JMP-HH J. Martínez Pérez (ed.), *Historia de los hospitales* (Madrid, 1993).

LGRP-HH L. Granshaw and R. Porter (eds.), *The hospital in History* (Routledge, London and New York, 1989).

LH *Labor Hospitalaria: humanización, pastoral y ética de la salud* (Hermanos de San Juan de Dios, Barcelona, Provincia de San Rafael).

MAS-LHH Miguel Ángel Sánchez, 'Los hospitales a través de la historia', in VA-LHHA, pp.13-77.

MF-TBOC Michel Foucault. 1973. *The Birth of the Clinic: An Archeology of Medical Perception* (Pantheon, New York, 1973).

MG-CM Manuel Gesteira, 'Christus Medicus. Jesús ante el problema del mal' *Revista Española de Teología,* vol LI, 1991, quad. 2-3, 254-300.

MP-OC Massimo Petrini, 'Ospedale catolico', in VA-DTPS, pp. 800-4.

PLE-HM Pedro Laín Entralgo, *Historia de la Medicina* (Salvat, Barcelona, 1978).

PLE-HUM Pedro Laín Entralgo, *Historia universal de la Medicina* (Masson Multimedia, digital ed., Barcelona).

PLE-LMA Pedro Laín Entralgo, *La Medicina actual* (Dossat, Madrid, 1981).

PLE-LRME Pedro Laín Entralgo, *La relación médico-enfermo. Historia y teoría* (Alianza Universidad Textos, Madrid).

RGV-HI Ricardo García Villoslada, *Historia de la Iglesia,* II, *Edad Media (800-1303)* (BAC, Madrid, MCMLXIII).

RSB Regula Sancti Benedicti (Regla de San Benito), *www.thelatinlibrary.com/benedict.html*.

SL-OC Salvino Leone, 'Ospedale civile', in VA-DTPS, pp. 804-11.

TSM Timothy S. Miller, 'Hospital', in *Encyclopedia of Bioethics* (digital ed., Washington D. C., 1995).

UB-PFMM Urs Boschung, 'Principios físicos y morales de la medicina', in VA-CM, pp. 201-249.

VA-CM Various authors, *Crónica de la Medicina* (Plaza-Janés, Barcelona, 1993).

VA-DTPS Various authors, *Dizionario di Teologia Pastorale Sanitaria* (Camilliane, Tu-rin, 1997).

VA-LHHA Various authors, *Los hospitales a través de la historia y del arte* (Ars Medica, Barcelona, 2005).

WUE-QMMM Wolfgang U. Eckart, 'La química y la mecánica. modelos médicos', in VA-CM, pp. 162-200.

WW-AT W. Westendorf, '*Antiguo Egipto*', on VA-CM, p. 17s.

www.archimadrid.es/dpsanitaria.

www.artehistoria.com.

www.etimo.it.

www.geocities.com/milan313/indice.html.

Notes

[1] This text was revised and summarised for *Dolentium Hominum* from the paper presented to the XXXI National Day of Pastoral Care in Health (Madrid, 25-28 September 2006) and then published in the monographic edition of the review *Labor Hospitalaria*.

[2] Given the frequency with which many historians, whose work I have chosen, are alternately cited and quoted, and in order to make the identification of each quotation as brief as possible, I have used abbreviations in the form of acronyms which are in brackets at the end of each quotation or citation of an author. The complete list of acronyms of authors and documents quoted and cited can be found at the end of this paper under the heading 'Bibliography'. When the number of the page is not indicated this means that the work that is quoted or cited is in digital form and is not always paginated.

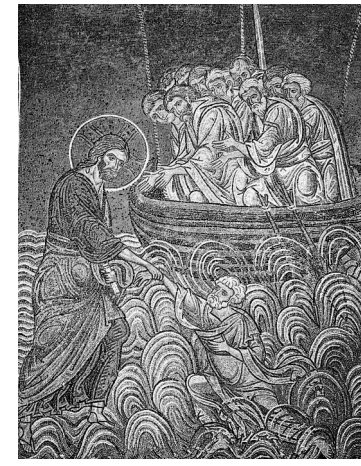
[3] An annual campaign that has been promoted since1986 by the Department for Pastoral Care in Health of the Spanish Bishops' Conference.

[4] In 2005 a book on the history of hospitals was published - *Los hospitales a través de la storia y del arte* (VA-LHHA). The historical part of this volume is quoted and cited on a number of occasions in this paper. Other publications on the same subject, with the common denominator of the history of hospitals but not always sharing the same approach, are referred to with the acronyms GR-TH; JDTGG-HSAH; JMP-HH; and LGRP-HH.

[5] The research methodology of Pedro Laín Entralgo shows in many of his works that the systematic moment – which defines and explains a dynamic and changing reality – must always be preceded by a description of its historical evolution.

[6] Cf. JMLP-MH, p. 109.

[7] Dieter Jetter alludes to the so-termed hospitals of Asoka (264-228 BC) based on Buddhism in ancient India (DJ-LHEM). A. Casera also does this in AC-LOAM, p. 16 without, however, entering into details.



[8] 'The ancient physicians were tired of practicing medicine in public squares or in small dispensaries known as ιατρεια which did not provide for the permanent admission of patients; and when the condition or the gravity of their patients so advised it, the physicians went to provide their services in their homes' (MAS-LHH, p. 16).

[9] A more detailed description of the structure and the functions of the *asclepieia* scan be found in MAS-LHH, p. 20s and in AC-LOAM, p. 19s.

[10] Archaeological clues still remain today regarding the move of the Greek *asclepieia* to the Roman world. For example, the current hospital centre on the island in the Tiber in Rome, owned by the Hospital Order of St. John of God, was constructed on the ancient Roman sanctuary of Aesculapius and conserves various vestiges of it.

[11] This Latin term (in the singular *valetudinarium)* comes from *valetud* which means good or bad *state of health* from which come *valetudinarius,* sick, and *valetudinarium,* infirmary.

[12] Understood specifically beginning with its meaning in the New Testament, that is to say as αγαπη *caritas,* love of giving.

[13] Cf. below in B.1.

[14] *In novitate vitae ambulemus,* εν καινοτητι ζωης περιπατησωμεν (Rom 6,:4).

[15] Cf. PLE-LRME, pp.104-107; cf. also JCH-IPS, p. 26.

[16] Εις ιατρος εστιν, σαρκικος τε και πνευματικος... Ιησους Χριστος ο κυ–ριος ημων (DRB-PA, p. 451 s.). Those who are interested in the theological development of this subject I recommend

the magnificent work of research of Manuel Gesteira, *Christus Medicus* (MG-CM).

[17] For more detailed information on this subject with quotations and a bibliography see J. Álvarez Gómez: *Las "obras de nuestra justicia" y de "nuestra misericordia"* (JAG-YEC, p. 19-21).

[18] *Hospitalitatem sectantes,* την φιλοξενιαν διωκοντες.

[19] Cf. JCH-IPS, pp. 26-30 where there is the testimony of the *Didascalia Apostolorum,* a work written during the first decades of the third century according to which the territorial demarcation of a bishopric was divided into neighbourhoods, to each of which was assigned a deacon who was to be the ears, the eyes and the heart of the bishop as regards care for the sick and those in need.

[20] JAG-YEC, p. 34, quoting the first *Apología* of St. Justine (67, 6).

[21] Επισκεπτομενοι παντας ασθενεις (DRB-PA, p. 665).

[22] A term made up of ξενος, foreigner, stranger, pilgrim, and y δοχη reception, welcome, banquet.

[23] Cf. JAG-YEC, p. 43.

[24] A Roman city built by Pompey near to ancient Samaria.

[25] On the appearance of Christian doctors in the Greco-roman world in the first centuries AD, taking on the Hippocratic tradition and the magisterium of Galenus, see PLE-LRME, pp. 127-132.

[26] Fragments of the text of these Rules can be found on the web page web *www.geocities.com/milan313/indice.html* The Order of the Carmelites continues to observe these Rules.

[27] Cf. JAG-YEC, p. 45-47; MAS-LHH, p. 27.

[28] Indeed, until the time when Galenus settled in Rome (roundabout the year 166 AD) these had not really triumphed in the capital of the Empire. Previously from Greece was only accepted the *asclepieia,* the exponents of a medical science of idiosyncrasy which was more popular and was linked to religious beliefs (see note 8).

[29] The inequality referred to in this quotation does not allude to the number of centres that arose in Europe, which, as will be seen below, were much more numerous than in medieval Byzantium, but to the allocation to, and integration within, hospitals of services and structures that were specifically medical in character.

[30] 'To collect sick people from the streets and treat the unfortunate people who suffered from illnesses and poverty' (cf. F. H. Garrison, citato in AN-HCAD, p. 9).

[31] Cf. below 6.c.

[32] *Nosocomio* comes from the Latin *nosocomium,* a word which in its turn comes from the Greek *νοσοχομιυν, hospital,* a composite word made up of *νοσος*, sickness, and *χομιος* (*comios*), which in turn comes from the Greek verb *κομεο*, to treat (www.etimo.it). The word *nosocomio* is still used in certain countries to refer to a hospital.

[33] 'First and foremost care for the sick must be takeb on as true service to Christ who is in them'..

[34] The quotation is taken from *Handbuch der Geschichte der Medizin* ('Textbook on the History of Medicine'), published in 1903 (cf. DJ-LHE M).

[35] For the copying, amongst other texts, if the medical writings of classical antiquity that could then be kept or acquired.

[36] For the Benedictine monks this *Regula vitae* continued to be an approach to daily life according to which every day was made up of seven hours of prayer, seven hours of work and seven hours of rest. A portrayal of this can be found in the entrance to the monastery of St. Domenic of Silos. This was a version transformed by St. Benedict of the Hippocratic-Galenic diet (*diaita*). Other information on the monastic concept of 'diet' can be found in FRH-CM, p. 67.

[37] The prioress Hildegard of Bingen was a representative and fascinating figure of medical religious. She cultivated mysticism, medicine and music and personally cared for sick nuns and those people who came to her *hospitale pauperum* (Cf. PLE-HM, p. 197 and 217; FRH-TCMA, p. 92s.

[38] On the School of Medicine of Salerno see for example FRH-TCMA, p. 88.

[39] On the medieval military Orders, and more specifically those mentioned in the quotations of this chapter see RGV -HI, p. 697-703.

[40] 'Jerusalem became Islamic in the year 638. However, access to the Holy Sepulchre from that data onwards was not totally forbidden to Christian pilgrims until the arrival of the Seleucid Turks who in the year 1071 occupied Jerusalem and forbade Christians access to the holy places. This was the immediate cause of the Crusades' (JL-HI, vol. 1, p. 388).

[41] Saladin managed to restore the city to Islam in the year 1187.

[42] In addition to the kinds of hospital mentioned below there are authors that refer to others such as those for mothers and the poor, abandoned children and the elderly (CGQ-LAMH).

[43] These were lay (neither ecclesiastic nor monastic) associations created to provide care to the sick. Some of them have survived until the present day.

[44] This hospital still today provides service and bears the name of Hospital of the Holy Spirit in Sassia.

[45] Cf. ***III. 1. a.*** and ***b.***

[46] *Hotel-Dieu,* lite rally, means accommodation house or hotel of God. That in Paris was founded in 1195 near to the cathedral of Notre-Dame and the residence of the bishop..

[47] 'Hospital of the poor built near to the principal church'

[48] Cf. III. A. 6**.**

[49] 'During the medieval period the term 'leprosy' was used to refer to any infectious illness that involved changes to the skin (for example syphilis). The repugnant character of these patients led to their isolation from society. However, when the Crusaders fell ill with leprosy, this diseases ceased to be considered a sin and became a holy disease. In 1179 the third Lateran Council established that leprosy was not a reason for exclusion. The Order of St. Lazarus, which was founded in Jerusalem in 1120, dedicated itself especially to caring for lepers in leper hospitals'(FRH-TCMA, p. 94).

[50] 'In 583 the assembly of bishops of the Council of Lyon decided in favour of the creation of *homes for lepers* (*lebbrosari*). These sick people continued to live relatively isolated from the rest of society and outside the walls of the cities and monasteries... The Church, which shouldered the principal responsibility for maintaining these sick people, decided at the Council of Orleans (549) to attend to the feeding and clothing of lepers' (FRH-TCMA, p.68).

[51] There is an enormous bibliography on the hospital Orders that came into being during the sixteenth and seventeenth centuries and which contributed to the history of care the figure of the male or female health-care religious. See for example on the subject: JAG-YEC, pp. 77-95 and JCH-AIS, p. 75s.

[52] On this subject cf. also JAG-YEC, pp. 93-95.

[53] Where reference is also made to the contribution of other religious Congregations for women to hospital care (p. 101s).

[54] Florence Nightingale was entrusted with caring for the wounded soldiers of the Crimean war (1853-6) at the Renkoi war hospital, She had studied nursing at the Kaiserwerth Institute and with the Daughters of Charity in Paris. Because she managed to reduce death rates in a drastic way in the above-mentioned hospital she became the initiator of modern nursing through the School of Nursing of St. Thomas Hospital in London (cf. MAS-LHH, p. 50).

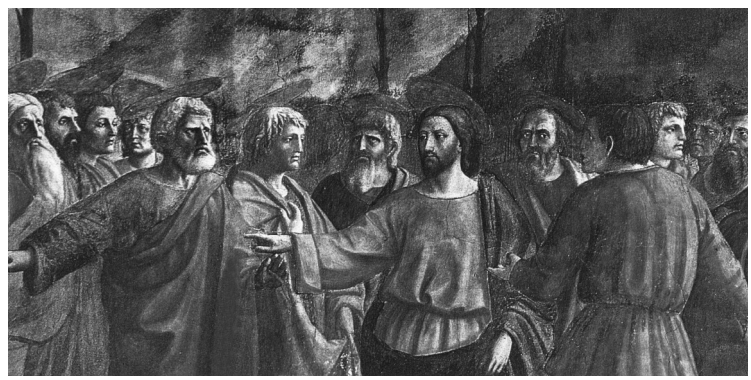
[55] The web site of the Delegation for Health of the Archdiocese of Madrid (*www.archimadrid.es/dpsanitaria*) offers various recent studies on this topic. A good summary can also be found in MAS-LHH, p. 61.

[56] This phrase is understood as meaning a direct interpersonal relationship directed towards recovery of health and the treatment of patients and not a mere technical action from far away carried out by those responsible for treating patients.

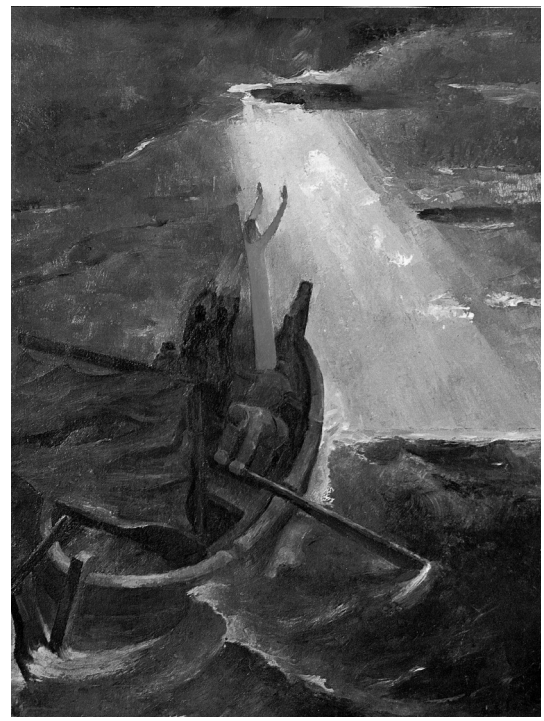
[57] According to the latest statistics provided by the Holy See, the 'Catholic Church has 109,363 health-care centres in the world; of these, 5,236 are hospitals in the strict sense of the term' (JLB-PSI, p. 29).

[58] Cf. CEP-DPS, pp. 257-269.

[59] Cf. JCH-CP, p. 59.



Testimonies



The Progress of Pastoral Care in Health in Chile

Models of Evangelisation in the Health-Care Field: Manuel Lozano Garrido, 'Lolo', Paralytic and Blind Man, Journalist and Writer, Twenty-eight Years Spent in a Wheelchair

Psychology in Nursing

The Eleventh Congress of the European Federation of Catholic Medical Associations - EFCMA

The Progress of Pastoral Care in Health in Chile

For Chile the year 2007 was one of great transformations at an economic, political, social, religious and cultural level. Beginning with technological and social progress in the sphere of health and health care, concurrently there has been an improvement in pastoral opportunities and today there is a new pastoral context: the need to humanise the world of health and health care, the right of every sick person and his or her family to receive treatment and spiritual support, and pastoral care in health in the academic world.

Historical Summary of Public Health and Pastoral Care in Health in Chile

With colonisation during the sixteenth century the first hospitals and health centres developed as a result of the Chilean Church and charitable institutions. Only in 1842 was the first faculty of medicine founded – at the University of Chile. Forty-four years later with the enactment of a special law (*Reglamento Orgánico de Juntas de Beneficiencia*) the state took gradual responsibility for the hygiene and health of citizens. In 1917 a High Council of Social Insurance of the state unified the health-care and technological levels in all the hospitals of the country and in 1918 the Health Code was created. In 1924 obligatory health insurance for workers was introduced. In 1938 the state created a health-care programme which in 1952 became the *Servicio Nacional de Salud* (SNS). In the 1960s a large number of health centres were created throughout the country with the provision of major investments. From 1973 (the year of the coup) to 1979 state aid to the national health service decreased and at the end of this period two systems of health insurance were created – a public system known as FONASA (*Fondo nacional de salud*) and a private one known as ISAPRE (*Institución de salud previsional*). These are still active and assure health-care services for almost the whole of the population of Chile. In the 1980s the decentralisation of the health system to the town councils began and the expansion of the private sector also commenced. The 1990s witnessed the division of the administration of the health service in Chile into twenty-nine districts. The last great initiative of the public system in Chile was the activation in 2005 of the AUGE (*Atención Única con Garantìa Explícita*) Project which offers free and rapid health services to an increasing number of categories of patients (by 2008 it was covering eighty pathologies).

The Chilean Church in a census of the Pontifical Council for Health Care Workers of 1992 registered the presence of the Catholic Church in the health-care field as follows: one university hospital, seven Catholic hospitals (in 2008 there remained just one), thirty-four public hospitals, thirty-five old people's homes, twenty-five rural clinics and other institutions such as mobile clinics, centres for the mentally disabled, centres for rehabilitation, etc. The total was one hundred and five health-care institutions, involving thirty religious congregations.

According to other data, during the 1990s the Church in Chile had a very large number of voluntary workers, four hundred and forty-six Caritas centres, a national centre for the distribution of drugs and medicines, a centre for the treatment of AIDS victims, and various centres for the rehabilitation of alcoholics. The *Hogar de Cristo* (The Hearth of Christ) homes to take in and look after the homeless, which are spread throughout the country and were founded at the end of the 1940s by a Chilean Jesuit, today a saint, St. Alberto Hurtado, have been transformed into a private association supported by charity.

Contemporary Challenges in Health Care

Despite this progress in the health-care field, the problems in Chile remain notable. The rural areas have situations that are completely different from the urban areas where, indeed, the majority of the population and health-care services are to be found. Because of the poverty or material difficulties that afflict a large part of the population, there are problems or obstructions in dealing with certain types of pathology (above all surgery and cancer – this last has been officially recognised in hospitals as having a separate department as it is 'catastrophic' in its consequences).

Alcoholism is endemic with levels at 29.9% (25% in 1990). Men who are 'strong drinkers' constitute 5% of the adult population and there is an increase in alcoholism rates in women and teenagers. An even more worrying national challenge is depression (30% in neurotic form and 13% in grave form); suicides are increasing slightly (in some provincial towns there are as many as three suicides of young people every month); and there is also the drug problem: 19% of young people in Santiago use drugs and levels of drug abuse reach 90-95% amongst teenagers in the outskirts of the city and in a number of the urban areas of Santiago. Obesity (26.7% in men, 38.8% in women, on the increase amongst children) is at a higher level than many other developed countries. Pathogenic stress levels in women and men over the age of twenty is above the 31% level.

Backstreet abortions (Chile is one of the few countries in the Western world not to have legalised abortion)[1] increased between 1990 and 2005 from 180,000 cases a year to 280,000 cases a year. Over the same period the number of Catholic marriages declined by a half and the birth rate fell to 1.9 children every family.

Other pathologies which have a high incidence in Chile are diabetes, with all its complications and a higher frequency than elsewhere; cancer of the pancreas, gastric cancer (17 cases for every 100,000 in-

habitants), prostrate cancer (20 cases for every 100,000 inhabitants), breast cancer and cancer of the womb

Disabled people (22% of the population) receive very little support from the state and mentally ill people even less. These are categories the responsibility for whom falls on the shoulders of families who often live silent dramas. Elderly people with a lack of self-sufficiency and economic problems are an emerging problem in Chile because of the declining birth rate and urbanisation.

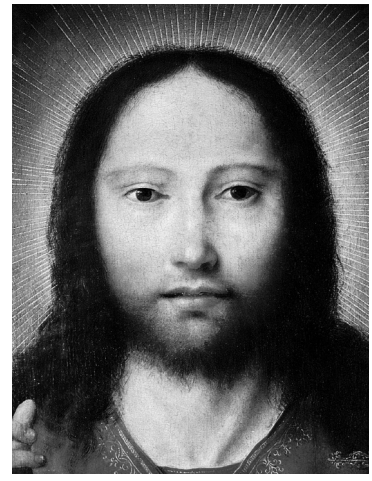
As one can observe, the problems of globalisation, consumerism, urbanisation (with the growth of megalopolises like Santiago), practical materialism, and post-modern philosophy (an existential void) have had a full impact in the world of health and health care in Chile. Increasingly felt amongst people are the problems of illness in all its forms (borne witness to by the large number of pharmacies which have grown up over recent years), but also the problem of values (bioethics), of dehumanisation, of depersonalisation, difficulties in relationships expressed in health, a lack of justice for the less well-off classes, etc. In a word, Chile today needs not only 'to treat pathologies' but also 'to humanise the world of health and health care'.

Public and Ecclesial Responses

For all these reasons, when in 2000 a number of Camillians visited Chile who were experts in the humanisation of the health-care world and presented an interdisciplinary model of pastoral care (of a theological character with medical humanities), they encountered a climate of great acceptance and a wish to investigate the subject of the humanisation of health and health care.

The Catholic Pontifical University of Chile (in Santiago) organised a Magister in 'Humanisation and Health' thanks to the programme for medical-humanistic studies that had been established a few years previously at the Faculty of the Medicine.

The same acceptance, this time by the members of the Ministry of Health, was experienced in 2003 by a project that the medical doctor and permanent deacon Josè Alvear had experimented with in his paediatric hospital in Santiago, the Roberto del Rìo Hospital. This was an UAE (*Unidad de Acompañamiento Espiritual*) for patients and their family relatives. The Ministry of Health decided to spread this project to all the public hospitals in Chile. The parliamentary Bill, which was proposed in 2007, was published on 11 August 2008, and will be operational in 100% of hospital structures by 2010. This is a law that obliges every hospital structure to organise an ecumenical team (with representatives who already work in the health-care world), with a team director who is a professional of the same hospital with a specific training in this field and an annual plan to humanise the hospital concerned, to assure spiritual assistance to all patients that ask for it or need it, and to create a human climate and human treatment and a respectful reception.



Other initiatives to respond to the health-care challenges facing Chile after the year 2000 have been the following: the annual congress and training in pastoral care in health in the diocese of Santiago and Concepción, the school for pastoral care in health organised by the pastoral team (animated by the Women Ministers of the Sick) of the clinic of the Catholic University of Santiago, and the master's degree in psycho-spiritual assistance organised by the P. Hurtado University of the Jesuits.

But the real 'big bang' in terms of initiatives in the field of pastoral care in health and humanisation in the world of Chilean health care began in 2007. At a national level, the Ministry of Health of Chile, in addition to the Spiritual Accompaniment Units, also activated a project called *Hospital Amigo* in order to bring the family relatives of patients nearer to health-care workers. In addition, in all the health-care districts of the country a 'Day of Humanisation' is being set in motion. This Day will involve conferences and opportunities created by a project of health and humanisation which demonstrates the therapeutic and healing value of spirituality at moments of illness, suffering and death. The characteristic of this approach is, in theory, ecumenism, the integration of faith and reason, respect for the rights and religious freedom of the person who has been admitted to hospital, and defence againsr a proselytising approach in the health-care world.

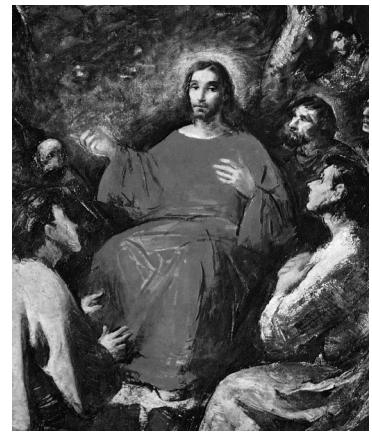
In 2007 a person responsible for pastoral care in health within the Chilean Bishops' Conference was appointed – Msgr. Marcos Ordenes, the Bishop of Iquique. He created a work group (made up of eight people) whose goal is to ensure that every diocese of Chile (of which there are twenty-seven) has a committee for pastoral care in health to coordinate and organise activities in this area. The first activities to be planned were: a census of health-care institutions which have a Catholic presence, an increase in the importance of the Day for the Sick (in Chile this falls on 15 September, the feast of the Suffering Virgin), a course on pastoral care in health to contact the representatives of this form of pastoral care at a national level (held on 9-11 August 2008) and a course on Internet to continue training at a national level (this will be organised by the Catholic Pontifical University September-November 2008).

The aim is to make the

Church of Chile more aware of a subject (namely pastoral care in health) that has been neglected for a long time, demonstrating the value of professional evangelisation and the presence of spirituality in this pastoral context, through which pass 100% of the population. A theoretical (theological) and practical (pastoral) response to the challenges of health and health care can offer, if adopted by the whole of the Church of Chile, original ways by which to evangelise culture and inculturate the faith in Chile and act in an increasingly secularist world.

Another three initiatives were created recently at the Catholic Pontifical University of Chile. As a result of the 'Programme for Medical-Humanistic Studies' of the Faculty of Medicine, a diploma in humanisation and health was established. This involves a course of a hundred hours organised into four modules (medical anthropology, team work, theology and morality/theology and anthropology, and, lastly, psychology). This course is addressed to health-care professionals in order to make them promoters of humanisation in their respective spheres of work. The new feature of this diploma is to present a new concept of health and health care (not only biological or bio-psycho-social, but also biographical and transcendent) in order to help work in relation to oneself (as health-care workers), to live out humanisation and healing in one's own life, first of all, and then to offer it to one's patients, their family relatives, colleagues, and the environment. This is training to help health-care professionals think about and evangelise the culture of health and health care today. The various books produced by this programme of medical-humanistic studies help to produce a deeper knowledge of all these elements.

The second initiative was organised by the pastoral group of the clinic of the Catholic Pontifical University. In 2007 a course on pastoral care in health on the Internet (Teleduc) was activated with supervisors, the correction of work by the students, and interactive groups. Enrolments have always been above the envisaged maximum. The great advantage of this course is that it eliminates the problem of 'physical distance', which is especially felt in a narrow and long country such as Chile, and the interaction between students (by Internet) and between students and supervisors compensates for the anonymity of a virtual course. The wealth of the contents offered in this course (which are presented in a published book) help an appreciation of the technical and practical value of pastoral care in health.



The third initiative of the Catholic Pontifical University, which for many years has been involved in the task of humanising the world of health and health care, is the Bioethics Centre, whose director is the medical doctor and philosopher, Paulina Taboada. This centre engages in various activities and the most prestigious expression of its activities is the master's degree, in which Msgr. Elio Sgreccia is often involved as a lecturer.

Amongst the more localised initiatives of the year 2007 reference may be made to the diocese of San Bernardo, Valparaiso, and other dioceses, which have appointed a figure responsible for pastoral care in health and have planned and implemented their first courses in pastoral care in health.

The Samaritan Association is a self-help group that operates in parishes. The Calcutta Project is an initiative involving university health-care voluntary work that enables students to visit sick people. Many Christian volunteers work in all the hospitals of the country (Damas de Rojo, Damas de blanco, Damas de Burdeos) but the most numerous voluntary workers in Chile are the volunteers of Caritas Chile who are specialised in providing spiritual assistance to the sick. As is always the case, the people who make up these groups are adult women. A major movement for humanisation amongst the poor in Chile is animated by the *Hogar de Cristo* (The Hearth of Christ) with the help of the P. Hurtado University and public charity.

At a non-ecclesial level, the Centre for Quality of Life Studies, which was established in 2003 in the old hospital San José di Santiago, as a part of the 'Second Convergence in Humanised and Integrative Medicine', works in the field of dialogue between (conventional and non-conventional) medical knowledge and the medical humanities, being open to the spiritual and religious dimension.

The whole list, which also includes many other institutions which seek to humanise the world of sick people in Chile today, demonstrates the advances that have been made in this sphere in recent years.

The First National Congress for Pastoral Care in Health Organised by the Bishops' Conference of Chile, 6-8 August 2008

Amongst the various pastoral projects subjected to consideration during this congress, two in particular stand out: formation and sensitisation. The guidelines for action will be, apart from those of the theology of pastoral care in health that come from the Camillianum and pontifical documents, the most recent suggestions produced by the 'Final Document of Aparecida' (the fifth general conference of the Latin American and Caribbean episcopate, 13-32 May 2007). Some suggestions are directed towards pastoral care in health (nn. 417-426) and others, more indirect ones, invite people to be courageous disciples and

missionaries of Christ amongst those who suffer, to be the bearers of a hope that does not disappoint, facing up to challenges and difficulties that inhibit and discourage pastoral action today, above all pastoral cultures and forms that are not suited to the transmission of the faith.

I will end with hope, which arises from faith, that this new chapter in pastoral care in health in Chile, unified and coordinated at the level of the national Bishops' Conference, will allow a new evangelisation that will follow the example of Christ, who welcomed and spoke with everyone, ate with and forgave sinners, and healed the sick *(cf. Docum. conclusivo Aparecida* n. 135).

Conclusion

The movement for humanisation and pastoral care in the world of health and health care that can be seen in the complex and lively society and culture of Chile today demonstrates certain novelties, which are really seen and present at the same time in the same country, but which are to be found in Chile at the current time.

– *Pastoral ecumenism*, already implemented with success in two hospitals in Santiago and in the diocese of Concepción.

– *The state (through the Ministry of Health) promotes spiritual assistance* in hospitals and makes available economic resources for the building of inter-religious places of worship where these do not already exist.

– *Humanisation organised at an academic (university) level* with the production of books and courses, with the intention of engaging in experimental research.

– *Experimental projects of humanisation* in various hospitals or hospital departments, once the theoretical courses have been completed.

– *The spread of training in humanisation and evangelisation of the world of the health and health care* at every level (parishes, hospitals, dioceses, schools, society) and to every category of people (voluntary workers, health-care workers and professionals, sick people and their family relatives, the general population).

The difficulties of this movement for humanisation in the world of health and health care, to achieve, as John Paul II said, 'man becoming more human', are on a large scale and are linked to the social and cultural realities of the whole of Latin America – *a region of major problems but great hope*.

The principal difficulty, however, is the fact that the word 'humanisation' is liable, like other very general words (heart, love, spirituality, healing) to be manipulated and exploited by fashionable ideologies that use 'man' as a means by which to acquire power for themselves. The most important challenge will not be so much that of having a large number of centres for humanisation and pastoral care in health but for all of them to have the same objective (or a similar objective): to help the person (above all when he or she is most suffering, weak or vulnerable) to live according to a project of salvation, to develop his or her most human dimensions: relationships, uniqueness or personalisation, the wholeness of his or her being, and the biographical and transcendent dynamism of his or her life. For a Christian, all of this acquires a transcendent value, in an approach that is Gospel-based and Trinitarian.

Another difficulty is that, as indeed takes place in other geographical contexts, after initial moments of curiosity, euphoria, interest and enthusiasm about a new subject, the number of people who are interested in humanisation and pastoral care in health begins to decrease. To prevent this it is important to avoid repetition, create a research engine in order to create pastoral care that grows and develops with data and discoveries that are always news in order to 'provide care evangelising and evangelise providing care'. It is important to create a form of pastoral care in health which is inculturated (and Chilean) and which grows and develops in the Chilean context.

Where these conditions exist the 'movement for the humanisation of the world of health and health care' in Chile could be and become a light for the Western world of health and health care, aiming at something that goes beyond 'psycho-physical and social well-being' in order to create a form of medicine and a health system on a human scale, worthy of the person, of a person *imago Dei,* and *Gloria Dei*.

Rev. PIETRO MAGLIOZZI, M.I.
Member of the Diocesan Committee for Health Pastoral Care, Vicariate of Rome

Bibliography

AA.VV., *Humanización en salud* (San Pablo, Bogotá, 2003).

Brusco Angelo, *Humanización de la asistencia al enfermo* (Sal Terrae – Cuadernos del Centro de Humanizacion de la salud (Religiosos Camilos), Tres Cantos (Madrid), 1999).

Brusco Angelo and Pintor Sergio, *Tras las huellas de Cristo Médico. Manual de teología pastoral sanitaria* (Sal Terrae, Santander, Maliaño (Cantabria), 2001).

Lozano Barragán J., *Teología y Medicina* (Instituto Méxicano de Doctrina Social Cristiana, Mexico DF, 2000).

Magliozzi Pietro, *De la salud biológica a la salud biográfica. Humanización y salud* (Ed. Universidad Católica de Chile – Programa de Estudios Médicos Humanísticos Fac. de Medicina UC, Santiago de Chile, 2006).

Conferencia Episcopal de Chile, *Nueva Evangelización para Chile* (orientaciones pastoralse, 1991-1994).

Conferencia Episcopal de Chile, *Discípulos misioneros de Jesucristo para que en él nuestro pueblo tenga vida* (orientaciones pastorales 2008-2012).

Jiménez Jorge and Rojas Paulina, *Organización de la atención sanitaria chilena* (pubblicato in internet, 2006).

Sandrin Luciano, *la Iglesia, comunidad sanante. Un reto pastoral* (San Pablo, Madrid, 2000).

Santi Baldo, 'Pastorale sanitaria in Cile, una riflessione piú che una relazione', *Dolentium Hominum*, 20/1992, pp. 55-57.

Santi Baldo, 'Cile, cura ospedaliera nel contesto di una medicina di ispirazione cattolica' *Dolentium Hominum*, 24/1993, pp. 50-52.

www.ine.cl (instituto nacional de estadistica).

www.minsal.cl (ministerio de salud de Chile).

Notes

[1] That year (2008) in the new Chilean medical deontological code (but not without long and suffered discussions), the concept of the duty of a medical doctor to defend life from conception to its natural end was upheld. The outcome of conception was seen as a person with his or her own rights and not as an object dependent on the will of the mother.

Models of Evangelisation in the Health-care Field
Manuel Lozano Garrido, 'Lolo'
Paralytic and Blind Man, Journalist and Writer
Twenty-eight Years Spent in a Wheelchair

'The life of Manuel Lozano Garrido was a long Good Friday, presaging at every moment the Easter of the Resurrection'[1]

1. Who was 'Lolo'?

Manuel Lozano, 'Lolo' to his friends, was born in Linartes (Jaén, Spain) on 9 August 1920 and he died there in 1971. His profile is the following. At first he was an apostolic, unsettled and militant young man who was very active in the youth section of Catholic Action during his few years of health. He had joined Catholic Action and immersed himself in its spirit from the age of ten onwards. During the years of religious persecution in Spain (1936-1939) he brought people the Eucharist in a clandestine way and for this reason he was put in prison. From prison he was taken to the front at the age of seventeen.

Because his life as a militant young man was on a major scale, one must ask to what extent this period of profoundly Christian formation, in his places of study and in the piety that Catholic Action promoted, is the key to understanding the over twenty-five years that he spent totally paralysed (in his last years he was also blind). However, during these very long years of pain ('Lolo, the sacrament of pain', was what Roger di Taizé called him) were years of Christian maturity, of spiritual depth, and of fertile apostleship, when he wrote nine books and hundred of articles; it was then that he founded his work 'Sinai'.[2]

Valuable instruments by which to explore our knowledge of this Venerable Servant of God are examine his spirit of prayer, with its traces of profound mysticism and his devotion to the Eucharist and to Mary, to such an extent, indeed, as to say that this was the 'secret diary' of his life of pain; or to study his fertile apostleship, lived out of love for the Church, from his wheelchair, with a total immobility in every part of his body. I may refer here to the bibliography already cited in footnote 2.

At this point I would like to dwell upon the 'long Good Friday presaging Easter', that is to say upon pain *taken upon himself* as a pathway of his life of 'suffering with Christ', in order to make up for in his own body that which was lacking in the Passion of the Lord (cf. II Cor 4:10 and Col 1: 24). Despite this, Lolo lived out this pain with *contagious joy*.

2. An Apostle and a Model of Evangelisation Beginning with Illness

Frequent themes in his writings are *the joyful acceptance of the cross*, the redemptive value of pain associated with the passion of Christ, and the purifying force that springs from this acceptance. Lolo described these realities in the following way: 'there are three approaches to the presence of pain: that of those who have not yet gone beyond the burning of their wounds: 'God has abandoned me…'; those who accept without entering its spirit of sanctifying activity: 'God has asked me…'; and those who, understanding the communitarian value of suffering, offer themselves fully to the ideal of redemption: 'God, I offer you…'[3]

The figure of this sick man, who made his wheelchair into a redemptive Calvary, without doubt has a great deal to say to contemporary man, who is brought up in a society that offers easy pleasure and ensures that the man of our times has lost the meaning of pain and even of life and death.

For Manuel Lozano strength came from his faith, from his devotion to the Eucharist and from his devotion to Mary.

He felt pain which had not 'fallen asleep' in front of him. For this reason, in one of the pages that he wrote, when speaking about it to the Lord, he declares: 'How great is my tribulation; you, too, well know what agony means, without me having to tell you what it is'.[4]

There can be not doubt that what greatly characterised Lolo was the very long period of time that marked his painful illness. He was an invalid and during the last years of his life he was also blind. The whole of this illness was accompanied by a context of permanent events that brought him increasingly close to death.

The work and the pain of the world are symbolised by the bread and wine that are the materials of the Eucharist. This man was a worker in pain or a sick man who worked. During his life, hard work and acute illness were intertwined year after year. But his profound devotion to the Eucharist that was present in his life made him live his life united to the sacrifice of Christ. His work and his pain of each day of his life were united – like bread and wine – to the Eucharistic sacrifice of Jesus Christ in the daily welcoming of the Eucharist.

The Second Vatican Council included the sick in the universal call to holiness: 'They should know that they are united in a special way to the suffering Christ for the health of the world…'[5]

The immense force of human pain cannot be useless. Redemptive action has its supreme expression in the Cross of Christ.

Perhaps for this reason, the most abundant literary output of the pen of this Servant of God is that which seeks to reflect in a Christian way on pain. He sought to do nothing else in his first book, *El sillón de ruedas*. But in another book as well, namely, *Cartas con la señal de la Cruz*, he dwells upon pain, writing a Via Crucis, commenting on its various stations, and adding a further fourteen letters to the sick.[6]

The review *Sinai* had the goal of uniting the pain of all the sick people and the prayers of the monasteries that belonged to this apostolic work and of offering their suffering and prayers for the Catholic press. For this reason, this public review, in all of its editions, published writings on the value of pain.

The subject of pain permeated his diary-books: *Dios habla todos los días*, *Las golondrinas nunca saben la hora* and *Las estrellas se ven de noche*.

When in April 1959 Manuel Lozano began his first diaries he wrote: 'my biography could be as follows: thirty-nine years old. A bachelor and an Andalucian, a teacher. An invalid for almost eighteen years. Afflicted by a rheumatic illness. My life is confined to a home…Think of a man rigorously laid out in a position like the number 4, his hands lightly resting on his legs, with his fingers curled, as though they were holding a coin, and his head laid back'.[7]

However, more than what Lolo wrote about pain, his experience of pain was what counted; how he lived out his 'identity' as a sick person.[8]

Lolo saw pain as the pathway of redemption; he thought that his illness was a gift from God: 'In the end I fell on my knees and gave free expression to my gratitude… I did not want to complain; bring me a smile and allow happiness to put garlands and roses in my heart because the overflowing of my heart is already shaping the architecture of suffering'. And thus he summed up its benefits: following God who was looking for him, faith, Providence, spiritual tribulation, affection, his personal vocation, because 'if one road closes, other side paths are offered which take its place'.[9]

He entitled one of the chapters of *El sillón de ruedas* 'Pain Kneels Down'[10]. What he writes about in it is his life: he lived acceptance of pain in such a way that he came to publicise his 'creed of suffering': 'I believe in suffering as a choice…I believe in the redemptive mission of suffering…I will draw near to those who suffer as though they were a reliquary that conserves the *lignumcrucis* of the Passion…I believe that Christian action and sacrifice are enveloped with each other like wax and the flame of a candle: the purer the immolation, the more resplendent the witness…'[11]

3. Lolo's Exultant Joy in Pain

'What is joy?', he himself asked in an article published in the review *Vida Nueva*.[12] And he answered: 'Joy is a vital manifestation of man and this of essential importance in his evolution'. And he quoted Bernanon: 'there is a great joy in God and a poorer joy'. The ideas spread throughout his writings were rightly brought together when his death was announced: 'I am yours and I renew with you my appointment in Joy'. Joy with a capital letter, that Joy that is Christ and the encounter with the Father.

Everybody who knew Lolo speaks about his joy, his smile, his good mood, and his joviality. He wrote: 'notwithstanding the bitter or sugary sweet men, beyond the silences or the din of lips, we must believe that joy makes a man dance as the effect of a tension and ascesis: joy is the fruit of a conquest…', and he added 'Christianity is first of all an operation of joy'.[13]

Lolo continually expressed and transmitted this joy. An inner joy and a happiness that infected those who drew near to him, to the point that one witness in the process of canonisation called him 'the saint of joy'.

In a metaphor that portrayed his life he wrote: 'with a life that gives off little more light than a very small candle, I believe in you, spring…Now, tomorrow and for ever, I believe in God who gave us spring and who made springs possible for us'.[14] This is what this Servant of God wrote when he noticed that the end of his life was drawing near. This text is to be found in his posthumous book, the proofs of which were brought to his home by the printers a few minutes after he had died, when he was already in the eternal spring of his encounter with God.

The life of this man, a man of pain and a sower of joy, deserved a separate study by the Congregation for the Causes of Saints. The Holy Father Benedict XVI, on 17 December 2007, declared that his life and his virtues had been heroic, and granted him the title of 'Venerable'. The process of his canonisation proceeds apace and we hope that one day we will be able to see Lolo raised to the glory of the altars.

The life of this young man, a lay apostle of Catholic Action, devoted to the Eucharist and to Mary, a paralytic and a blind man, a writer and a journalist, joyous in his pain, who lived an existence marked by an unusual condition of illness as though it were a totally normal situation, could be a kind of mirror for many Christians in this time now being lived by the Church.

His apostolic fervour meant that this paralytic was 'useful' (*Ep. ad Philem*, 12); that although he was blind he shone like a 'star in the firmament of the Catholic laity' (Decree on the heroic life and virtues of the Venerable Lozano Garrido); and that as a journalist and writer he implemented in his life the rule of 'serving the fruit of vines, pure and full of hope as it is'.[15] A joyful young man who when dying invited us to 'meet each other in JOY'.

Don RAFAEL
HIGUERAS ÀLAMO
Postulator of the Cause of Canonisation

Notes

[1] F.J. MARTÍN ABRIL, i"Prólogo" to *Las estrellas se ven de noche*, a postumous work by M. Lozano Garrido.

[2] There are various biographies of the Venerable Lozano Garrido: J. RUBIO, *Un ciego a los altares*; R. HIGUERAS, *La alegría vivida*; B. AGUILAR, *El secreto de Lolo*;. The whole of his literary output has been brought together by the association that has promoted his canonisation:; c/ Viriato, 27. Apt. 208; 23700 Linares; www.amigosdelolo.com.

[3] MANUEL LOZANO GARRIDO, *Las estrellas se ven de noche* (Edibesa, Madrid, 1997).

[4] MANUEL LOZANO GARRIDO, *Las golondrinas nunca saben la hora* (Edibesa, Madrid, 2000), p. 152.

[5] *LG*, n. 41.

[6] MANUEL LOZANO GARRIDO, *Cartas con la señal de la Cruz* (Bilbao ,1967), pp. 149-196 and 29-103.

[7] MANUEL LOZANO GARRIDO, *Dios habla todos los días* (Edibesa, Madrid, 2000), pp. 19-20.

[8] Cf. Msgr. J.L. REDRADO, 'El sufrimiento, escuela de vida. El Siervo de Dios Manuel Lozano Garrido', (Simposium sobre médicos santos FIAMC, Barcelona, 2006).

[9] MANUEL LOZANO GARRIDO, *El sillón de ruedas*, pp. 7, 19, 72 and 88.

[10] MANUEL LOZANO GARRIDO, *El sillón de ruedas*, p. 267.

[11] MANUEL LOZANO GARRIDO, *Cartas con la señal de la Cruz* (Bilbao, 1967), p. 202.

[12] *Vida Nueva,* 1-XII-1957.

[13] MANUEL LOZANO GARRIDO, *El sillón de ruedas*, pp. 203 and 205.

[14] MANUEL LOZANO GARRIDO, *Las estrellas se ven de noche* (Bilbao, 1973), p. 309.

[15] MANUEL LOZANO GARRIDO, 'Decálogo del periodista'.

Psychology in Nursing

Caring for the sick is an art; and if it is to be practiced as a art it requires total devotion and training, as is the case with the any work by a painter or sculptor; but with the difference that one does not have and one is not dealing with a canvass but with a body – the temple of the Spirit of God. It is one of the fine arts, indeed the most beautiful of the fine arts.[1]

Florence Nightingale

If caring for the sick is an art, as indeed it is described F. Nightingale in a very evocative way, it follows that in order to learn this art one must learn about its rules. Now a fundamental principle, a golden rule of nursing care, is the following: 'the patient is a human person'.

Caring for a sick person means taking care of a human person when he is passing through a difficult and often critical stage of his life. This person suffers not only in the physical dimension of his body (*soma*) but also in the mental dimension, that is the soul (*psiche*). It is not sufficient, therefore, for a health-care worker in the care process to concentrate exclusively on the physical aspect of pain, ignoring what the patient is experiencing in the depths of his spirit. A study of psychology and a psychological training of nurses are necessary for sick people to receive suitable therapy and for managing to establish between the two individuals a true relationship of health with a health-giving effect.

1. A Look at the Psychology of the Patient

It is alarming to read in the book *Capire e aiutare il malato* ('Understanding and Helping the Sick Person') the following words: 'although technical – theoretical and practical – training occupies an essential place in the training programmes of health-care workers, little attention is paid to their relational capacity. The psychology of the sick person and theories of communication have almost no relevance in the training of health-care workers'.[2]

The psychology of the sick person, which is concerned with the psychological experience of that person, his forms of behaviour and the psychological aspects of the relationship between the patient and health-care workers, is fundamental both in understanding the situation of the person who is suffering and in providing him with suitable help. We may observe that the Italian term '*aiutare*' ('to help') in Latin is made up of '*ad*' and '*iuvare*' and means to be of use or to obtain benefit. An individual who lives in conditions of physical, mental or social malaise perceives at an individual level an unsatisfactory situation which limits his reactions. The relationship of help is installed between he who experiences this malaise and he who possesses the instruments to intervene upon this state of discomfort. The person who provides help and the person who suffers enter into a relationship so that each one gives to the other what he himself does nor have.

The experience of illness certainly varies from individual to individual and depends on a series of factors: the gravity, the typology and the modality of the emergence of the illness itself; the moment at which it occurs; the personality of the patient; his age and his previous experiences in this field; and the ability of the family and the health-care environment to respond to his needs. A nurse must never forget that the patient who has been admitted to a care centre is made insecure by a thousand factors: by the illness itself, by the newness of the hospital environment and by an ignorance of its laws, by separation from his family relatives, and by the difficulties he encounters by placing and knowing the medical doctors, nurses and others that find themselves at his bedside. His illness, as such, is experienced as a collapse of his forms of security. Indeed, it presents itself as the fall of all the forms of his security.

As has already been observed in this paper, those who take care of a sick person cannot concentrate exclusively on the pathology of his body and ignore his psycho-social aspects or minimise their importance. Instead, they should reflect on the fact that an illness in the context of the life of an individual always has consequences at a psychological level. A person who falls sick lives out a kind of 'disorientation of his own identity' which is not always easily resolved.

The psychology of the patient helps the health-care workers to understand the needs and the reactions that are to be met with in that sick person. Both these realities are of a biological and psychological nature. They intensify proportionately with the gravity of the illness and the level of complication of a surgical operation.

As regards the needs of the patient, first of all the fundamental physiological ones appear, but those of a mental kind are no less important, such as for example: feeling secure, being accepted, honoured, es-

teemed and even loved. Not attending to any of them, neglecting any of these needs, will have a negative influence on the process of care and treatment.

Amongst the most characteristic reactions of patients one may list following: danger and fear; loss and depression; and obstruction and rage. These differences in reactions can be in part explained on the basis of the way in which the patient concerned perceives his illness, on the basis, that is to say, of the meaning that gives to his illness. This meaning can be conscious and evident to varying degrees or unconscious and linked to personal symbols or it can the outcome of an elaboration that takes place at deep levels of his psyche.

It is important to know that in the psychology of sick people various typologies are to be encountered: the psychology of a sick person who is dying, the psychology of an elderly person, the psychology of a child, the psychology of a chronically sick person or of an AIDS patient, etc. Analysis of all these psychologies brings out a fundamental need that every sick person perceives in the same way, that is to say the need for trust in those who care for and treat him. Medical doctors and nurses are called to do everything possible so that the person who is entrusted to them is treated with dignity as a person who is well received, esteemed, respected, and who does not remain disappointed.

2. Psychological Aspects of Nursing – the Relationship of Help

Real nursing care, in English the term is 'nursing',[3] as is the case with all the other fine arts, is not to be found in the mechanical performance of details or in the ability of the performer, but in creative imagination, in a spirit of sensitivity, and in the intelligence that are behind these techniques and these abilities.

The developments in psychosomatic medicine and nursing have emphasised the therapeutic approach of the holistic and overall approach, which involves encountering the person of the patient in his totality as a bio-psycho-social-spiritual being. A joint approach to the technical aspects and to the relational aspects works to the advantage of the person who is being subjected to care and treatment.

In this context, the following observation is worrying: 'despite the fact that the various theories that have been formulated on nursing stress the importance of having a good relationship between the nurse and the patient, the research that has been recently carried out has demonstrated that the average nurse has few of the requisites to establish such a relationship'.[4] The study of psychology and the theories of communications have as their aim that of providing such requisites and consequently improving nursing care. 'In nursing', Acuarolo rightly observes, 'it is necessary to communicate in a creative and effective way, otherwise it is not possible to understand, to care for or to help, that is to say one cannot establish any positive interaction with the patient'.[5]

The first step that a health-care worker must take to achieve a positive interaction is to pay objective attention to what the patient communicates and to pay subjective attention to his own emotional reactions. In this relationship it is of fundamental importance to 'see the other as the other'. Indeed, the relationship of help is described as a relationship in which one of the two interlocutors seeks to create those conditions that promote in the other a capacity to address and overcome creatively the difficult situation in which the person finds himself.

As regards the principal characteristics of the relationship of help we should emphasise the following: listening, empathy, accompanying, welcome, respect, professionalism and trust. Obviously enough, everything begins with listening. Knowing how to listen is without doubt one of the most effective forms of respect for the sick person, who wants to communicate with those who are caring for and treating him.

The subject of listening leads on to that of empathetic understanding or empathy. Etymologically, this term comes from Greek and means '*en*' (inside) and '*pathos*' (feeling), that is to say entering into the intimate reality of a person. As regards a nurse this is a matter of entering into the world of the patient, of listening to what he says and of placing herself in his point of view in seeing the situation in which that patient finds himself.

A relationship of help is characteristic of every nurse who acts with empathy, with warmth, with respect, with care, and with acceptance. This is a complex process in which the quality of the person of practices it is reflected. Every action, as an approach centred around the person, presupposes that each person already has inside them resources to understand and to modify realities. These resources are favourable in a climate with facilitating conditions and one is dealing not only with a resolution of problems but also with mutual growth. It should not be forgotten that the need for love certainly includes receiving but it also includes giving. To give affection and love to a sick person is of fundamental importance. But it is equally important to recognise that he is a subject who is able to love, whatever his illness may be.

To sum up we may say that the role of the nurse unites two options: one is technical and scientific in character and the other is relational in character. The underlying value shared by both these options is that of taking responsibility for a sick person in all his complexity and totality. In more practical terms this means: being at his side, taking care of him, listening to him, compensating him, accompanying him, taking his place, supplementing him, and separating from him. All of these forms of presence at the side of a sick person form of a part of the relationship of help in which, as has already been observed in this paper, what matters is not so much the presence itself but the way in which a nurse is present.

Conclusions

In this paper of ours, even if it has been arranged under general headings, we have sought to demonstrate that psychology is an integral part of nursing. Thanks to psychology it is possible to have a better understanding of the needs and the fears of a patient and as a consequence to establish with him a suitable relationship of help. A psychological training for health-care workers is thus of indispensable importance for their professional training, from the point of view of the famous humanisation of medicine as well.[6] Iandolo is therefore right when he says: 'my experience as a hospital doctor has demonstrated to me with what frequency not only one of but all the fundamental needs of a patient are not met; they are often not met because they are not known about or wrongly understood by medical doctors and nurses. The humanisation of hospital care is not to be obtained through laws and reforms but through a better psychological training of medical doctors and nurses' (p. 56).

Prof. CATERINA SAVINA,
Student NELA SUKACH,
Degree Course in Nursing,
General Psychology,
Institute of the Sisters of Mercy,
St. John's Hospital,
Catholic University
of the Sacred Heart,
Rome

Bibliography

ACUAROLO T., *L'interrelazione infermiere professionale/paziente e la comunicazione terapeutica come relazione di aiuto* (Cernusco sul Naviglio, 1997).

BASILE A., 'Il significato della clinica infermieristica: l'Ad-sistere' in *Infermiere oggi. Periodico di idee, informazione e cultura del Collegio Ipasvi di Roma*, n. 3/2006, pp. 9-14.

COTINAUD O., *Psychologie et soins infirmiers. Approche relationelle* (Paris, 1983).

IANDOLO C., *L'approccio umano al malato. Aspetti psicologici dell'assistenza* (Rome, 1979).

SANDRIN L., BRUSCO A., and POLICANTE G., *Capire e aiutare il malato. Elementi di psicologia, sociologia e relazione d'aiuto* (Turin, 1989).

Notes

[1] A. BASILE, *Il significato della clinica infermieristica: l'Ad-sistere*, p. 9.

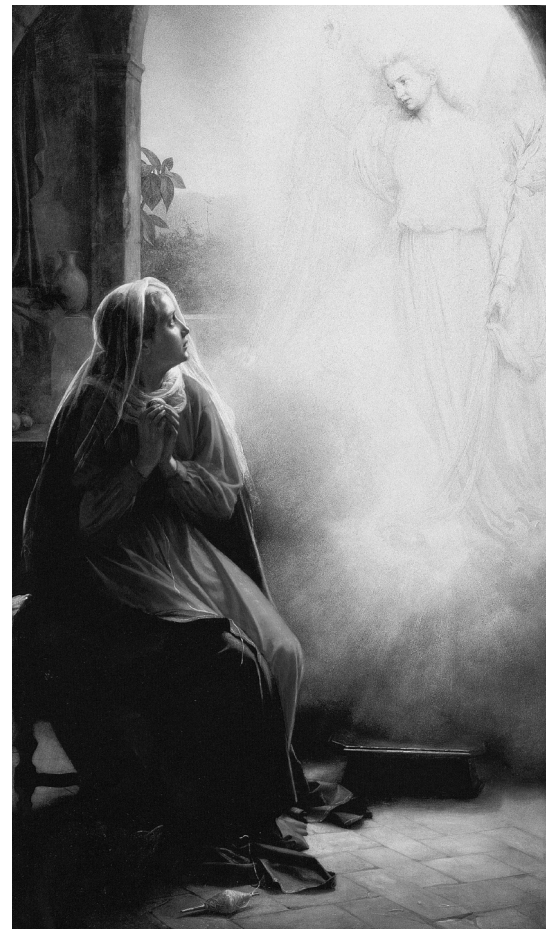
[2] L. SANDRIN, A. BRUSCO, and G. POLICANTE, *Capire e aiutare il malato. Elementi di psicologia, sociologia e relazione d'aiuto*, p. 151.

[3] It is worthwhile remembering that the word 'nursing' has its origins in the care that mothers provide to their newly-born children. The term comes from the Latin '*nutrire*' and the word 'nurse' has its roots in the Latin word '*nutrix*' which means a breastfeeding mother. Only towards the seventeenth century did this word begin to include the meaning of a 'person, usually a woman, who takes care of the sick': A. BASILE, p. 9.

[4] C. BIZOUARD, *Dall'accoglienza al dialogo* (Milan, 1986), p. 96.

[5] T. ACUAROLO, *L'interrelazione infermiere professionale/paziente e la comunicazione terapeutica come relazione di aiuto*, p. 7.

[6] 'We know that a very important pharmaceutical for the health of the patient is always available to the medical doctor, to the nurse, to the social worker and to the spiritual assistant, it is that of the *personality* of he who cares for another. It is said in clear and simple terms that a good medical doctor is also a good psychologist…A medical doctor who wants to remain at the side of a person who suffers cannot and must not confine himself to fleeing into the body…he must treat at one and the same time both the illness and the sick person' P. MARCHESI, *Umanizzazione. Storia e utopia* (Elledici, Turin, 2006), pp. 465-466.



The Eleventh Congress of the European Federation of Catholic Medical Associations (EFCMA)

The eleventh congress of the European Federation of Catholic Medical Associations took place on 11-14 September 2008 in the Polish city of Danzig (Gdansk). This is the European branch of the International Federation of Catholic Medical Associations (IFCMA) and in terms of quality and number of associations it is a point of reference for Catholic medical doctors around the world.

Some groups of European doctors began their visit by going to the birth place of John Paul II in Krakow and then went to Czestochowa, to Warsaw, and finished their journey in Danzig, the so-called 'three-cities' (Danzig, Oliwa and Gdynia), the homeland of the Solidarity movement. They discovered a cordial, welcoming and very pious country, one profoundly proud of the great Polish Pope Karol Wojtyla, as one can observe from the large number of sculptures and monuments and fresh flowers that adorn it.

The general subject of the congress was 'natural law and human law inscribed in contemporary European medicine'. The approximately four hundred participants, with a strong presence of medical doctors and students from the countries of Eastern Europe, were able to take part in days of intense study, follow very well prepared liturgies, and participate in vigils accompanied by music and fraternal meals.

We were able to count upon the presence of the Primate of Poland, Card. Jozef Glemp, and of Cardinal Javier Lozano Barragán, the President of the Pontifical council for Health Care Workers, who was the bearer of a message from the Holy Father and of a papal blessing. Also present were the Archbishop of the city and the Bishop responsible for pastoral care in health within the Polish Bishops' Conference. For the civil authorities there was the President of Poland, Mr. Sig. Lech Kaczynski, who sent a letter, together with academic authorities and the President of the IFCMA, Dr. José M. Simón.

The deliberations of the congress took place at the Collegium Biomedicum, with a small commercial exhibition, and the participation of students, the Polish medical doctors of the future.

The congress was opened with the celebration of the Eucharist presided over by H.Em. Cardinal Lozano Barragán in the cathedral of Danzig. The deliberations began with the magisterial paper by Cardinal Lozano with the title 'the natural law in medicine'. An analysis was then made of the social situation of European Catholic doctors and the difficulties that are encountered in making certain foundations of Christian bioethics understood in the European context, which is increasingly secularised.

At the same time as the congress, the elective General Assembly of the EFCMA also took place. The voting led to the following being elected: Dr. François Blin (France) as President; Dr. Hans Stevens (Holland) as General Secretary, and Dr. Alexandre Laureano Santos (Portugal) as Treasurer. A warm greeting of farewell was given to the outgoing President, Prof. Dr. Joseph Marek, of the Czech Republic, who had so worthily led the Foundation over the previous years. One may observe that the entrance of the associations of the countries of the former Soviet bloc after the fall of the Berlin Wall constituted a breath of fresh air for European Catholic medical doctors. Since that time congresses have been held in Prague and Bratislava.

At the end of the congress the Declaration of Danzig was issued and a Holy Mass was celebrated in the Church of St. Mary.

Dr. J.Mª. SIMÓN,
President of the IFCMA

The Danzig Declaration

Conscious of the trust placed in us as physicians and defenders of life, of the progress in medical knowledge and technologies, and of the ever greater understanding gained about the physical, psychological, educational, spiritual, religious and existential needs of our patients and our society,

– while aware of the dangers of ethical relativism and of moral permissiveness around us and in our midst;

– in view of ongoing debates over the permissibility of abortion, euthanasia, the use of human embryos for research and so-called therapeutic purposes, human cloning, the creation of human-animal hybrid embryos, contraceptive and sterilization procedures and artificial reproductive technologies;

– faced with the silent assumption that those carrying out the above procedures will be doctors;

authorized by the Christian traditions and ethos of European and world medicine, in dialogue with all doctors who believe in the dignity and freedom of the human being,

1. We affirm that ethical norms and principles precede enacted laws and should influence their contents in accordance with natural law and the teaching of the Church.

2. We affirm that in making decisions on the medical treatment of the patients who place in us so great a trust, we should be guided above all by our conscience. Moral evaluation of medical practice must not be based upon superficial opinions or passing trends but on the sensitivity of a conscience formed according to objective ethical norms common to all people and consistently defended by the Church.

3. In order to guarantee the freedom of practice of the profession, we have to uphold the

right to conscientious objection

4. We believe that one of the basic demands made of doctors should be ongoing personal development in both practical know-how and in moral stature.

5. The special vocation of the doctor to serve the life and health of others requires a clear formulation of the principles of objective and universal ethics.

6. We affirm that the source and basis for all ethical norms is the inalienable dignity of the human person throughout the course of his or her life – from conception to natural death.

7. Just as human dignity requires the protection of human life, it also demands special concern for its initial phases and respect for human procreation and sexuality.

8. We promote activities which permit the protection of patients from procedures that violate their human dignity:

– Decisively rejecting euthanasia, we support the development of palliative medicine.

– Refusing to agree to abortion, we aim to ensure proper all-round care for the family and the sick child both before and after birth.

– We choose the treatment of the underlying causes of infertility and not successive techniques of artificial reproduction.

– We support the development of research into the use of stem cells taken from adults and umbilical-cord blood, rejecting the use of human embryos for this purpose.

9. We affirm and emphasize that medical practice with respect to such matters as genetic manipulation and the end of life has to be carried out without the intentional loss of human life.

10. We want to protect our children and young people from neglect, abuse and other threats to their health and dignity. We have to ensure proper education for all aspects of life.

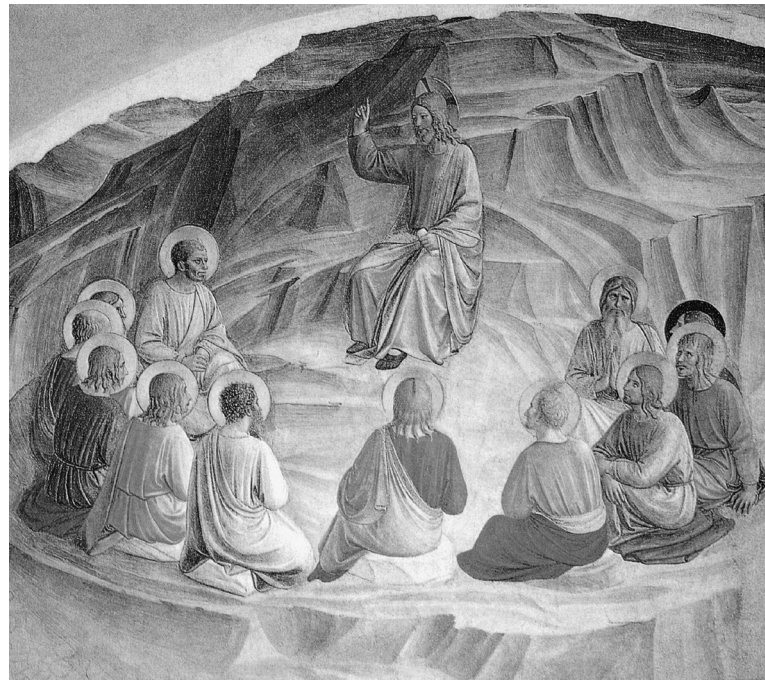
11. Aware of the number of people in our midst who are subject to abject poverty or are under threats caused by misfortune, we uphold the tradition of the freedom of physicians to offer humanitarian and charitable aid, especially in neglected areas of the world, on the basis of principles and criteria that lie beyond economics.

12. Taking into account the responsibility doctors bear for the health and life of patients, we are convinced that medicine must be practiced in dignified conditions, due to both patients and to doctors, and we consistently affirm that in our activities the good of patients should have priority over other obligations.

Prof. JOSEF MAREK
The President of the XI Congress of the European Federation of Catholic Medical Associations,

Dr. ANNA GRÊZIAK
The President of the Catholic Association of Polish Doctors,

Dr. HANS STEVENS
The Secretary of the European Federation of Catholic Medical Associations



Pontifical Council for Health Pastoral Care

Pontificio Consiglio per la Pastorale della Salute

Pontifical Council for Health Pastoral Care

The Fifty-Sixth World Leprosy Day - Sunday 25 January 2009

January 26, 2009

HEADLINES

Message of the Holy Father for the Sixteenth World Day of the Sick

«On 11 February, the memorial of the Blessed Mary Virgin of Lourdes, the World Day of the Sick will be celebrated, a propitious occasion to reflect on the meaning of pain and the Christian duty to take responsibility for it in whatever situation it arises.» [View more]

HIGHLIGHTED

The Fifty-Sixth World Leprosy Day

This 'Fifty-Sixth World Day' is a suitable opportunity to offer the human community correct, broad and capillary information about leprosy, about the devastating effects that it can have on people's bodies if they are not treated and on families and on society, and to stimulate the individual and collective duty to engage in active fraternal solidarity. [View more]

NEWS UPDATE

Alarmante nexo entre pobreza y patologías visuales, advierte el dicasterio para la Salud

«La santé est une tension vers l'harmonie et vers Dieu»

La souffrance doit être combattue, déclare le card. Barragan

Search

Tel. +39-(06)698.83138, +39(06)69884720, +39(06)698.84799 / Fax +39-(06)698.83139
opersanit@hlthwork.va