DOLENTIUM HOMINUM

No. 79 – year XXVII – No. 2, 2012

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

Editorial and Business Offices:
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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

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Vatican City

Twenty-Five Years of the Pontifical Council for Health Care Workers under the Protection of Mary 'Salus infirmorum'

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Twenty-five years have passed since His Holiness John Paul II on 11 February 1985, by his Motu Proprio *'Dolentium Hominum'*, instituted the Pontifical Commission for Pastoral Assistance to Health Care Workers, which would subsequently become, with the Apostolic Constitution '*Pastor Bonus*' of 28 June 1988, the Pontifical Council for Pastoral Assistance to Health Care Workers. In his homily at the Mass for the sick of 11 February 1986 the Supreme Pontiff stressed that: 'It is necessary to stimulate and promote the work of formation and study that the various Catholic institutions carry out in the health-car world; it is necessary to spread and defend the teachings of the Church in this field; it is necessary above all else to arouse and coordinate the living energies present in the Church, so that they direct themselves with a renewed spirit of service towards our brothers and sisters afflicted by illness, seeing in them the limbs of suffering Christ. With these goals is born the new institution of the Holy See, which is taking specifically today its first steps, under the guidance of Cardinal Edoardo Pironio, the President, and Archbishop Fiorenzo Angelini, the Vice-President. I invite you to pray that the new Pontifical Commission can fully achieve its goal, that is to say that of improving and enlarging the material and spiritual assistance that the Church has always promoted in favour of the sick' (*Insegnamenti,* VIII,1 (1985), p. 480).

Much has been done since then under its three Presidents: Cardinal Fiorenzo Angelini first, Cardinal Javier Lozano Barragán secondly, and lastly the current holder of this position, Archbishop Zygmunt Zimowski. There is a still a great deal to be done and to celebrate its 'silver jubilee' this year (February 2010-February 2011) the Pontifical Council for Health Care Workers (for Health Pastoral Care) has promoted, and is now organising, numerous events: a series of initiatives which began 9 February 2010 with the international symposium, the painting exhibition and the concert of classical music, inspired by the Message of His Holiness Pope Benedict XVI for the World Day of the Sick (WDS) of 2010 and thus entitled 'The Church at the Service of Love for the Suffering'. The Holy Father then presided over the solemn Mass celebrated on 11 February, the day of the eighteenth WDS, in St. Peter's Basilica.

Archbishop Zimowski and the other Superiors of the Pontifical Council, the Secretary, Msgr. José L. Redrado O.H, and the Under-Secretary, Msgr. Jean-Marie Mupendawatu, have engaged in various pastoral visits to sick people in Roman hospitals. In April was held the pilgrimage to Ars and Lourdes of hospital chaplains (from twelve countries and four continents), which was followed, amongst other activities, by the visit of the personnel of the Pontifical Council to Poland at the end of April and the beginning of May, 'In the footsteps of the Founder, the Servant of God Pope John Paul II'. The same itinerary was then followed at the beginning of July by about sixty pilgrims, non-sighted people and pastoral workers in this field, from over ten Italian dioceses, from Ireland, from Brazil and from Peru. This group also took part in the international meeting for deaf people which is held annually in the Polish city of Kalkow on the first Saturday of July.

One should here also remember the twenty-third World Congress of FIAMC (the world federation of Catholic doctors) at Lourdes on 6-9 May 2010, in which Archbishop Zimowski also took part.

These were all initiatives when the participants felt enveloped as never before in the maternal presence of Mary. 'Her motherhood, which began in Nazareth and was lived most intensely in Jerusalem at the foot of the Cross, will be felt….as a loving and urgent invitation addressed to all the children of God, so that they will return to the house of the Father when they hear her maternal voice' (*Tertio Millennio Adveniente,* n. 54).

A maternal protection that has certainly accompanied the twenty-five years of work of the Pontifical Council and the attention that it has paid to the present context, to globalisation and to faithfulness to its general objective which the Servant of God Pope John Paul II summed up as follows: '*reveal the suffering and glorious face of Christ enlightening* the world of health care, suffering and illness with the Gospel, *sanctifying* the sick and healthcare workers and *promoting* the coordination of pastoral health care of sick persons in the Church' (John Paul II, 'Audience to those taking part in the Plenary Assembly of the Pontifical Council for Health Care Workers', Rome, 2 May 2002, n. 3).

The apostolic letter *Salvifici Doloris* on the Christian meaning of human suffering, like the Pontifical Council for Health Care workers, was, indeed, a personal, courageous and incisive initiative taken by John Paul II. Assert-

ing once again the full contemporary relevance of the predilection of Jesus for those who suffer, he also launched in our globalised, tormented and divided world a decisive factor for dialogue, for solidarity and for co-operation (cf. Fiorenzo Angelini, *Ero infermo… La Pastorale sanitaria nella vita della Chiesa*, PCPOS, 1996, p. 153).

The idea of instituting a World Day of the Sick thus matured during the course of the general assembly of the Pontifical Council for Pastoral Assistance to Health Care Workers of February 1992. John Paul II himself had spoken about it in his address to those taking part in the plenary assembly. 'The liturgical memorial of the Blessed Mary Virgin of Lourdes, on whose day I wanted to institute your dicastery through my Motu Proprio *Dolentium Hominum*', the Pope said, 'also illuminates this plenary session of yours. I know that you are working on the proposal to institute a World Day of the Sick, with the dual goal of making those who suffer aware of the importance of the gift of their suffering and making the whole of the People of God aware of the duty to become neighbours to every sick person. May the Blessed Virgin, celebrated and evoked at Lourdes as Health for the Sick, be a model for such a fundamental apostolate! She, the mother of love and of pain, blesses your work' (*Insegnamenti* XV, 1 1992, p. 268).

In the letter of 13 May 1993 addressed to Cardinal Fiorenzo Angelini, the first President of the Pontifical Council, John Paul II explained the reason for the choice of 11 February as the date for the WDS. On 11 February 'of 1984 I published the apostolic letter *Salvifici Doloris* on the Christian meaning of human suffering and the next year I instituted this Pontifical Council for Pastoral Assistance for Health Care Workers, and so I think it is significant to establish the same day for the celebration of the World Day of the Sick. Indeed 'Together with Mary, Mother of Christ, who stood beneath the cross, we pause beside all the crosses of contemporary man' (*Salvifici Doloris,* n. 31). And Lourdes, the Marian sanctuary which is one of those held most dear by the Christian people, is a place and at the same time a symbol of hope and grace under the sign of the acceptance and the offering up of saving suffering' (*L'Osservatore Romano*, 14 May 1993, p.6).

Cardinal Fiorenzo Angelini subsequently said in a speech that 'in response to my special request John Paul II' instituted the dicastery on 13 May, 'the eleventh anniversary of the attempt on his life in St. Peter's Square, with a special handwritten letter that he sent me'.

Twenty-five years of life and activity, therefore, linked to the date of 11 February and to Our Lady *Salus Infirmorum*. The theme of the Virgin Mary the Health of the Sick is indeed of great pastoral relevance and the date of 11 February was wanted by John Paul II. It was on this day that in different years the Supreme Pontiff published *Salvifici Doloris* and *Dolentium Hominum*, and also established the World Day of the Sick. This, therefore, was no accidental choice or one that was solely devotional. It emphasises the living and inseparable relationship that the Virgin of Lourdes has with the world of sock people and the institutions that work for them.

In 1908, fifty years after the events of Massabielle, Pius X decreed that 11 February, the first day of the apparation of the Virgin to St. Bernadette Soubirous, should be celebrated as the feast of Our Lady of Lourdes throughout the Church. A liturgical memorial of great relevance, after the reforms following the Second Vatican Council as well.

Indeed, perhaps this time I have not sufficiently dwelt upon the fact that the relationship between this Pontifical Council and Mary, Mother of the Sick, was the outcome of an inspiration and an initiative of Pope John Paul II: divine inspiration, a pontifical initiative, which he paid for with his love and with his suffering. Because it is certainly the case that the World Day of the Sick also bears not only the inspiration and the initiative of John Paul II but also his sacrifice as a foundation for its work. 'The tandem 'Mary and the sick' profoundly characterises the life, the spirituality, the magisterium, and the exemplariness of John Paul II' (Riccarda Lazzari, *Maria nel mondo della salute*, San Paolo, Cinisello Balsamo, 2010, p. 191).

A Marian Impress Wanted by John Paul II

It was this Pope who, living an intense Marian spirituality as well, knew how to understand with a charismatic insight the nexus between Mary and the sick and led the Church with this perspective. His was, in his life and his doctrine, a Marian theological existence. The Servant of God and Supreme Pontiff John Paul II had a singular and preferential relationship with the world of suffering. Undoubtedly, after the tragic assassination attempt of 13 May 1981, the Pope immediately perceived that the hand of Mary had marked his life by making that murderous bullet deviate on its path. A life in which Mary comes forth, reveals herself and makes herself present, with force and conviction, as in a Marian icon, through the Supreme Pontiff of '*Totus tuus*'. He himself left us a description of the early fruit of his devotion to Mary in his autobiographical book *Dono e mistero* (Giovanni Paolo II, *Dono e mistero. Nel 50° del mio sacerdozio,* Libreria Editrice Vaticana 1996, p. 37). Personal devotion, doctrine, deeds and pilgrimages were the Marian expression of a life that reveals the characteristic note of his existence and his pontificate. Let us remember his words from the beginning of his papacy and the explicit reference to the Mother of the Lord: 'May Jesus Christ be praised. Dearest brothers and sisters, we are all still sorrowful after the death of our most beloved Pope John Paul II. And thus the Most Eminent Cardinals have called a new bishop to Rome. They have called him from a faraway country…faraway but always so near because of communion in faith and the Christian tradition. I was afraid when receiving this appointment

but I did it in the spirit of obedience to Our Lord Jesus Christ and in total trust in His Mother, Our Most Holy Lady. And thus I present myself to you to confess our common faith, our hope, our trust in the Mother of Christ and of the Church, and also to begin again on this road of history and of the Church, with the help of God and with the help of men' ('Il primo saluto di Giovanni Paolo II ai fedeli' (16 October 1978), in *Insegnamenti di Giovanni Paolo II,* I (1978) p. 3).

We cannot but remember how the Virgin Mary was also present in his testament: "Watch, therefore, for you do not know on what day your Lord is coming" (*Mt* 24: 42) – these words remind me of the last call that will come at whatever time the Lord desires. I want to follow Him and I want all that is part of my earthly life to prepare me for this moment. I do not know when it will come but I place this moment, like all other things, in the hands of the Mother of my Master: *Totus Tuus.* In these same motherly hands I leave everything and everyone with whom my life and my vocation have brought me into contact' (in *Insegnamenti di Giovanni Paolo II,* XXVIII (2005) p. 257).

To me it seems that the Pope was in everything a constant expression of communion with Mary, which had its constant forms of prayer and life: devotion to images of the Virgin Mary. In the Marian biography of John Paul II the assassination attempt of 13 May 1981 has a privileged place: the Pope always stated that he did not die because of the maternal intercession of Mary. For this reason he wanted to go to Fatima on the first anniversary of that attempt, 13-14 May 1982. The predecessor of Pope Benedict XVI went back to Fatima on the same days in 1991 and for the last time in the year 2000. In my view, his tie to Our Lady of Fatima certainly led him to write the letter instituting the World Day of the Sick on 13 May 1992 (this letter was published the next day in the *L'Osservatore Romano* of 14 May 1992, pp. 1, 6).

His ties with the sanctuary of Lourdes was also of great importance. He visited it twice during his pontificate and during one of his last apostolic journeys, in the month of August 2004, he wanted to commemorate the hundred and fiftieth anniversary of the proclamation of the dogma of the immaculate conception, which Mary confirmed during her apparations to St. Bernadette. Lourdes has by now for a long time been a place of encounter of charity between people in good health and the sick, a setting where faith inspires a host of initiatives and pastoral care is entirely directed towards the formation of faith and to existential conversion after the pilgrimage.

This is why in the light of the special devotion of the Pope to the Virgin Mary we can understand his wish to link and entrust the Pontifical Council for Pastoral Assistance to Health Care Workers to Mary *Salus infirmorum*. On 11 February 1984, a year before the institution of this dicastery, John Paul II wrote: 'It is especially consoling to note – and also accurate in accordance with the Gospel and history – that at the side of Christ, in the first and most exalted place, there is always his Mother through the exemplary testimony that she bears *by her whole life* to this particular Gospel of suffering. In her, the many and intense sufferings were amassed in such an interconnected way that they were not only a proof of her unshakeable faith but also a contribution to the redemption of all…As a witness *to* her Son's Passion by her *presence,* and as a sharer in it by her *compassion,* Mary offered a unique contribution to the Gospel of suffering, by embodying in anticipation the expression of Saint Paul which was quoted at the beginning. She truly has a special title to be able to claim that she "completes in her flesh"—as already in her heart—"what is lacking in Christ's afflictions' (*Salvifici Doloris*, n. 25).

In his homilies and his Messages for the World Day of the Sick from 1993 to 2005 John Paul II always pointed out the role of Mary *Salus infirmorum* for sick people. In these homilies and Messages various dimensions of the presence of Mary at the side of the suffering appear. 'No Pope has ever written as much as John Paul II did; and no Supreme Pontiff has transmitted to the Church such a vast and profound Marian inheritance as he did, not only because his pontificate (1978-2005) was one of the longest in history but above all because of his total dedication to Mary (*'Totus tuus')*, which instinctively led him to speak about her. His magisterium goes through all the documentary fields (from encyclicals to the Angelus) and is open, we may say, to all Mariological and Marian subjects' (E.M. Toniolo, 'Nota sul magistero mariano di Giovanni Paolo II', in AA.VV. *Il magistero mariano di Giovanni Paolo II. Percorsi e punti salienti*, Centro di cultura Mariana, Rome 2006, p. 7).

We can also say that from his example, from his personal impress, we have inherited in deeds, example, and writings, an authentic Marian spirituality which was expressed by the Pope in particular in the encyclical *Redemptoris Mater*. This is his evident note of spirituality in constant communion with the Mother of the Lord, made up of prayer, of contemplation, of constant familiarity and of tender sonship.

His Holiness Benedict XVI following on from his predecessor has continued to demonstrate the importance of the Virgin Mary in the lives of sick people: 'Fourteen years ago, 11 February, the liturgical Memorial of Our Lady of Lourdes, became the World Day of the Sick. We all know that the Virgin expressed God's tenderness for the suffering in the Grotto of Massabielle. This tenderness, this loving concern, is felt in an especially lively way in the world precisely on the day of the Feast of Our Lady of Lourdes, re-presenting in the liturgy, and especially in the Eucharist, the mystery of Christ, Redeemer of Man, of whom the Immaculate Virgin is the first fruit. In presenting herself to Bernadette as the Immaculate Conception, Mary Most Holy came to remind the modern world, which was in danger of forgetting it, of the primacy of divine grace which is stronger

than sin and death. And so it was that the site of her apparition, the Grotto of Massabielle at Lourdes, became a focal point that attracts the entire People of God, especially those who feel oppressed and suffering in body and spirit. "Come to me all of you who labour and are heavy laden, and I will give you rest" (Mt 11: 28), Jesus said. In Lourdes he continues to repeat this invitation, with the motherly mediation of Mary, to all those who turn to him with trust' (Benedetto XVI, *Insegnamenti* II,1 (2006), p.177). 'If professional and pastoral healthcare workers know how to visit the sick in conformity with the model of the Virgin of the Visitation, they will bring to those who suffer the gifts of the spirit: joy, peace and salvation. It is from the heart of each that will spring the Marian canticle of praise: my soul magnifies the Lord (Lk 1:46-55)' (Riccarda Lazzari, *Maria nel mondo della salute*, p.54).

The Virgin Mary Health of the Sick

Through her consent to the Incarnation of the Son of God, Mary placed herself at the root of the work of universal salvation. Health is connected with salvation which implies the duty to conserve one's life as a gift of God at the service of His Kingdom. The mystery of the participation of the sorrowful Virgin in the passion and death of the Son, her 'com-passion', is a gospel event that has found understanding and vast resonance in popular religiosity. The invocation of the litany which defines Mary as 'health of the sick has a rich Biblical, patristic and liturgical background' (F. Angelini, 'Infermi', in *NDM*, p.709). For centuries Christians have invoked her as Consoler of the Afflicted and Health of the Sick. The Servant of God John Paul II defined her as 'the living icon of the Gospel of Suffering'. The preface to the Mass in honour of the Virgin Mary Health of the Sick expresses this clearly: 'she participates in a singular way in the mystery of pain, shines forth as a sign of salvation and hope to those who in infirmity invoke her support; to all the suffering people who look to her she offers the perfect model for perfect adherence to your will, and of full conformity to Christ, who in his immense love for us bore our weakness and took on our pains' (Conferenza Episcopale Italiana, *Messe della Beata Vergine Maria. Raccolta di formulari secondo l'anno liturgico*, LEV, Vatican City, 1989, p. 143).

In the introduction to the mass of the Virgin Mary Health of the Sick the reasons for and the history of this celebration are provided: 'The salvation of God concerns the whole of man, his body, his soul, his spirit, both when he is a pilgrim on earth and, above all else, when he becomes a citizen of heaven. Because of the salvation obtained for us by Christ in the Holy Spirit, the condition of man is completely changed: oppression becomes freedom; ignorance, knowledge of the true; infirmity, health; affliction, joy; death, life; and the slavery of sin changes into sharing in the nature of God. However, on earth man cannot fully enjoy salvation: his life, indeed, still knows pain, illness, death. 'The Salvation of God' is Christ himself, whom the Father sent into world as the Saviour of man and physician of bodies and souls…The Virgin Mary as Mother of the Saviour of man and believers is attentive and tender in coming to the help of her children who are in pain. For this reason very many sick people turn to her – often also going to sanctuaries dedicated to her – to receive health through her intercession' (C*ollectio missarum de Beata Maria Virgine*, p. 142).

Over the last twenty-five years the Pontifical Council for Health Care Workers has celebrated the World Day of the Sick in many Marian sanctuaries: Lourdes in France, Loreto in Italy, Czestochowa in Poland, Yamoussoukro in the Ivory Coast, and Nostra Signora di Guadalupe in Mexico.

Mary, Mother of Christians and *Salus Infirmorum*. Mary is one of us. She also felt her soul rip and her heart break on hearing the cry of the crowd against her innocent Son: 'death to him'. To the Virgin Mary Health of the Sick we can now turn with the oldest Christian text in which she is invoked with the title 'Mother of God': 'We seek shelter under your protection, Holy Mother of God: do not disdain the supplications we, who are in tribulation, make, and always free us from all dangers, O glorious and blessed Virgin!' ■

The Associationism of the Faithful, with Special Reference to the Promotion of the Culture of Life

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The Constant Lineage of the Associationism of the Faithful

The associationism of the faithful, in various forms, traverses the whole of the history of the Church. Down the centuries, declared the Venerable John Paul II, 'we have constantly witnessed the phenomenon of groups of varying sizes of the faithful, who, because of a mysterious impulse of the Spirit, have been spontaneously led to come together with the aim of pursuing specific goals of charity or of holiness, in relation to particular needs of the Church of their time or also to cooperate with its essential and permanent mission'.[1] 'In some ways lay associations have always been present throughout the Church's history',[2] observes the apostolic exhortation *Christifideles laici.* Were not lay people the principal protagonists of the various monastic movements of the first Christian millennium, followed by many experiences of 'apostolic life' lived out amongst these movements? We still have the testimony of the third 'secular' orders which have their roots in the early medieval period. Subsequently there were the 'orators', the 'Marian congregations', various associative experiences of Christian women and a thick network of lay brotherhoods, above all at the time of the tridentine baroque.

During the process of the irruption of bourgeois capitalism, the associations in general were seen as obstacles to economic and cultural freedom and thus they came to be persecuted and suppressed. The Napoleonic Code decreed their abolition. The phenomenon of secular and ecclesiastical associations, however, underwent a significant rebirth beginning in the second half of the nineteenth century. On the one hand, the steady weakening of the 'temporal' power and influence of the Church, the anti-clerical and anti-religious aggression of rationalist and liberal attitudes, the steady breakdown of rural Christianity under the impact of the propagation of the urban-industrial revolution, and the rise of new social groups and ideological movements, required on the part of the Church the promotion of new organisational instruments for the formation and action of Catholics, in particular for a general mobilisation of the lay faithful, going beyond the limits of a narrow clericalism. On the other hand, Biblical and patristic studies, the pathway undertaken by ecclesiological renewal, new charisms and educational, charitable and missionary communities, the emergence of the 'Catholic movement' with its numerous and various components and works, and the currents and experiences of 'social Catholicism', opened up the way to the entrance onto the stage of protagonists of the lay faithful. The Spirit of God generated providential experiences of associations of the faithful, such as the conferences of Ozanam, the brilliant insight of the 'Catholic apostolate' of Vincenzo Pallotti, the educational work for youths of the working classes carried out by Giovanni Bosco and Adolph Kolping, and many other experiences of the involvement in associations of the lay faithful.

During the course of the first half of the twentieth century, the dynamic of associations experienced an even greater and more diversified development. Its spinal column was Catholic Action which had already come into existence towards the end of the nineteenth century but which was more specifically defined and structured, and propagated at an international level, in particular during the pontificate of Pope Pius XI, following his 'providential inspiration'. Catholic Action was the fundamental matrix of lay associationism, at least until the Second Vatican Council, and in it generations of Catholic lay men and women received a solid Christian formation, being aware of their vocation of holiness and the apostolate.

During the decades 1920-1970 numerous associations of the faithful with an international dimension were created, with a great variety of goals, in harmony with the gradual configuration and institutionalisation of international life and the historical development of the Catholic world, giving rise to the family of the so-called Catholic international organisations which worked in the field of the apostolate of the environment, works of charity, and the Christian presence in the world of the professions, of education and of social communications.[3]

It should not, therefore, surprise us that the Second Vatican Council upheld the right of the faithful to found and direct associations, with a due 'relationship with Church authority' and emphasised that 'The group apostolate is very important' as a suitable response to 'human and Christian need and at the same time signifies the communion and unity of the Church in Christ'. It also stressed that 'the global nature of the Church's mission requires that apostolic enterpris-

es of Catholics should more and more develop organized forms in the international sphere'.[4].

Despite all this, towards the beginning of the 1960s, during the first stage of the post-Second Vatican Council period, reference was commonly made to the 'crisis of Catholic associationism' in a turbulent situation where many traditional associations were profoundly questioned and shaken by barrages of revisions and renewals and at the same time by uncertainty and crisis.

In this context of ecclesial life, Cardinal Joseph Ratzinger, who was then the Prefect of the Congregation for the Doctrine of the Faith, well grasped the surprising character of an unexpected innovation: 'What opens up to hope at the level of the universal Church – and this is taking place specifically in the centre of the crisis of the universal Church – is the emergence of new movements which nobody planned but which have sprung spontaneously from the interior vitality of faith itself… A new generation of the Church is emerging here'. 'I find it wonderful', he ended, 'that the Spirit is still once again stronger than our programmes and values other things than we ourselves imagined'.[5]

Indeed, it was Pope John Paul II who perceived in the post-synodal apostolic exhortation *Christifideles laici* that 'In recent days the phenomenon of lay people associating among themselves has taken on a character of particular variety and vitality…We can speak of a *new era of group endeavours* of the lay faithful. In fact, "alongside the traditional forming of associations, and at times coming from their very roots, movements and new sodalities have sprouted, with a specific feature and purpose, so great is the richness and the versatility of resources that the Holy Spirit nourishes in the ecclesial community, and so great is the capacity of initiative and the generosity of our lay people"'.[6] In particular, this Servant of God was well aware that they represented 'a certain innovation', but that this, he observed, 'still has to be fully understood in all its positive efficacy for the kingdom of God at work in today in history'.[7] Indeed, John Paul II himself, a few years later, emphasised the fact that such movements 'constitute one of the most important fruits of that spring of the Church that was already foreseen by the Second Vatican Council but which, unfortunately, is by no means rarely obstructed by the spreading process of secularisation',[8] stressing that their charismatic, educational and missionary riches were a providential gift of the Spirit of God for the good of the Church and of men. The strong appreciation, encouragement and recognition of these new realities – which were conventionally called 'ecclesial movements and new communities' – was expressed with special clarity and determination during the subsequent large meetings in St. Peter's Square, first with John Paul II on 30 May 1998 and then with Benedict XVI on 3 June 2006, with hundreds of thousands of members of these movements and communities.[9]

In addressing the composite reality of the contemporary stage of the associationism of faithful in the Church, the present *Code of Canon Law* makes clear that 'In the Church there are associations distinct from institutes of consecrated life and societies of apostolic life; in these associations the Christian faithful, whether clerics, lay persons, or clerics and lay persons together, strive in a common endeavor to foster a more perfect life, to promote public worship or Christian doctrine, or to exercise other works of the apostolate such as initiatives of evangelization, works of piety or charity, and those which animate the temporal order with a Christian spirit'.[10]

Reasons for the Development of Associations in Our Time

The major development of the associationism of the faithful in our time is connected with a series of factors of determining importance in the life and mission of the Church. This is above all else the outcome of the Holy Spirit who through providential inspirations, charisms and other movements leads the faithful to associate, moved by a strong impetus towards holiness and the apostolate. At the basis of every aggregation of the faithful there is the work of the Holy Spirit which in a timely way bestows his various gifts. 'It is significant here', declared John Paul II, 'how the Spirit, to continue with contemporary man that dialogue begun by God in Christ and continued down Christian history, has generated in the contemporary Church a multiplicity of ecclesial movements'.[11] And on another occasion he himself repeated this concept with emphasis when referring to the reality of ecclesial movements: 'The Church, born from the passion and the resurrection of Christ and the effusion of the Spirit, and propagated throughout the world and all ages on the basis of the apostles, has been enriched down the centuries by the grace of new gifts. They have allowed it, during the various epochs, to be present in a new and suitable form to respond to the thirst for beauty and justice which Christ has generated in the hearts of men and to which he himself is the only satisfying and complete answer'. [12]

A second factor to be borne in mind is the link that exists between being aware of the dignity and the responsibility of the lay faithful and their dynamism at the level of associations. At the celebration of the twentieth anniversary of the promulgation of the decree *Apostolicam Actuositatem*, but bearing in mind the vast historical current of the so-termed 'promotion of the laity', the Venerable John Paul II offered an illuminating summary of the teachings of the Second Vatican Council, emphasising that 'full recognition of the dignity and the responsibility of the laity inasmuch as *Christifideles*, inasmuch as incorporated in Christ, that is to say as living members of his body, participants in that mystery of communion, in virtue of the sacrament of baptism and confirmation and consequent shared and universal priesthood of all Christians…are called to live, to bear witness to, and to share the power of the redemption of Christ – the key to the full of meaning for hu-

man existence – within all ecclesial communities and in all the areas of human co-existence: in the family, at work, within nations, in the international order'.[13] Awareness of the dignity and responsibility that this implies has led many lay faithful to form associations, as can be read in the decree *Apostolicam Actuositatem,* looking for a 'suitable answer' to their 'human and Christian need'.[14] Indeed, 'the hour of the laity', is also inseparably 'the hour of the associationism of the laity', a sign of the need that the lay faithful feel to be accompanied, supported and animated in living Christian communities that embrace their whole lives, that call them to always have the presence of Christ present in everything, that lead them to have greater communion with him, that make them grow in their Christian formation as disciples, witnesses and missionaries, and that help them to mature in their Christian judgement and behaviour in the face of questions of family life, working life and social life.

The third factor that emerges from the teachings of the Second Vatican Council as regards the associationism of the faithful is the renewed self-awareness of the Church as a sacrament of communion which helps in putting in a strong light the full membership of the lay faithful of this ministry. The achievement of the ecclesiology of communion has led to a growth in the lay faithful of a sense of belonging to the Church and the importance of being rooted in a community in the lives of Christians. It is not for nothing that the reality of associations is seen by the teachings of the Second Vatican Council as a 'sign of the unity and the communion of the church in Christ'.[15] Despite the fundamental tasks of the family community and parish communities, many lay faithful are moved by Christian requirements that find in associations of the faithful suitable responses by which to live their Christian lives more radically, as well as their sense of belonging to the Church and the Christian responsibility to take part in its mission.

The associationsim of the faithful has also been stimulated by taking into account the 'apostolic efficacy' to which the decree *Apostolicam Actuositatem* refers.[16] It is true that this reference to apostolic efficacy can be ambiguous because who sows, who makes grow and mature and who marks the times of harvest is the Holy Spirit, but it can also refer to a meek intelligent and suitable involvement of the human modalities through which he works. Nothing can take the place of personal witness and the involvement of each Christian, at a personal level, in the work of evangelisation, but in societies that are increasingly secularised and fragmented the risk is that there will be a diaspora of Christians who are isolated and unable to provide Christian answers to questions of society that are increasingly differentiated and complex and to propose witness of communion within the various fields of which it is constituted. The fact, for example, that within a hospital those health-care workers that profess themselves Catholics do not even know each other as such indicates a serious failing. In this sense, the associationism of the faithful meets this request for 'apostolic efficacy', concentrating and communicating Christian energies for discernment, witness and service within realities in which they share their lives and their work.

In addition, the associative life of the lay faithful was fostered by the clear recognition by the Second Vatican Council of the right of the faithful to create and run such associations, on the condition that the 'the proper relationship is kept to Church authority'.[17] This right cannot be seen as the benevolent concession of pastors but is, rather, based upon respect for the natural right of every person to associate freely and upon the baptismal status of the faithful. There is a field of legitimate associative autonomy within communion which brings out the freedom and the responsibility of associative life itself. Later, in 1983, the Code of Canon Law stressed that 'The Christian faithful are at liberty freely to found and direct associations for purposes of charity or piety or for the promotion of the Christian vocation in the world'[18] and established a different set of regulations for associations of public law (which act '*in nominae ecclesiae*' and therefore are subject to a closer tie with the authority of the Church) and the associations of private law (which act according to their own freedom and responsibility with a wider margin of autonomy).[19]

Lastly, the freedom of the faithful to form associations and promote their development is a reaffirmation of their *libertas ecclesiae* both in the Church's life and its mission. If we look at the modern process of development of statism, understood as the claim of the state to dominate, absorb and determine civil society, we realise how this led to the birth of totalitarian regimes which were characterised by the wish to repress, compress or exploit the free forms of association of their peoples in order to empty the 'intermediate bodies', depress civil society, isolate individuals from each other and thereby create a situation that could be more easily manipulated by those holding power. For the Catholic Church, instead, the development of the associationism of the faithful is a sign and a guarantee of the exercise of *libertas ecclesiae* which is the root of, and at the same time has an intimate relationship with, that authentic freedom that should govern the lives of nations. Catholic associations strengthen the fabric of freedom and participation in the light of respect for, and the application of, the principle of subidiarity.[20]

Criteria for Discernment and Ecclesiality

Over the last twenty years the Pontifical Council for the Laity has proceeded to recognise canonically, in conformity with the power of jurisdiction that was conferred upon it by the Supreme Pontiff, numerous ecclesial movements, new communities and new associations, and has set in motion the canonical reconfiguration of numerous international associations which were previous-

ly recognised by the Holy See in the light of the *Documento di orientamento concernente i criteri di definizione delle Organizzazioni Internazionali Cattoliche*.[21] The *Repertorio delle associazioni internazionali di fedeli*,[22] which was published by this Pontifical council, described more than 120 of these associations recognised by the Holy See (to which have been added others in recent years).

In order to address the variegated reality and also the newness of very many associations in this 'new aggregative season of the lay faithful' in the Church, which are characterised by a great diversity of charisms and goals at the level of associations, of fields and styles of action, and of canonical status, the post-synodal apostolic exhortation *Christifideles laici* suitably describes '*clear and definite criteria for discerning and recognizing'* that are applicable to all associations of the faithful.[23] These criteria in the first instance are milestones on the pathway of the 'growth of associations of the lay faithful in the communion and the mission of the Church', [24] which are indispensable features of their identity and their mission. They are especially given to pastors of the Church so that they may exercise their non-delegable service of discernment, of guidance and of encouragement in favour of all associations of the faithful. Indeed, it is of fundamental importance, and a duty, for every association to 'be subjected to the discernment of the relevant ecclesiastical authority', who makes judgements as regards the genuineness of its Catholic identity, and for pastors 'to exercise paternal vigilance according to their ministry of unity in charity and truth'.[25]

The first criterion of ecclesiality indicated for all associations of the faithful requires them to bear in mind and actuate '*The primacy given to the call of every Christian to holiness,* as it is manifested "in the fruits of grace which the spirit produces in the faithful"'.[26] Thus a Catholic association of the faithful should have as its first purpose that of generating amongst its members a renewed encounter with the Lord, a more anchored supplication for the grace of his Spirit, a greater trust in the mercy of God the Father, going back to the sources of faith, rediscovering the gift of baptism, and confirming or deepening a feeling of Christian responsibility and commitment. Associations of the faithful, therefore, are called to be places and pathways of encounter with, and following, the Lord, of communion with him, and f a renewed radical approach to the Christian life. In this sense, they provide an answer to that invitation with which the pontificate of John Paul II was begun: 'open the doors wide to Christ', [27] the same invitation with which his pontificate was ended: 'start afresh from Christ',[28] and which Benedict XVI took up in his encyclical *Deus caritas est:* 'Being Christian is not the result of an ethical choice or a lofty idea, but the encounter with an event, a person, which gives new life to a new horizon and decisive direction'.[29] Indeed, participation in the life of an association of the faithful is, and should be, a sign and at the same time a propitious opportunity for a life conversion to take seriously the vocation of holiness. Without this, participation in an association of the faithful becomes a formal and marginal fact.

The second criterion for the discernment of the life of associations of the faithful relates to '*The responsibility of professing the Catholic faith,* embracing and proclaiming the truth about Christ, the Church and humanity, in obedience to the Church's Magisterium' so as to be forums for education in the faith in its total content.[30] It may appear obvious to restate the need for obedience to the teachings of the Church for an association that professes itself Catholic, which is recognised as such, but we well know how important it is today for faithfulness to Christ and his Church to be supported by an ecclesial context that is truly aware of this necessary faithfulness. Do there not perhaps exist opinion polls that refer to a significantly high percentage of baptised people, and even 'pastoral workers' and so-termed 'committed' Catholics, who do not adhere to the fixed doctrinal and moral points of the teachings of the Church? The associations of the faithful are educational methods or pathways that lead people to rediscover the reasonableness and the beauty of the truth stewarded by the Church, its possession for all men. Specifically in this sense, the movements and the new communities deserve the appellation 'providential'[31] because they respond to the contemporary educational emergency, because they accompany people in their Christian formation, in the development of a Christian mindset that is able to react in the face of the events, the situations and the questions of personal and social life with a judgement of faith, according to the need to give 'form' to life which is affected in all its dimensions by the Christian event.

The third criterion of discernment and ecclesiality requires that associations of the faithful bear '*witness to a strong and authentic communion* in filial relationship to the Pope, in total adherence to the belief that he is the perpetual and visible center of unity of the universal Church, and with the local Bishop, "the visible principle and foundation of unity" in the particular Church, and in "mutual esteem for all forms of the Church's apostolate"'.[32] It has been said that these associations are signs and reflections of the mystery of communion, in a diversity of forms, in which the one Church is achieved. They thus help people to adhere to a true *sensum ecclesiae*, in the wholeness of its divine and human, sacramental and charismatic, hierarchical and communitarian, temporal and eternal, dimensions, without any oppositions or reductions. This ecclesiality, however, is assured by affective and effective communion with the Successor to Peter in the collegiality of the bishops, by obedience to legitimate pastors, and by participation in the one Eucharist. In addition, observed John Paul II, 'For the sound building of a common house it is necessary, furthermore, that every spirit of antagonism and conflict be put aside and that the competition be in outdoing one another in showing hon-

our (cf. *Rom* 12:10), in attaining a mutual affection, a will towards collaboration, with patience, farsightedness, and readiness to sacrifice which will at times be required', making prevail 'always that which is required in a hymn to charity'. [33] All opposition between offices of pastoral care, parishes, associations and movements should be avoided. Everyone is required, in freedom and plurality of forms, to offer their own contribution to building the Church as a 'home and school of communion',[34] with a profound sense of belonging to that mystery which is celebration in liturgical action which finds its sources and its apex in the Eucharist, bringing out a spirituality of communion, the 'guiding principle of education wherever individuals and Christians are formed, wherever families and communities are being built up'.[35]

The fourth criterion of discernment indicated by *Christifideles laici* requires from associations of the faithful '*Conformity to and participation in the Church's apostolic goals*', with a new 'missionary zeal' that increasingly makes them 'participants in a re-evangelisation'.[36] Indeed, John Paul II repeated emphatically: 'A radical conversion in thinking is required in order to become missionary, and this holds true both for individuals and for entire communities. The Lord is always calling us to come out of ourselves and to share with others the goods we possess, starting with the most precious gift of all – our faith. The effectiveness of the Church's organizations, movements, parishes and apostolic works must be measured in the light of this missionary imperative. Only by becoming missionary will the Christian community be able to overcome its internal divisions and tensions, and rediscover its unity and its strength of faith'.[37] It is specifically their experience which demonstrates that mission is not a task that is added to the Christian vocation and life, it is not a pastoral programme or strategy, it is not in the least fanatical proselitysm, but, rather, the communication of the gift of encounter with Christ, the sharing of truth, of beauty and happiness that is encountered and intended for the good of everyone. It is experienced as a policy of sharing one's own experience proposed to the freedom of other people, whether near to hand or far away, out of passion for their lives and their destinies. In this way the call to a 'new evangelisation'[38] – which is all the more urgent because multitudes of men live 'as though God did not exist'[39] and 'the number of people who ignore Christ and do not belong to the Church is constantly increasing, indeed has almost doubled since the end of the Council'[40] – is certainly not reduced to repetitive ecclesial rhetoric, neither does it remain in the quick sands of an inhibiting stress on problems and difficulties which still consumes and blocks by no means few 'pastoral workers, but, rather, finds ardour and zeal in achieving success. What is especially striking is that missionary propensity of movements and communities to go towards all frontiers and to bring their own experience to new peoples and nations, in particular in lands of extreme deChristianisation or where the presence of the Church is in a situation of being a small minority and/or strongly limited in its freedom. The Christian witness that is offered in the most varying fields of civil life is also striking, witness to the point of 'new *areopagi*' where the presence of the Church at an institutional and local level does not manage to bear upon the fabric of the real lives of people, their work and the driving interests of their existence. The experience of associations of the faithful often calls the whole of the community of believers to the importance of, and need for, a Christian presence, to the point of a '*plantatio*' of the Church in schools, universities, hospitals, cultural centres and research laboratories, the mass media, companies and factories, the civil service and parliament, and in the human outskirts of needs and poverty. Indeed, many forms of presence and action are needed to bring the words and the grace of the Gospel to the various conditions of life of contemporary man, as well as many other functions of religious irradiation and apostolate of the environment, in the cultural, social, educational and professional fields (as well as others).[41] One can state, therefore, that the rooting of the Christian, Catholic, identity, of associations is not achieved by self-closure in 'ghettoes' for protective purposes, or by placing oneself in pleasant and gratifying company, but, rather, by putting oneself in such a condition, and achieving a renewed impetus, so as to be present in an explicit and visible way, without fears or calculations, in all the contexts and situations of life as communicators of the extraordinary gift of encounter with Christ. For this very reason, meetings that take place in the ordinary reality of daily life are charged with positivity, and increased in number, and become deeper, thanks to the Christian outlook that values in reality every trace of good and of truth, every sense of Mystery, every nostalgia and wish for God, within the divine plan that is actuated in Jesus Christ, the only Revealer, the only Mediator, the only Lord, the only Saviour.[42]

This apostolic exhortation makes clear, lastly, that these fundamental criteria 'find their verification in the *actual fruits* that various group forms show in their organizational life and the works they perform'.[43] In this sense we can summarise what has been said by stating that the ripest fruit, the most valuable fruit, which is to be seen in the experience of associations, movements and new communities over the last decades, and that even more is expected from them, is that of the production of a new generation of men and women who rediscover the gratitude, the joy, the truth and the beauty of being Christians, who bear witness to this everywhere and who communicate with conviction and persuasion the reasons for the gift that has been received and has been offered to everyone. They are like schools and homes of new disciples of the Lord who have rediscovered their own baptism – 'Incorporation into Christ through faith and Baptism is the source of being a Christian in the mystery of the Church. This mystery con-

stitutes the Christian's most basic "features" and serves as the basis for all the vocations and dynamism of the Christian life of the lay faithful'[44] – and who, therefore, approach their existences in the light of his Presence, thereby constituting generations of 'new men' and 'new women', the protagonists of Christian newness in the world.

Associations of the Faithful: the Promoters of a Culture of Life

I have left to the end of this paper an exploration of the third criterion of discernment and direction for associations of the faithful – which asks from them a commitment to a presence in society so as to place themselves 'at the service of the total dignity of the person', thereby becoming living currents of participation, solidarity and justice[45] – in order to emphasis, within the context of the celebrations of the twenty-fifth anniversary of the institution of the Pontifical Council for Health Care Workers, the requirement applied to all Catholic associations to become promoters of a culture of life. '*To rediscover and make others rediscover the inviolable dignity of every human person',* something that requires respect for his or her natural and universal rights, and above all else the right to life', 'makes up an essential task, in a certain sense, the central and unifying task of the service which the Church, and the lay faithful in her, are called to render to the human family'.[46] This is thus an essential task for associations of the faithful as well, and without any exceptions. Many recent documents of the Church, amongst which apostolic exhortations such as *Familiaris consortio* and *Christifideles laici,* and encyclicals such as *Veritatis splendor* and *Evangelium vitae*, cite that strong text of the Second Vatican Council which openly proclaims that 'All offences against life itself, such as every kind of murder, genocide, abortion, euthanasia and willful suicide; all violations of the integrity of the human person, such as mutilation, physical and mental torture, undue psychological pressures; all offences against human dignity, such as subhuman living conditions, arbitrary imprisonment, deportation, slavery, prostitution, the selling of women and children, degrading working conditions where men are treated as mere tools for profit… all these and the like are certainly criminal: they poison human society; and they do more harm to those who practice them than those who suffer from the injury. Moreover, they are a supreme dishonour to the Creator'.[47]

Unfortunately, fifty years later we are still witnessing an 'extraordinary increase and gravity of threats to the life of the individuals and peoples, especially where life is weak and defenceless'.[48] International organisations, strong international powers, highly organised lobbies, and conformism and relativism which are spreading everywhere in societies that are marked by individualism, place on the agenda laws and programmes that seek to banalise the abhorrent mass practice of abortions, the promotion of euthanasia, the temptations of eugenics, crimes against life which are even presented and propagated as expressions of individual freedom, as recognised individual rights that are protected and guaranteed. How can we not bear in mind that also 'The enormous development of *biological and medical science,* united to an amazing *power in technology,* today provides possibilities on the very frontier of human life which imply new responsibilities', both for the defence of life and the treatment of illness and for manipulations that alter genetic inheritance and attack life'?[49]

Faced with these great challenges, as a result of which the social question has become an anthropological question, the first service that the associations of the faithful can render to people and society is always to bear witness to, and preach, the Gospel, because it is the eclipse of the sense of God that obfuscates the sense of man, which makes him lose awareness of his dignity, of the sacred and inviolable character of life and the gift of true life and life in abundance. This service of associations of the faithful passes by way of their persevering educational commitment to a religious sense and a culture of life that becomes witness in the newness of life of marriages and Christian families. It is also expressed in their participation in the extraordinary history of charity which through the Church embraces the lives of those in need and weak people who are undefended, the suffering, the poor and the oppressed. Often associations of the faithful are inspiring and animating forces of variegated works in favour of the disabled, young people who experience pregnancy in conditions of loneliness and poverty, elderly people who are not self-sufficient, the terminally ill, those afflicted by AIDS, abandoned young people, the victims of drugs and prostitution… Associations of the faithful should also know how to speak out in public life, being on the side of life, against everything that attacks life, following the teachings of the pastors of the Church and supporting in a solidarity-inspired way their timely interventions. In addition, they must be a support and light for a Christian presence in settings where the fundamental questions of life and the dignity of people are raised, in schools and in universities as well as in governments and parliaments, in research laboratories and hospitals, helping people to form a moral judgement and generate courageous, intelligent and coherent conduct. 'If charity is to be realistic and effective', one reads in the encyclical *Evangelium vitae*, 'it demands that the Gospel of life be implemented also by means of certain forms of social activity and commitment in the political field', where Catholic associations should engage in the drawing up of 'cultural, economic, political and legislative projects which, with respect for all and in keeping with democratic principles, will contribute to the building of a society in which the dignity of each person is recognized and protected and the lives of all are defended and enhanced'.[50]

I would like to finish this paper

with the words of Pope Benedict XVI which he addressed to those members of Church movements and new communities on 3 June 2006 who had gathered together in St. Peter's Square: 'We find life in communion with He who is life in person – in communion with the living God, a communion into which we are introduced by the Holy Spirit, called… a living source… Dear friends, movements are born specifically from a thirst for true life; they are movement for life from all points of view. Where the true spring of life no longer flows, where life is only appropriated rather being given, there the life of others is also in danger; there is a propensity to exclude undefended unborn life, because room for one's own life also seems to be removed. If we want to protect life, then we must above all rediscover the source of life; then life itself must reemerge in all its beauty and sublime character; then we must allow ourselves to be vivified by the Holy Spirit, the creative source of life'.[51]

Notes

[1] Giovanni Paolo II, *Discorso ai movimenti ecclesiali riuniti per il colloquio internazionale,* Vatican City, 12 March 1987, n.2, in *Insegnamenti di Giovanni Paolo II*, X/1 (1987) 477.

[2] John Paul II, Post-synodal Apostolic Exhortation *Christifideles laici*, Vatican City, 1988, n. 29.

[3] Centro Studi sugli Enti Ecclesiastici, *Statuti delle Organizzazioni Internazionali Cattolici*, prologo del Prof. Guzman Carriquiry, *Lo sviluppo del fenomeno associativo nella Chiesa cattolica,* (Giufrè, Milan, 2001).

[4] The Second Vatican Ecumenical Council, Decree *Apostolicam Actuositatem*, nn. 18, 19; Pastoral Constitution *Gaudium et Spes*, n. 90; *Christrifideles laici*, n. 29.

[5] Joseph Ratzinger, *Rapporto sulla fede* (Paoline, Turin, 1985). Cf. J. Ratzinger, *I movimenti ecclesiali e la loro collocazione teologica*, published in Pontificio Consiglio per i Laici, *I movimenti nella Chiesa* (Vatican City, 1999).

[6] *Christifideles laici,* n. 29.

[7] Giovanni Paolo II, *Discorso al movimento Comunione e Liberazione*, Vatican City, 30 September 1984, quoted by Benedetto XVI in *Discorso ai partecipanti al Seminario per Vescovi su Pastori e Movimenti*, Vatican City, 17 May 2008.

[8] Giovanni Paolo II, *Messaggio al Congresso Mondiale dei movimenti ecclesiali*, Vatican City, 28. May 1988, quoted by Benedetto XVI in *Discorso ai partecipanti alla XII Conferenza Internazionale del Rinnovamento Carismatico Cattolico*, Vatican City, 31 October 2008.

[9] The proceedings of these two international meetings of these Popes with the members of movements and new communities were published by the Pontifical Council for the Laity, *I movimenti nella Chiesa* and *La bellezza di essere cristiani. I movimenti nella Chiesa* (Vatican City, 2007).

[10] *Code of Canon Law*, can. 298.

[11] Giovanni Paolo II, *Discorso o.c.*, 30 September 1984, n. 3.

[12] Giovanni Paolo II, *Discorso ai partecipanti agli esercizi spirituali di Comunione e Liberazione,* Vatican City, 12 September 1985, n. 1, in *Insegnamenti di Giovanni Paolo II*, VIII/2 (1985) 658.

[13] Giovanni Paolo II, *Discorso nella commemorazione del vigessimo anniversario della promulgazione del Decreto Apostolicam Actuositatem,* Vatican City, 18 November 1985, n.2.

[14] *Apostolicam Actuositatem,* n. 18.

[15] *Ibidem*.

[16] *Apostolicam Actuositatem*, n. 19.

[17] *Ibid,*, n. 18.

[18] *Code of Canon Law*, can. 215.

[19] Cf. *Code of Canon Law*, Book II, Title V, cann. 298-329.

[20] Cf. Carriquiry, Guzman, *Le associazioni dei fedeli, con speciale riferimento all'Azione Cattolica e ai nuovi movimenti ecclesiali*, in Pontificio Consiglio per i Laici, *La voce dei laici nel Sinodo* (Vatican City, 1988).

[21] Segreteria di Stato, 'Documento di orientamento concernente i criteri di definizione delle Organizzazioni Internazionali dei fedeli', *Acta Apostolicae Sedis*, LXIII, 1971, pp. 948-956.

[22] Pontificio Consiglio per i Laici, *Repertorio delle Associazioni Internazionali dei fedeli* (Vatican City, 2004),

[23] *Christifideles laici,* n. 30.

[24] *Ibidem*.

[25] Cf. Giovanni Paolo II, *Discorso nell'incontro mondiale con gli aderenti di 50 movimenti ecclesiali e nuove comunità*, Vatican City, 30 May 1998 ; Joseph Ratzinger, *Omelia nei Vespri della vigilia di Pentecoste, celebrata con gli aderenti a più di 100 movimenti ecclesiali e nuove comunità,* Vatican City, 3 June 2006.

[26] *Christifideles laici,* n. 30.

[27] Giovanni Paolo II, *Omelia durante la Messa di inaugurazione ufficiale del Pontificato*, Vatican City, 2 October 1978.

[28] John Paul II, Apostolic letter *Novo Millennio Ineunte,* Vatican City, 2001, n. 29.

[29] Benedict XVI, Encyclical letter *Deus Caritas Est,* Vatican City, 2006, n. 1.

[30] *Christifideles laici*, n. 30.

[31] Giovanni Paolo II, *Discorso* o.c., 30 May 1988; Benedetto XVI, *Discorso ai vescovi amici del Movimento dei Focolari e della Comunità di Sant'Egidio*, Vatican City, 8 FEbrauary 2007.

[32] *Christifideles laici,* n. 30.

33 Giovanni Paolo II, *Discorso al Convegno della Chiesa italiana a Loreto,* Loreto, 11 April 1985, quoted in *Christifideles laici,* n. 31.

[34] *Novo Millennio Ineunte,* n. 50.

[35] *Ibidem*.

[36] *Christifideles laici,* n. 30.

[37] *Redemptoris Missio,* n. 49.

[38] Cf. Giovanni Paolo II, *Discorso all'Assemblea del CELAM,* Port-au-Prince, 9 March 1983; *Christifideles laici,* n. 34.

[39] *Christifideles laici,* n. 34.

[40] John Paul II, Encyclical letter *Redemptoris Missio*, Vatican City, 1991, n. 3.

[41] *Redemptoris Missio,* n. 49.

[42] Congregation for the Doctrine of the Faith, Decree *Dominus Jesus*, Vatican City, 6 August 2000.

[43] *Christifideles laici,* n. 30.

[44] *Christifideles laici,* n. 9.

[45] *Christifideles laici,* n. 30.

[46] *Christifideles laici,* nn. 37, 38.

[47] *Gaudium et Spes*. n. 27.

[48] John Paul II, Encyclical letter *Evangelium Vitae*, Vatican City, 1995, n. 3.

[49] *Christifideles laici*, n. 38; cf. *Evangelium Vitae,* n. 14.

[50] *Evangelium Vitae,* n. 89.

[51] Benedetto XVI, *Omelia o.c.,* 3 June 2006.

Catholic Associationism at the Service of Life: Issues and Prospects

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1. The Need for Associationism

In today's world, associationism is a fact. Indeed, thousands of associations work in the most varied fields. Human beings associate and so do Catholics. They have to do this, above all nowadays, for a series of reasons that I will now briefly describe.

a. Associationism belongs to the essence of Christianity

Christianity is communitarian. Jesus chose a group of people to work with him (Mt 10:1-4; Mk 3:13-19). In his work he gave preference to their formation, following the process step by step as an educator: in this group each member expressed his own way of being (Mk 8:32), his own interests and his own forms of selfishness (Mk 10:37), and his own experiences. Jesus took his disciples with him so that they could speak about what they had experienced (Mk 1:17); he compared their interests with those of the Kingdom of God (Lk 22:24-30); he expressed his own disappointment about the ways of thinking of certain members of the group (Mt 20:26-28; Mk 9:35); he sent them out to people and then examined what they had done ((Mk 6:30; Lk 9:-10); he encouraged them when they were faced with failure (Mt 5:11-12); he chose seventy-two disciples and sent them out two by two to preach the Kingdom (Lk 10:1); he celebrated the Last Supper with them and prayed for them to be as one and to be united; he sent the Holy Spirit and revealed the mystery of the Most Holy Trinity: Father, Son and Holy Spirit (Mt 28:19).[1]

Both the Acts of the Apostles and the apostolic Letters emphasise the communitarian dimension of Christianity. St. Paul, in his epistles, refers to the Church's feature of being the body of Christ with many organs (1 Cor 12:12-31).

Living communally, therefore, is consubstantial with Christianity inasmuch as this is present in its roots.

b. Associations are needed to evangelise our democratic world

In order to carry out our mission as a Church to evangelise the world of health and health care in an effective way, we Christian health-care professionals must come together with others, associate with them, because, as we are reminded by Paul VI in *Evangelii Nuntiandi* and John Paul II in *Christifidelis Laici*, bringing the message of Jesus to every part of the world and to every individual is obtained through organisations or associations. The means for this are necessary and this involves a certain infrastructure.

In the world of the twenty-first century – which is democratic (especially in the West) and globalised – social groups create opinion, influence the beliefs and behaviour of people, as well as politicians who legislate on the social norms of human society. Information and communications technology (ICT) is profoundly changing the values, the political styles and lifestyles through the creation of a new model of society that is based upon cooperation between equals and not upon hierarchy, upon interdependence (what concerns one person concerns many people at a distance), upon openness and transparency (it is always difficult for any organisation to conceal information and this facilitates integrity and honesty), and upon sharing intellectual property (openware of knowledge helps to create wealth). 'Global interconnectedness has led to the emergence of a new political power, that of *consumers and their associations*. This is a phenomenon that needs to be further explored, as it contains positive elements to be encouraged as well as excesses to be avoided' (*Caritas in veritate*, n. 66).

We Catholics must be present in this world not only at a personal level but also in the form of associations if we want to be effective and contribute all the wealth of our tradition to the issues of life, to visions of life, and to approaches to economic, social, religious and bioethical questions. We must use the new instruments of communication of the digital age to transmit our messages and reach today's young people.

c. Associations are needed in an empty world that is searching

In modern society there is a vein of unhappiness that we could interpret as an expression of a hunger for deep spirituality. Carl Rahner predicted that the twenty-first century would be spiritual or it would not be. An increasing number of people feel an inner void that they do not manage to fill with hedonism, consumerism and the satisfaction of their own instincts, and they are looking for something that will give them the inner strength to address life in a different way. It is difficult to live a life that has no goal

and existence ends up by becoming unbearable when everything is reduced to pragmatism and frivolity.

d. They are needed because of what they contribute

In a lay association it is easier to mature the feeling of belonging to the Church. An association, indeed, provides a more suitable ecclesial setting for the discernment of one's vocation, for shouldering one's responsibilities, and for reviewing the commitments that have been made.

In an association it is easier to sustain witness and act upon a commitment to transformation by joining forces.

The framework of an association allows a cultivation of one's own lay spirituality through dialogue and the communication of one's experiences. It is always easier to achieve a synthesis of faith and life within the setting of a Christian group.

'An association fosters and makes possible a specific and ongoing formation. Without associations we could never have a laity that is trained and works apostolically in a significant way' *(Msgr. Fernando Sebastián)*.

The presence of an association is in general more significant and effective than a mere individual presence.

Thus:

Now more than ever before, the health-care world and the Church need associations that provide *Christian health-care professionals*:

– Who are men and women of faith who answer the call of God in their lives and live and bear witness to the Gospel in their professions and in their lives, expressing its authentic humanising value, and who make the face of Christ who passes by today doing good, caring or treating present in men and women. Professionals, that is to say, who strive to imitate Christ, taking care above all else of those people who are most marginalised because of their illness.

– Who are professionals who aspire to be 'the living sign of Jesus Christ and his Church in showing love towards the sick and suffering' (*Christifideles laici*, n. 53) and are witnesses to, and preachers of, the Good News of Jesus in the heart of the health-care world through the exercise of their professions.

– Who are professionals who in the world of their work make visible through their lives the Christian values of love, generosity, dedication, honour and honesty, humility, service to other people, free giving, joy in work, tenderness and hope.

– Who are professionals who are servants of life, of all of life and the lives of everyone, but especially of the weakest and most in need.

– Who are professionals who know how to be the Church and feel a part of the Church, being jointly responsible for the mission that has been entrusted to them together with other members of the Church itself: pastors, religious and the lay faithful.

– Who are professionals who are able to work in a team, who are open, and who cooperate with other people, contributing their wealth and their poverty.

– Who are professionals who walk at the side of sick people, who are united to them, and who give and receive.

2. The Characteristic Features of Catholic Associationism

a. Evangelising the world of health and illness

Associations are never an end in themselves but a means by which to achieve goals, and the principal goal of Catholic health-care associations is to evangelise the world of health and illness.

The primary and immediate field of the lay faithful is their presence in the world. 'the laity, by their very vocation, seek the kingdom of God by engaging in temporal affairs and by ordering them according to the plan of God' (*Lumen Gentium*, n. 31). They are called there by God that by exercising their proper function and led by the spirit of the Gospel they may work for the sanctification of the world from within as a leaven' (*Lumen Gentium* n. 31).

The specific field of Christian health-care professionals is the world of health and illness where, indeed, fundamental experiences of human beings are lived (birth, illness, healing, old age and death), where great questions are posed, where grave human, social, ethical and moral problems are present and faced today by mankind and the Church, and which require careful analysis and illumination by faith.

b. Evangelising being witnesses to the humanising and healing power of Jesus

Life witness is essential in evangelisation. 'Their main duty, whether they are men or women, is the witness which they are bound to bear to Christ by their life and works in the home, in their social milieu, and in their own professional circle' (*Ad Gentes*, n. 21).

It is not sufficient to be practising Catholics. We should be witnesses to Jesus in our lives, in our daily professional work.

As baptised people we are called to live the life of Christ, to follow him with faithfulness, to configure our being and our action with our eyes fixed upon Jesus who is our model. We must live faith – which has been received as a gift – in the exercise of our profession (professional conscience, honesty, formation), in the treatment of sick people (treating and looking after them all in an integral, disinterested and loving way, demonstrating preferential concern for the most abandoned people), in our relationships with other professionals (the overcoming of unhelpful classism, team cooperation and work, the overcoming of individualism and rivalries that do harm to the sick), and in a commitment to transform institutions, culture and public opinion.

For these reasons, associations (meetings, days of reflection, prayer, courses of formation) must be directed towards promoting the wellbeing of Christian lay people in the world of health and illness, who are united by the same faith and vocation and who

as a Church exercise in this world the mission that Jesus has entrusted to them, the mission, that is to say, to be witnesses to the humanising, healing and saving power of Christ through the exercise of their professions.

Msgr. Tonino Bello encouraged the diocesan heads of Catholic Action and taught them with the following words: 'Take your working clothes into church but take your baptismal clothes to your places of work. Investigate and analyse the profound needs of people; the needs for meaning, the yearnings for peace, the concern for justice, the search for dignity, the hope for a new economic order which assures every human being the most elementary rights. Abstain from 'simplifying' problems. The Lord will give you a taste for essential things. May he make you ministers of the happiness of your people! May he make you faithful co-workers of your presbyters! Love and serve your Church not to pursue its glory but so that it is a faithful servant of the Kingdom. Attend to connections with other ecclesial aggregations, and ensure that the complementariness of everyone without injury to anyone comes forth. Respect the internal laws of technology and science, but ensure that all temporal realities look 'at he who was pierced'.

c. Evangelising starting from certain gospel perspectives

1. Evangelising *starting from the experience of God* who is the friend of life. People who accept the gospel and live it, evangelise, and to do this they need to return often to that intimate *sacrarium* where we are before god.

2. Evangelising with *eyes fixed on the Lord Jesus*, the epiphany of tenderness, of the compassion of God, who passed by doing good and healing, so that we adopt his attitudes, his words, and his deeds. We should constantly pose ourselves the same questions: would Jesus act like me if he were here today? Would he be satisfied with what I do, with my life, with my association? What would he ask? To clean myself and my association? What would he ask of me?

3. Evangelising *allowing ourselves to be guided by the Holy Sprit* who is present and works in us and other people

4. Evangelising acting *as instruments of God* who calls us to continue the healing work of Jesus.

5. Evangelising *feeling ourselves* the Church, in ecclesial communion with our pastors (with their orientations and their directives) and with other lay associations and movements (united in the essential, complementary in what makes us different).

6. Evangelising giving freely what we have received for free. An evangeliser loves, serves, sows tenderness, suggests God, offers his or her life as witness. But nothing is imposed. His or her action is an invitation, a question, a call. He or she does not act for economic motives or seeking personal prestige, or for the purposes of proselytism, but out of deep love for those people who suffer.

7. Evangelising *being nourished by reflection* and personal and community study.

8. Evangelising *beginning with our wounds* and limitations which make us humble.

9. Evangelising *being open to all those who* work for a more human, supportive, fraternal and healthy world of health, even if they do this for other reasons.

10. Evangelising being *witnesses* to the Gospel *who are joyous and full of hope*.

Evangelisation is necessary and today people are receptive to the message of Jesus who through his preaching and life's example taught us the way that really leads to fullness of life, to the Kingdom of God. When reading the gospels one clearly sees that Jesus wants people who are committed to humanising society so that nobody suffers, so that there are no exploited poor people, so that we use our abilities to serve people, especially the weakest. The least, the weak, the defenceless and the sick are those privileged by God; they are the blessed who will obtain the Kingdom, which it is more difficult to reach in the case of the rich and the powerful than it is for a camel to pass through the eye of a needle. It is clear that for Jesus it is no use saying 'Lord, Lord'. The important thing is to do the will of God (Mt 7:21), which means practical engagement and not only praying or living a life dissociated from faith. It means that Love is the principal thing, unconditional love for God and neighbour.

We could also say that Christianity is by definition fully involved in the lives of people and not something of the past. Jesus is still alive today, he is not dead and we remember him. The incarnated God is alive and present in every social context. From this point of view one can understand the 'updating' that the Blessed John XXIII wanted for the Church and that great moment of the Spirit, the Second Vatican Council. Our responsibility is to know how to be instruments of Jesus and to translate his message for today so that it may be the salt of the earth and yeast for dough. For this reason, we must transmit it with an up-to-date language and using the modern mass media. Indeed, it would be counterproductive to use these media to transmit an antiquated message.

3. The Lights and Shadows of the Catholic Lay Faithful in the World of Health

I believe that the *shadows* of the Catholic lay faithful today are:

– The passiveness of the great majority of lay people. A notable number of lay people constitute inside the Church what someone called the 'silent majority'. They have a passive approach within the Church; they do not ask for nor do they hold up the prospect of a more active and engaged participation. Everything is reduced to being 'good Christians'. They have a low level of cultural, religious, ethical political and social formation.

– The dissociation of the life of faith from the exercise of a profession. There are many Christian professionals involved at an individual level and at the level of associations outside their world of work, for example family movements, Christian communities,

parishes etc. Their centres of interest and their work are different from that of other professionals.

– The reluctance of by no means few Christians in this as in other contexts when it is a matter of expressing their faith or belonging to associations, both out of a fear of being labelled and because of a question of individualism. They live their Christianity in their places of work in an individualised way, at times hiding themselves behind the lack of credibility of the Church and certain Christians, and they do not feel the need for a communitarian presence of the Church in their place of work or to analyse, from a Christian point of view, their style of life in their professions.

– The scarce presence of Christian professionals in the world. In general, they are involved above all else in tasks and services within the ecclesial community (catechesis, liturgy, charity work), with the risk of forgetting the specific and proper mission of members of the laity in their family, professional, cultural, social and political lives. One should remember what Paul VI said: 'Their primary and immediate task is not to establish and develop the ecclesial community... but to put to use every Christian and evangelical possibility latent but already present and active in the affairs of the world' (*Evangelii Nuntiandi*, n. 70)

The shadows of Catholic associations:

– The lack of coordination of associations which is the outcome of their isolation and a lack of knowing each other which leads to an atomism, does not allow them to help each other, enrich each other or complete each other, and leads them to absolutise their spiritual and pastoral approaches and impoverishes everyone, but first of all the members themselves of the association involved.

– The danger of sectarianism. Keeping one's own identity without entering into dialogue with others leads to a loss of a vision of the gifts and charisms with which the Spirit enriches the Church. To absolutise one's own ecclesial and charismatic experience, making that movement the 'greatest' ecclesial horizon and losing that of the local Church where one lives, leads to sectarian pathways, with the creation of structures that can suffocate the spirit.

– The crisis of some associations and the low level of vitality of others.

– The use of an association as a structure of power which makes it lose credibility, especially in a social context such as the present one which is so critical, providing an image of a pressure group with a thirst for power which wants to impose its own beliefs on others. Struggles to be elected members of the guiding councils in order to obtain personal rewards: prestige, influence, curricula.

– The image of being antiquated and opposed to scientific progress.

The *lights* that exist today amongst the lay faithful and in Catholic associations are:

– Involved Catholics are involved out of conviction because the more common social environment is not favourable to them.

– The existence of health-care professionals in Catholic associations who defend faith in Jesus and in the Church, sometimes losing an opportunity for promotion and time to dedicate to recreational or exclusively professional activity.

– The presence of organised pastoral care in health to which any health-care professional can turn when he or she feels the need. The fact that twenty-five years ago H.E. Msgr José Luis Redrado promoted, together with Cardinal Angelini, and Pope John Paul II created, the Pontifical Council for Health Care Workers, constituted a before and after as regards organised attention being paid to the sick by the Church.

– The growing number of people who are looking for something that will give them the strength to address life in a different way. It is difficult to live a life that has no goal and it is not enough to have fun. Existence ends up by becoming unbearable when everything is reduced to pragmatism and frivolity.

– The need for peace, security and inner healing, which is something felt by many people.

4. The Action and Commitments of Catholic Health-Care Associations

Bearing in mind the goals of associations and the contemporary situation of the world of health and health care, as well as the challenges that it poses, I would like to propose certain initiatives and commitment that these associations should adopt and carry out. I detect three separate fields: that within associations, the health-care world, and the Church.

a. Actions within associations

Associations should be an *area* where their members can meet each other, share experiences, create ties of friendship and cooperation, achieve formation at a human, religious and pastoral level, support each other in the carrying out of their mission, celebrate the words and the example of Jesus in the Eucharist, review their commitments, share work that has been carried out, and plan future action.

A Catholic association should provide spaces for prayer and for reflecting on the gospels, concentrating on Jesus, the model and guide. For this reason, it must be a place of welcoming, without exclusions, where its members must feel loved, even though not 'secure'. Security, in fact, generates fears that paralyse and provoke distrust towards the world, closure within the association, which is the opposite to what the gospel of Jesus proclaims. A pastoral action of conservation and nostalgia for the past with the intention of trying to go back injures us and the Church. I do not believe that a Church as a structure of power is evangelical, even though a mass reality with many members. Jesus did not fall into this trap in the desert, where he suffered temptations, nor when they wanted to make him a king, and he was on his guard against the temptation of power. Many of us, however, fall into this trap very often, out of fear or because of what is convenient, because of a lack of sufficient faith.

b. Actions in the world of health and health care

b.1 Promoting a more responsible culture of health

Basing themselves on the health-giving values of the Gospel, associations must contribute to evangelising the culture of health through action such as:

Promoting a more healthy life by living and encouraging an evangelical style of life. Showing that it is healthy to believe, to hope, to love, to live in communion and in peace with oneself, with God and with other people.

Educating people to live their lives as a whole in a healthy way, and this includes their limitations, their downs, their sufferings, their illnesses and death.

'The Christian vision of the human being opposes a notion of health reduced to pure, exuberant vitality and satisfaction with one's own physical fitness, far removed from any real consideration of suffering… strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level' (John Paul II, Message for the World Day of the Sick, 2000).

We should propose a culture of the body that emphasises not only vigour, beauty and physical wellbeing but also affective, mental and spiritual health.

Supporting, and cooperating with, initiatives and programmes directed towards this. The field is vast: the fight for healthier conditions of life for everyone (diet, hygiene, housing, respect for and improvement of the environment, safety at work and on roads…); the creation of more human institutions which facilitate the integral wellbeing of people; cultivating healthier and more cordial relationships; the promotion of healthy habits in lifestyles, the use of free time, rest, taking care of one's body and one's spirit, etc.

b.2 Promoting integral assistance for the sick

Sick people are persons, they are not things, and their treatment requires intense and repeated dialogue. Healing does not take place only through the administration of medicinal products or surgery. Sick people ask for an increasingly human, personal, comprehensive and near assistance. It is not illnesses that are treated but sick people. Assistance for the sick is becoming increasingly complex. The existence of an interdisciplinary team is inescapable today for good practical assistance. To this team should belong various professional figures – medical doctors, nurses, psychologists, social workers and priests – in order to grasp the complex reality of man: the somatic, the psychological, the social, the cultural and the spiritual. An interdisciplinary approach improves care for the patient and his or her family.

A health-care professional must work in his or her care for a patient in a way that it is a sign of God who is a Friend and Saviour, and an invitation to receive His salvation. The health-care professional must define all of his or her health-care work according to the Spirit of Christ, reproducing and extending in the contemporary health-care world the healing action of Jesus. As John Paul II said, a health-care professional is 'the living sign of Jesus Christ and his Church in showing love towards the sick and suffering' (*Christifideles laici*, n. 53).

b.3 Promoting solidarity

Health-care has had important successes but it also has failings and problems. For example: long waiting lists in public health-care systems, insufficient attention paid to specific groups of patients, an inadequate or unjust distribution of resources, and the waste of medicinal products. Growing disenchantment and a lack of motivation in by no means few health-care professionals who fall victim to the burn out syndrome. Making this world of health care more human and supportive is a challenge that offers associations an opportunity to:

Educate people in values such as: respect for human beings, solidarity, mutual help, helping the needy, detachment from earthly realities, the control of unchecked consumption, the search for goals other than enjoyment, etc.

Offering the contribution of the gospel and the rich tradition of care of the Church to health care: the dignity of the human person, the value of the resources present in every human being for self-treatment and treatment by others, the importance of the personal relationship between the person who treats and the patient, and the impossibility of taking care of and treating a patient without taking responsibility for his or her problems and without giving him or her a little of oneself.

Appreciating the multiplicity of therapeutic initiatives, *the seeds of the gospel* present in the health-care world.

Promoting solidarity-inspired responsibility in this field: giving blood and the donation of organs, the rational consumption of resources, care for sick people who are most in need, etc.

Identifying and denouncing the insufficiencies and failings that exist in real health-care coverage, representing the voice of the weakest and most defenceless, making up for the failings of a health-care system and giving an impulse to those initiatives which seek to make up for them.

b.4 Taking care of people and populations who are the least helped

Christian health-care professionals are not allowed to ignore those who are most in need of health, which is more marked in situations of marginalisation, and this pre-supposes, as well, a lack of health care: economic poverty, social uprooting, loneliness, old age, alcoholism, drug addiction or the situations of disabled people or the chronically sick in general. Catholic associations of health-care professionals must engage in prophetic denunciation as a general body, making themselves the voice of those who have no voice. Always, but especially at the present time when the condition of wellbeing is called into question because of the world economic crisis, where in Europe we run the risk of returning to medicine for the rich and medicine for the poor, where, in addition, there exist many problems of a bioethical character and the rights of sick people are often trampled upon, we cannot keep

quite either as professionals or as Christians. We must denounce anti-evangelical situations and fight for a fair development of the world, so that there is an end to the daily scandal of the death of very many children and adults because of a lack of water, of food, of health care and of instruction. We must directly sensitise professionals and work in coordination with those other associations that are dedicated to helping the third and fourth worlds. 'The effective treatment of various pathologies, commitment to further research and the investment of adequate resources are praiseworthy objectives which have been successfully pursued in vast areas of the globe. However, while applauding the efforts made, one cannot overlook the fact that not everyone enjoys the same opportunities. I therefore make a pressing appeal that everything be done to encourage the necessary development of health services in the still numerous countries which are unable to offer their inhabitants proper living conditions and appropriate health care' (John Paul II, Message for the World Day of the Sick, 2001).

b.5 Illuminating ethical problems

In this world of health and health care delicate and grave problems of an ethical nature, which are increasingly numerous and complex, are posed. Some are linked to the *beginning of life*: demography and birth control, techniques of assisted reproduction, genetic engineering, prenatal diagnosis and genetic consultancy, the anthropological status of the embryo, abortion… Others are linked to the *end of life*: old age and elderly people, dying and death, the choice of patients as regards transplants, the interruption of life-saving treatment, intensive care and palliative care, the treatment of pain, AIDS, euthanasia, hunger strikes… Others, lastly, are connected to *clinical relationships*: informed consent, conscientious objection, strikes in the health care world, the distribution of resources, the quality of care, the ethics of committees in clinical research and clinical assistance, etc.

Meeting the important challenge of illuminating these questions requires associations of Christian health-care professionals in order to: follow the questions that are raised; know about and discern the concrete ethical questions that arise in the health-care world and in relation to which health-care professionals must take decisions; know which are the underlying bases of the question in frontier matters connected with life: the morning after pill, gene therapy, (embryo and adult) stem cells, cloning, the manipulation and use of embryos, and the distinction between ends and means; cooperate in the interdisciplinary search for solutions to these problems; spread reflection about Christian bioethics which guarantees the dignity of people and defence against attacks on, the use of, and manipulation of that dignity, especially when this is in a weaker state: at the beginning of life, in illness, in physical and mental deterioration, and near to death; promote the ethical formation of health-care professionals and citizens; foster the active participation of Christian health-care professionals in the creation and the deliberations of ethics committees; attend to the ethical counselling of patients and their families; retrieve the ethical dimension to health care, and help professionals to discover the values and the meaning present in it, trying to unite technical competence, honesty in behaviour, nearness and dedication to patients.

c. Actions inside the Church

The action of associations of professionals of the world of health and health care has a dual role:

c.1 Making the Church present in the health-care world

'You should make the Church present in the world of health', said Msgr. Osés to health-care professionals, 'without you this will not happen. You have been sent into the world to transform it gradually through your action into the Kingdom of God, working humbly and silently like lymph and yeast. Do not shut yourselves up in a group! Come out and give yourselves to the world'.

The presence of members of the laity in the world is absolutely necessary to ensure that the Church can extend today the 'healing deeds' of Jesus. In a society that is increasingly autonomous and secularised and when the number of practising Christians continues to decrease, the presence of Christian members of the lay faithful will be increasingly important within health-care institutions.

'For Christians to really be a capillary presence of the Church in the very flesh of society', declared Msgr. Fernando Sebastián at the Congress on Lay apostolate (Madrid 2004), 'they should first of all be the Church, they should be taken over by the love of Christ in a living and working faith, they should live according to the teachings of the Gospel and the Church in their personal lives, in the exercise of their professional lives, in their family lives and in the performance of their relationships and social obligations'.

c.2 Bringing the health-care world inside the Church

The Second Vatican Council invites lay people to bring 'to the Church community their own and the world's problems' (*Apostolicam Actuositatem,* n. 10). The Church cannot but know the profound changes that have been introduced by technology, by information and communications technology, by the use of computers and by internet, by diagnostics and in predictive medicine, in clinical relationships, in medical intervention, etc., nor can it become aware of the problems and questions raised by the development of genetic engineering, by cloning, by the appearance of new illnesses etc., other than through Christian members of the lay faithful who know and are a part of this world. Hence the need for the Church to be able to rely upon lay people who provide information and provide consultancy so that it can follow health-care issues and questions, and draw up documents or statements on bioethical questions or questions relating to the health-care world.

In the same way, their contribution can have great importance in the formation of people who work in pastoral care in health.

c.3 The interdependence of associations

'Strive to have relationships with other ecclesial groups, acting so that the complementariness of everyone shines forth', declared Msgr. Tonino to the lay associations of his diocese.

There should be interdependence between the various ecclesial associations, both of the world of health and health care and of other worlds, especially of lay movements or movements for the lay apostolate.

It is necessary to stimulate communication between Christian health-care professionals and other national or international groups, associations or societies so as to work together to achieve our goals and defend health and integral assistance for sick human beings, with special attention being paid to the development of health care in those populations that are most in need.

At a national and international level there exist specialised associations which have existed for a long time and which have a large number of members, such as the International Federation of Catholic Medical Associations (FIAMC), the International Committee of Nurses and Medico-social Assistants (CICIAMS), and the International Federation of Catholic Pharmacists (FIPC). I believe that if we want to provide an example of evangelical engagement and be more effective and up-to-date, it is indispensable to work strongly united since care for the sick is either team work or it is bad care. We all have a wholeness, we cannot have ourselves seen as pieces, and this is necessary to explore and treat specific illnesses – hence specialisation – taking into account the totality of the person.

5. What members of the lay faithful need and hope from the Church

We Catholic lay professionals need the Church to give us its support so as not to fail in our task of evangelising the world. We want 'to be in the world without being of the world', as Jesus said. Because of the fact that we live on the frontiers of science, of culture and of the world of health and health care, we need nearness, to be listened to, support, dialogue, appreciation, trust, fraternal correction, empathy, spirit, friendship and shared prayer. We need our pastors to be unafraid of dialogue between faith and science and between faith and culture, to help us in Christian discernment in our work in the world and not to demonstrate towards us attitudes involving an intellectual theoretical rigidity that is far from emotional intelligence. We need them not to leave us on our own but to rely upon our opinions without wanting to impose subjective criteria upon us. And we need to grow together as adult persons as a result of integral, theological and pastoral formation.

6. The Association of Christian Health-Care Professionals: PROSAC

With humility I offer you, as a example, the experience of the Association of Christian Health-Care Professionals (PROSAC) which was created in 1993 by the Spanish Bishops' Conference as an ecclesiastical public association.

The preamble to our statutes reflects what Christian health-care professionals are and what they want to be: 'United by the Lord in baptism, united by the same faith and vocation and, as the Church, we Christian health-care professionals want to perform in the world of health and illness the mission that Jesus, in his Church, has entrusted to us: to promote and care for the lives and the health of all human beings, to serve the sick with honesty, competence and dedication, to illuminate, starting from faith, the realities of care and the great questions that are raised in the field of our work, to pay special attention to the most abandoned sick people, and to commit ourselves to the achievement of a more human world of health in which the whole of the person and every person is recognised and helped, and whose rights and dignity are respected. We want to practise and live our profession as an authentic Christian vocation, without dissociating it from faith; we want to develop our community and ecclesial spirit, and promote the interdisciplinary character of our activities and be in communion with the whole of the people of God, open to cooperation with those who work in the world of health and health care'.

The *aims* of our association are: 1. to promote a Christian laity involved in health and health care which bears evangelical witness in its professional action; 2. to create programmes and settings for encounter, reflection and action for Christian health-care professionals; 3. to help health-care workers in their human, spiritual and religious development and as regards their formation in the field of bioethics; 4. to cooperate in the promotion of health, in integral care for the sick and in the humanisation of health care at all levels; and 5. to contribute to the defence of the rights of people, whether they are well or sick, without any form of discrimination for any reason.

The *most significant characteristics* of our association are as follows:

a) Its *interdisciplinary character*, that is to say that medical doctors, qualified nurses, clinical auxiliary workers, administrators, porters and all the professions that work in health care at the service of sick people can be members of it. The Christian aspect comes before the professional aspect and in addition medicine, today, is team work. However, this does not obstruct the fact that every member speaks and acts from his or her own personal and professional point of view. For that matter, the statutes of the association envisage the creation of sections (medical doctors, nurses, pharmacists and other professionals) which have the function of being able to work with other international associations, being part of the federations to which they belong.

b) Its link with *pastoral care*

in health and the organisations of that pastoral care, whether diocesan, inter-diocesan or national in character. Without neglecting problems of a technical, scientific or work character, they try to live in communion and to work together with all those who, in the Church, evangelise the world of health and health care

c) *Its emphasis in local areas*, that is to say the fact of promoting the work of members in their principal places of work so as to be yeast in the dough. The principal activity of members is the local action of evangelisation 'through direct contact'.

7. Proposals and Future Prospects

I believe that at the present and in the near future associations of Catholic lay people will be the key to a turning point in evangelisation and the growth of the Church, especially in the world of health and health care where at the present time its professionals are not for the most part united. For this reason, I suggest: giving relevance to personal witness and witness at the level of associations in the health-care world; fleeing from every temptation to obtain fame and the exercise of power; being 'authorities and not powers'; encouraging the integral formation of Christian health-care professionals, having Jesus as a model for life and a source of health and salvation; establishing ties with professional societies, with universities and with centres for ongoing professional training; fostering spirituality in Christian lay people; welcoming unconditionally all the people that draw near to us; seeking to attract young people by entering into contact with universities and centres for professional training, meeting them, listening to them and accompanying them – it is to these young people that we must consign witness and it is they who in the future will take care of us in health care and in the Church; appreciating, recognising and promoting the role of women in the world of health and in the Church – one of the signs of the times today is the recognition of the parity of the rights of men and the rights of women; illuminating the ethical question of the daily work of health-care professionals, which constitute the vast majority of the problems they encounter and to which at the present time little attention is paid; promoting and supporting the presence of Catholic health-care professionals in health-care bodies; using to a greater degree and in a better way modern means of communication (web pages, social networks, etc.), together with an up-to-date language; working in close connection and cooperation with pastoral care for health in the Church and in dioceses, cooperating with the services of religious assistance of health-care centres and in the teams for pastoral care in health in parishes; strengthening relationships between the associations of the world of health and health care (the laity, chaplains, health-care religious) and relying upon them and their points of view: the exchange of information, documentation, cooperation in shared tasks, periodic meetings, etc.; and encouraging an interdisciplinary approach which is absolutely essential for high quality health-care assistance. For this reason we propose the creation of a *federation of the various associations that exist in the health-care world*: an association of Catholic medical doctors, an association of nurses and Catholic social assistants, and an association of Catholic pharmacists.

I will end my paper with a *prayer* of the health-care professional which I invite you to say with me:

Lord, you chose me
To treat and help the sick.
I want to be, like you,
Welcoming with everybody,
And in a special way with the most defenceless,
Sensitive to their sufferings,
Patient with their limitations,
And freeing them of their fears.
Cure, Lord, my illnesses.
Accept my limitations.
Relieve my tiredness.
And strengthen me in my weakness.
Help me to be a good professional,
Competent in my work,
Human and ready to serve.
Bless the sick,
And bless health-care personnel!
Amen. ■

Note

[1] Commissione Episcopale di Pastorale della Conferenza Episcopale Spagnola, *L'assistenza religiosa nell'ospedale. Orientamenti pastorali* (EDICE), pp. 31-32.

The Raoul Follereau Foundation

MR. MICHEL RÉCIPON
President of the Directorate of the Raoul Follereau Foundation, France

Allow me first of all to express my gratitude – and also my joy – to you at the opportunity that has been offered to me to be with you today on the occasion of this seminar which brings to a close the twenty-fifth anniversary of the Motu Proprio 'Dolentium Hominum' by which the Pontifical Council for Health Care Workers was established. I am equally happy to have the privilege to describe the Raoul Follereau Foundation.

I thank you, Most Reverend Excellency Msgr. Zigmunt Zimowski, for the honour that you have given me of being able to take part in this important event.

But how can I speak about our organisation without remembering its founder, Raoul Follereau, the vagabond of charity?

A poet from an early age, he was only twenty years old when he published his first novel, *The Other Dream*. The preface to this work contains the Christian ideal, the commitment of a man of letters, and the struggle of the future man of action: 'To those who have never suffered, we do not want to speak of those who suffer… We want to say to those who have no pity because they do not know what suffering means: misery exists ! There are human beings who are hungry, hungry for peace and sleep, human beings who suffer, who weep… You happy ones, who have peace and faith, reach out a helping hand to your miserable brothers, whose only crime is be poor in money or in their souls… Perform a miracle: give back LIFE. Love! Love, because God is Love!'

Throughout his life Raoul Follereau called for a revolution in mentalities, the inversion of mentalities. Revolt, he used to say, so as to contribute to 'transfiguring' the world by placing yourself at the service of hope and of charity.

In 1927 he founded the League of the Latin Union to defend Christian civilisation against all forms of paganism and all forms of barbarity.

A reportage in North Africa in the footsteps of Charles de Foucauld was transformed into an interior retreat, into a spiritual encounter. The Knight of the Sands became a model for Raoul Follereau who mobilised himself to collect the funds that were needed to build a church in El Golea and chapels in Adrar and Timimoun.

Another decisive encounter during that trip was with people with leprosy. Raoul Follereau discovered the prejudices of which they were the victims, and also their dramatic fate: 'That was the day when I learnt that there existed an unforgiveable crime, connected with I do not know which punishment, a crime without appeal and without an amnesty – leprosy!'

In 1937 our founder gave the League of Latin Union the name of the 'Charles de Foucauld Foundations' and launched the first initiatives in favour of people who were poor in money and in their souls.

In December 1942 he created the Christmas of Fr. de Foucauld when he invited every child to put a third sock on the fireplace and share his or her presents with a more disadvantaged child.

On the Good Friday of 1943 he launched the Hour of the Poor and he asked everyone to give to charity at that time when Charity was born, an hour of a person's wage, income or earnings, in order to come to the help of the most unfortunate.

The first year he gave his first lecture – he would in all give 1,200 lectures – to help the Sisters of Our Lady of the Apostles to build the first village for lepers in Adzopé, in the Ivory Coast.

During the same period the Charles de Foucauld Foundations became the Order of Charity.

The work of Raoul Follereau acquired a universal dimension. He went round the world, in all, thirty-three times. He helped, he worked, he appealed, and he created impulses of charity. He influenced public opinion so that it would become aware of its role in the world and would not withdraw in the face of misfortune.

In 1954 he established the World Leper's Day in order to render less dramatic a disease which everybody agreed was incurable. He invited people to engage in a general mobilisation of minds and hearts, thereby creating ties between people who were habitually separated by everything.

The fifty-eighth edition of this World Lepers' Day has just been celebrated, that is to say last week. It brought together 30,000 Follereau volunteers throughout France who for three days informed and sensitised people, inviting them to active compassion and to the gathering of the funds needed to identity, treat and reintegrate with leprosy.

In 1968, Raoul Follereau entrusted his spiritual son and successor, André Récipon, my father, to carry on his work, to organise it and advance it to address future challenges. He brought together in the same organisation all the initiatives and associations that had been created through the impulse of the vagabond of charity, that is to say the future Raoul Follereau Foundation.

Faithful to the message and the orientations of the founder, administered voluntarily, animated by a paid team and supported by an important militant force, the Raoul Follereau Foundation is based today on three great principles: independence, long-term commitment, and the use and training of local capacities.

In placing the person, whatever his or her origins, at the centre of all its activity, it provides support for treatment, education, training and reintegration, and accompanies the most forgotten along the pathway of their autonomy.

Indeed, its mission is to fight leprosy but also to fight against other kinds of leprosy, such as ignorance and poverty, which stigmatise their victims and condemns them to exclusion.

At the present time this fight is to be found in thirty-nine countries, through four hundred projects supported by 150,000 donors who help us to promote charity without frontiers because the weapon by which to win this war against hunger, acute poverty, illness and ignorance, is specifically, Charity!

It is through charity that will be built, stone after stone, that world that is more just and more human, that world without forms of exclusion – that is to say without forms of leprosy – to which we aspire.

The battle against leprosy remains a priority for us. We wage it in coordination with the other associations that make up the International Federation for the Fight against Leprosy (IFFL) of which we are the founding members.

Once this scourge as a problem of public health care has been eliminated, the identification and early treatment of people with leprosy remains the key point of our action. However, faced with a relevant number of multi-bacterial diseases – which are the most contagious of all diseases – and of gravely handicapped afflicted people, we strive to help the countries where this disease is endemic to develop activities that aim at early identification, prevention and the re-adaption of those who have had it. We also support the Raoul Follereau national associations in order to generate initiatives that foster self-sufficiency and facilitate the reintegration of people who had the disease for a long time and have been healed – people who are at times invalids – into society.

For seventeen years the Foundation has played an important role in the fight against another mycobacterium, a cousin of leprosy: Buruli's ulcer. In particular, attention has been paid to improving the treatment of those afflicted with this disease and to the financing of research.

In particular, the Foundation support programmes that led in less then ten years to the sequencing of the genome of *Mycobacterium ulcerans*, to knowledge about some of its vectors, and above all to the creation of an anti-biotherapy that allowed a decrease of one half in surgical operations.

But in order to deal with constraints in the field and to facilitate access to treatment, the Foundation at the present time finances the creation and the testing of a therapy taken orally, a therapy which is more tolerable than the therapy administered by injection.

Lastly, in Pobé in Benin we have just finished the extension works which will allow the Raoul and Madeleine Follereau Centre for the diagnosis and treatment of Buruli's ulcer to develop its activities at a high level at the service of patients of all origins and situations.

These diseases are not very concerned about the social situation of their victims but they do afflict more grievously those people who live in disadvantaged regions which are far from the most elementary dispensaries. Poverty is a great ally of leprosy. We are thus obliged to make leprosy withdraw as well, basing ourselves on two columns built as a result of our experience: the training of the actors of development and the creation of micro-projects which generate earnings.

In our own small way we strive to foster the birth of development with a human face, supporting simple and pragmatic actions in order to help marginalised and forgotten populations to escape from hunger, from illiteracy and from acute poverty.

In France, as well, we give hope to those who are excluded because of the loss of employment. Applying in rural areas a concrete answer to the problem of unemployment, we have already helped hundreds of people to create or resume economic activity in this environment. Some people in very precarious situations received financial help which allowed them to set their own micro-company. Through this action we pursue three objectives: we contribute to beating back leprosy as it draws near to our doors; we allow families to start afresh; and we take part in the support for shops or small workshops in small communes in France.

But it above all for young people that Raoul Follereau made himself an apostle for a world without forms of leprosy.

For the committed intellectual, for those who stimulate consciences, ignorance is perhaps the worst form of leprosy. Whatever the case, it is ignorance that most certainly condemns to exclusion those children of war, of acute poverty and of the streets, that we encounter in our journey.

For them, for more than ten years, we have gradually encouraged the Follereau donors and volunteers to place education at the centre of our priorities. In remaining faithful to people with leprosy we have thus opened up a front against ignorance.

In practical terms we contribute to the construction, the renewal and the working of school and semi-school institutes. We support sponsorships, libraries, street cultural laboratories…, and abroad and also in France everything which in one way or another helps a child to become the actor of his or her own life and the architect of tomorrow's world.

In this great change that makes no noise we have partners who are reference points! In giving their lives to Christ, in trying to follow him by placing themselves at the service of the poorest, religious are our military wing in many fields.

We help them to anchor hope in the most disorientated hearts, to give hope and instruments once again to make them believe in the future and fight disease, against ignorance and against poverty. We are at their side in order to help them, if this is needed, so that acute poverty is not an obstacle to their vocation and their mission.

Thus in our small way, in founding a certain number of dispensaries and innumerable works run by the Church in the world, we bind the same wounds, alleviate the same sufferings, and fight the same forms of discrimination.

Through conviction and through the force of faith, the dream of Raoul Follereau has become a reality.

This is a question of commitment, of free self-giving, of chang-

es in mentality; a world without leprosy is on the move. How productively laborious is charity in truth!

People with leprosy are the first beneficiaries. They are followed, without any form of discrimination, by every human being who, like them, is despised and rejected because of ignorance and poverty.

For each one of them we also appeal to solidarity in order to assure justice and love for everyone.

The heirs of Raoul Follereau, who proclaimed that 'a leper suffers because he has leprosy and is a leper at the same time', we believe, like H.E. Msgr Zimowski, that 'a human being cannot be reduced to his body alone'.

Each of the projects that we support bears this conviction and this hope.

Each one of them confirms out commitment to the construction of a just and fraternal social order with the access of everyone to health, to knowledge and to dignity.

These rights are sacred and inviolable to the point of requiring as a counterpart the obligation to defend them: the right of one person becomes the duty of another.

This assumes facing up to prejudices, to instability, to indifference, to bad governance, to corruption and to everything that tends to work against the right of every individual to a worthy existence.

Fear and loneliness can weigh very heavily on the shoulders of our partners. For this reason, the ties that unite us go beyond mere financial support and express authentic accompanying and a shared fight in order to try to alleviate the suffering of the world.

Thus, together, we contribute our stone to the building of a world without forms of leprosy, to the edification of Civilisation of Love!

Thank you for listening to me. ■

The New Challenges for Cooperation between Catholic Health-Care Associations

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The importance of cooperation between Catholic health-care association in the promotion of the culture of life is very clear. On the other hand, however, the belief is growing that more should be done. This applies in particular when an overall view of the contemporary world and the capacities of the present media is engaged in. With respect to a new culture of life, one need only refer to the fourth chapter of the encyclical *Evangelium vitae* where John Paul II encourages a decided commitment connected with the new evangelisation: 'Evangelization is an all-embracing, progressive activity through which the Church participates in the prophetic, priestly and royal mission of the Lord Jesus… This is also the case with regard to the proclamation of the *Gospel of life*, an integral part of that Gospel which is Jesus Christ himself. We are at the service of this Gospel, sustained by the awareness that we have received it as a gift and are sent to preach it to all humanity, "to the ends of the earth" (Acts 1:8). With humility and gratitude we know that we are the *people of life and for life*, and this is how we present ourselves to everyone (*EV*, n. 78).[1]

The importance of the mission of Catholic associations, as well, is strongly stressed by John Paul II himself: 'If charity is to be realistic and effective, it demands that the *Gospel of life* be implemented also by means of *certain forms of social activity and commitment in the political field*, as a way of defending and promoting the value of life in our ever more complex and pluralistic societies. *Individuals, families, groups and associations*, albeit for different reasons and in different ways, all have a responsibility for shaping society and developing cultural, economic, political and legislative projects which, with respect for all and in keeping with democratic principles, will contribute to the building of a society in which the dignity of each person is recognized and protected and the lives of all are defended and enhanced' (*EV*, n. 90).

This article seeks to present discuss certain strategies of the last century, the enemies of human life which are seen as challenges for cooperation between Catholic health-care associations, as well as a summarising description of certain experiences in favour of life in Slovakia. It also proposes a model for cooperation at an international level.

The Eastern General Plan

In the years 1941-2, according to the government of that time, the German nation, seen as being 'without living space', was justified in its settlement and Germanisation of the 'Eastern occupied territories'. This vision was strengthened by the hope that there would be a very rapid military success, as had been the case in France and Poland. The government of the United States of America was also convinced that the resistance of the Soviet Union

would last for only a short time. This encouraged the authors of the Eastern General Plan to great commitment to the achievement of their intentions. One of the problems for the Germanisation of the 'Eastern living space' was the existing population which had not been eliminated by the war, political persecution or the systematic liquidation of the Jews. Thus the 'extraordinary biological strength of the reproduction of neighbouring peoples in the East' showed itself to be very dangerous. For these reasons, in addition to evacuation and deportations, demographic-political solutions were also drawn up.[2] In the proposals that were drawn up it was emphasised that the birth rate of the Russian zone had to be below the German birth rate. Through the press, radio, television, films, leaflets and public lectures etc., the belief had to be created that it was dangerous to have children. It was necessary to show the costs connected with the raising of children and also what it was possible to obtain with money that was saved. Through this propaganda, a strong campaign had to be organised directed towards the spread of contraceptives which would be supplied through mass production. The propagation and the spread of contraception and abortion were not to be punished. In this plan, the creation of institutions specialised in abortions, the propagation of voluntary sterilisation and divorce were recommended. Victory in the field of births would be achieved when the Russian population was convinced of the advantages of having one or two children. In the plan it was also observed that the Germans could not be interested in increasing the non-German population in the occupied territories.[3]

The Szeged Declaration

On 25-27 October 1993, in Szeged (Hungary), the representatives of governmental, inter-governmental and non-governmental organisations of sixteen countries of Central and Eastern Europe (Albania, Armenia, Bulgaria, Croatia, Estonia, Georgia, Latvia, Lithuania, Poland, the Czech Republic, Romania, Russia, Slovenia, Slovakia, the Ukraine and Hungary) held a meeting. This meeting sought to assess research and services in the field of reproductive health and cooperation in supporting reproductive health in the various populations of these countries. This meeting was organised together with the International Committee for Research in Reproduction (ICRR) in Geneva, the World Health Organisation (WHO), and the Collaborating Centre for Research in Human Reproduction in Szeged, with the technical help of the United Nations Development Programme (UNDP), the United Nations Population Fund (UNFPA), the World Bank, and the WHO Special Programme of Research, Development and Research Training in Human Reproduction in Geneva. Those taking part drew up the Szeged Declaration which analysed reproductive health in the region, identified the problems in this field and proposed fourteen recommendations. Amongst these last were to be found, in particular, the following: assuring a high use of contraception: drawing up national plans for planned fatherhood with high quality services, in particular safe abortion; helping sex education in schools; encouraging women and men as regards surgical sterilisation; involving governmental and non-governmental organisations; and facilitating cooperation and communication in the field of reproductive health between countries of the region. Two bodies, the International Committee for Research in Reproduction in Geneva and the Collaborating Centre for Research in Human Reproduction in Szeged, took the initiative in the coordination of cooperation between the organisations that were at the meeting, as did other organisations with similar aims.[4] The meeting at Szeged and the Szeged Declaration were seen as a preparation at a regional level for the international conference of the UN on population and development which was held in Cairo in 1994.

But how was it that in another historical and peaceful context the same strategy was arrived at against human life as that of the Nazi period? Why was it that the same methods wanted by the Nazis were used? Why was it that a general protest and condemnation was not heard?

Some Examples from Slovakia

a) Programmes of sex education

After the Velvet Revolution (1989), Slovakia became a witness to attempts to introduce practices into daily life that could have had very negative and long-term consequences. Experiments have intensified over recent years. One is dealing here with repeated attempts to introduce liberal sex education into state education at all levels. The first attempt goes back to the middle 1990s: with the approval of the Ministry of Education of the Slovak Republic, teaching programmes and videocassettes were prepared and distributed for all kinds of schools. Thanks to lay people involved in the field of health care and in particular to the Slovak Bishops' Conference a successful attempt was made to block the introduction of liberal sex education and all the programmes were withdrawn from schools. In 2004 the Ministry for Health committed itself to introducing the National Programme for the Protection of Sexual and Reproductive Health and this was proposed again in the years 2007, 2008 and 2009 under the title 'National Programme for the Care of Women, Safe Motherhood and Reproductive Health.[5] It involved not only information on sexual diseases but also the encouraging and the teaching of the use of contraceptives, in particular the condom, and 'services' of sexual and reproductive health were also recommended: contraception of all kinds, safe abortion, surgical sterilisation, etc. And naturally enough everything was to be financed by public funds. In these campaigns the representatives of the Slovak Society for Planned Paternity (a faithful child and member of the IPPF) took part, and the same was true of radical feminists. Both categories were very arrogant. Once again, with the close cooperation of involved lay people, Catholic associations and the Slovak Bish-

ops' Conference managed to block all these attempts. In short, the programmes of sex education have already been completely drawn up and it is a matter of only seeking the ways and the suitable moment to introduce them into daily life…

b) The UNFPA

In the year 2000 the United Nations Fund for Population Action (UNFPA) wanted to have its Regional Office for the countries of Central and Eastern Europe and Central Asia located in Bratislava. This concern was also supported by certain members of the then government of the Slovak Republic, but this office was not created. On 14 January 2009 the government of Slovakia decided that the Regional Office of the UNFPA could have its headquarters in Bratislava and its activities were to have begun on 1 July 2009. The government delegated the Minister for Foreign Affairs to sign a contract between Slovakia and the Fund for Population. The government wanted to offer about 150 officials of the UNFPA appropriate space, and committed itself to equipping all the offices and paying the yearly rent of about 215,000 euros. It is known that the UNFPA propagates abortion, sterilisation and contraception and is seen as an anti-Christian and anti-Catholic institution from the point of view of the value of human life, the family, responsible procreation and the responsible upbringing and education of young people. It is very interesting that 39 countries applied diplomatic pressure for the office to be in Bratislava. During the plenary session of the Slovak Bishops' Conference (16-17 March 2009) a letter to the Prime Minister was drawn up and handed in and he was called upon to eliminate the Regional Office of the UNFPA. In May 2009 Msgr. F. Tondra, the President of the Slovak Bishops' Conference informed all the Bishops' Conferences of Europe and the representatives of the Orthodox Churches of Central and Eastern Europe on this situation, asking for solidarity and help for Slovakia.

He received encouraging answers from many European Bishops' Conferences. After many initiatives and close cooperation between Catholic institutions and other representatives of the Catholic hierarchy, in June 2009 the government decided that given the economic and financial crisis it could not assure the financial resources for the Regional Office and it cancelled its previous decision. At the plenary meeting of the European Bishops' Conference in Paris (October 2009) the initiatives of the Bishops' Conference of Slovakia were appreciated and all the European Bishops' Conference were invited to engage in close cooperation in other fields as well.

c) The Metropolis mega-casino of Bratislava – Petržalka

In 2010 the idea was to begin the construction of the largest complex of gaming houses and entertainment in Europe on the outskirts of Bratislava. It was assumed that the building works would last between three and five years. This complex was to have been on a surface of about thirty hectares, located on the border with Austria and Hungary, on the crossroads of the motorways from Hungary to the Czech Republic and from Austria, and of a value of about 1,500 million euros. Three or four years ago, the same American group, Harrah's Entertainment (to which belong similar complexes in Las Vegas and other parts of the world), had a project rejected in Slovenia, near to the frontier with Italy and Austria. The project in Bratislava-Petržalka was supported by the former Minister of Finance whose intention was the strengthening of tourism and promoting jobs. This complex included a number of restaurants, three hotels, a golf course and wellness, congress centres, a multifunction hall, shops (a shopping centre), galleries, an aquatic park and the largest casino (in an American style) in the whole of Europe with over 500 places for slot machines. During the building of this complex it would have been possible to create about 20,000 jobs, after the completion of the complex about 9,000 new permanent jobs, with 600 euros in tax revenues every year for the state budget. It was expected that the complex every year would be visited by about five million people.

Naturally enough, this complex would also have had very destructive and long-term consequences for moral life in Slovakia and neighbouring countries. It could certainly have increased compulsive gambling, with serious damage for many individuals, with the destruction of many families, with a massive spread of drugs, drug addiction, prostitution, Mafia-style activity, organised crime, etc. In December 2009 a petition was launched which spread throughout Bratislava and then the whole of Slovakia, and this obtained more than 125,000 signatures, as a protest against the construction of this complex. At the beginning and in the development of the petition certain Catholic and civil associations were very active, in particular *Fórum života* (The Forum for Life). In this case as well some representatives of the Bishops' Conference of Slovakia were involved. In November 2010 a majority of parliament voted in favour of the petition and thus blocked the construction of the complex.

d) The culture of death

This has, unfortunately, its representatives in Slovakia as well. There are over twenty non-governmental institutions and organisations which through their programmes are against human life and dignity, and in particular are against conceived life and unborn life. The most active of these are: the Slovak Society for Planned Fatherhood – a member of the IPPF –, the IPPF, the Centre for Reproductive Rights, Pro-Choice, the Slovak Ženská Lobby (a women's lobby in Slovakia), Gender Mainstreaming and organisations that propagate homosexuality. The initiatives of the culture of death, and in particular those in favour of abortion, contraception and homosexuality are sponsored by certain private organisations, for example Soros – The Open Society Fund – and institutions in Slovakia and a number of countries such as the United States of

America, the European Union, Denmark, Norway, Lichtenstein, Iceland and the Czech Republic.

The institutions and the organisations of the culture of death and their activities in Slovakia are monitored by the Leo XIII Institute. This was founded in May 2009 and began to work publicly on 17 November 2009 – twenty years after the Velvet Revolution when the European Court for Human Rights created the Lautsi case which was directed against crucifixes in Italian schools. The European Union has clearly shown that it has an anti-Christian stance. The Leo XIII Institute is an association of young lay Catholics who want to mobilise Slovak society to protect the culture of life, the Church, and the nation.

e) The culture of life – Fórum života (The Forum for Life)

The Forum for Life is a non-governmental association that was founded in 2001 and brings together 38 organisations and tens of individuals. It aims at respect for, and the protection of, every human life from conception to natural death and promotes support for the family. The Forum for Life has activities in three fields: prevention, advocacy and concrete help. Amongst its various projects, the following should be emphasised: 1) 25 March – Day of the Conceived Child. This is a national campaign which seeks to propagate respect for every conceived and unborn child. An external sign of this campaign is a white strip worn on jackets for the whole of the week of 15 March. Those who wear a white strip demonstrate their respect for every conceived child. A part of this national campaign is an international conference entitled: 'Choose Life'. 2) The Anton Neuwirth Protector of Life Prize. This prize is awarded every year to a personality from Slovakia, to a personality from abroad and to an organisation for merits in the defence of life. 3) The candle for unborn children. This campaign is organised on 2 November (the commemoration of all deceased faithful) throughout Slovakia and seeks to remember all babies killed through abortion and babies who died because of miscarriages, with encouragement for the children of these latter.

Further cooperation

It has been observed that the strategies against human life are very well organised and always generously financed. This reality should be a very important challenge for Catholic health-care associations as well. Usually, at a national level one notices the lack of an overall vision. Faced with a concrete problem, he following kinds of questions are heard: what do other countries do as regards this problem? How have they faced up to it? With whom and how should one cooperate? How and where should the experience that has been acquired be applied?

As regards the defence of human life we are at war and we will be at war until the end of the world. In war it is very important to understand the strategy of the enemy and those who work with him. In a few words, in today's world one must know who is who, how he works, with whom and how one should work, with all of this being animated by the culture of life. And for this reason, it is very important to create a number of centres in various places in the world that could observe the activities and the strategies of the institutions and organisations involved in the culture of death and, on the other hand, could observe the activities and the strategies of the institutions and organisations involved in the culture of life. Initiatives connected with the culture of life could be useful not only as information but also as motivations for activity in other places. These centres could between them create an international network with the exchange of information. In this way, one could hope that the sophisticated strategies of the culture of death can also be perceived in other parts of the world and one can strengthen the culture of life. Catholic health-care associations could provide very effective help in this field.

Conclusion

As we have seen, unfortunately, in the fight against human life any ideology, such as Nazism, Communism or Liberalism, is acceptable. One may observe that the strategies have been similar. For this reason, the culture of life needs and will need every finger, every hand, every head and every heart. Only with the Lord of life and working to together can we do much more. In this approach we are also encouraged by Benedict XVI who in *Caritas in veritate* writes: '*God's love calls us to move beyond the limited and the ephemeral, it gives us the courage to continue seeking and working for the benefit of all*, even if this cannot be achieved immediately and if what we are able to achieve, alongside political authorities and those working in the field of economics, is always less than we might wish. God gives us the strength to fight and to suffer for love of the common good, because he is our All, our greatest hope' (*CiV*, n. 78). ■

Notes

[1] In another place of the same encyclical John Paul II continues: 'By virtue of our sharing in Christ's royal mission, our support and promotion of human life must be accomplished through the *service of charity*, which finds expression in personal witness, various forms of volunteer work, social activity and political commitment. *This is a particularly pressing need at the present time*, when the "culture of death" so forcefully opposes the "culture of life" and often seems to have the upper hand'. In *Caritas in veritate* Benedict XVI suitably emphasises, along the same lines: 'Yet we must not underestimate the disturbing scenarios that threaten our future, or the powerful new instruments that the "culture of death" has at its disposal' (*CiV*, n. 75).

[2] 'Generálny plán Východ (Dejiny sa nikdy neopakujú?)', in *«Kultúra smrti» versus «kultúra života» – súčasná situácia, súčasné potreby, súčasné možnosti – Zborník prednášok, Eds. Konferencia vyšších rehoľných predstavených na Slovensku – Konferencia vyšších predstavených ženských rehôľ na Slovensku: Košice, 12.11.2010, Príloha 3.*

[3] ‚Generálny plán Východ (Dejiny sa nikdy neopakujú?)', in *«Kultúra smrti» versus «kultúra života...»,* p. 3.

[4] 'Szegedská deklarácia', in *«Kultúra smrti» versus «kultúra života...»,* pp. 1-6.

[5] Cf. Ďačok, J., *'Úvod k slovenskému vydaniu',* in Schooyans, M., Evanjelium. Ako čeliť svetu v rozvrate?, (Inštitút Leva XIII, Bratislava, 2010), p. 18.

Conclusions

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The conclusions of this closing seminar of the twenty-fifth anniversary of the institution of the Pontifical Council for Health Care Workers cannot certainly claim to capture the richness of this day, with its various moments and various papers. However, I believe that it is useful to refer to its profound meaning, to refer to some elements that emerged, and to suggest some undertakings within the perspective of a continuity of our service and our journey.

1. The Meaning of the Celebration of the Twenty-Fifth Anniversary of the Institution and Life of the Pontifical Council for Health Care Workers

It is important to ask oneself, first of all, who and what have we sought to celebrate and why? The beginning of this day, with the celebration of the Eucharist, presided over by H.E. Msgr. Zigmunt Zimowski, helped us immediately to understand the meaning of our 'celebrating'.

We have celebrated, and we have sought to celebrate, the God of life and the source of life. The mystery of God, as mystery of life and love. And, within and in the light of the mystery of God, we have celebrated the mystery of man, of our lives, which share in the Easter of the Lord Jesus and are redeemed and saved in him.

We have celebrated in order to give thanks, to live the present illumined by the faith, so as to construct the future in hope.

We have celebrated in the mystery of the Church, as mystery of communion and of mission. In the Church: the people of God, rooted in the communion of God: Father and Son and Holy Spirit.

We have celebrated in the Church, the sign and instrument of the love and care of God towards every one of his children. A Church that has as her path to follow and travel that of her Teacher, Jesus Christ. The pathway of the Incarnation which was chosen by him as the taking on of our humanity with all its frailties, with the exception of sin; the pathway of service and total self-giving, under the sign of full gratuitousness.

Such are the riches of our 'celebrating' which, while it makes us feel immersed in the mystery of the God of Love, also makes us feel inseparably immersed in the mystery of man so as to take care of all our brothers and sisters.

2. Catholic Associationism: the Role of the Christian Laity in the World of Health and Health Care

In the light of the Church which celebrates and her mysterious dimension, which has just been referred to, one can have a better understanding of the role of Christian lay people in the world of health and health care, both as a personal commitment and as a commitment expressed through Catholic associations.

This is a subject on which we have been able to reflect, with the sharing of experiences, of problems and of interesting prospects: riches that cannot be summarised within the limitations of a conclusion.

However, it seems to me to be appropriate to emphasise how important elements have emerged which should be taken up so that they can continue to be reflected on the different realities in which we live and work, so as to renew ourselves internally as regards our motivations, and then plan by small steps a growth in quality and incisiveness.

I will refer to only some of the needs that have emerged:

– The need to be 'authentic' and 'true', without occasional 'masks' or other interests;

– to be more united and open to cooperation, both within individual associations and between different associations, and as openness to the whole of the Church;

– to be capable of service and free giving;

– to be true witnesses to a care for the lives and the health of people which is based upon love, upon high quality, and upon a spirit of service and gratuitousness;

– to grow in a spirit of catholicity and missionary endeavour.

It is self-evident that all of these values and approaches should be lived at the level of daily life and that membership of a Catholic association involved in the world of health and health care should be interpreted and experienced as 'being yeast' that is positive in innovation, and not as membership of a 'power group' for one's own self-interest.

In particular, those associations that are present here today with their representatives at an international level (the association of Catholic doctors, Catholic pharmacists, Catholic women nurses) have laid emphasis on the need for ongoing training pathways at a variety of levels.

I believe, however, that other realities and other subjects should not be forgotten, new ones as well, which interact in health care (associations of social/health-care volunteers, social workers, psychologists, administrators, people involved in various ways and with different services in care and assistance…).

Equally, I wish to stress the need for the paying of especial attention today to the various health-care structures and institutions based on the Gospel which are undergoing times and condi-

tions that are difficult. As well as the need to develop at an international level as well an International Association of Catholic Health-Care Structures and Institutions.

3. Some Special Concerns

In order to develop and make more responsive 'pastoral care in health', in which everyone feels involved, and in continuity with the various needs that have already emerged, it may be useful, in conclusion, to refer in an essential way to certain concerns and commitments:

a. Helping the faithful to rediscover the gift of faith as a missionary vocation and a vocation of service that is rooted in baptism. A Christian is asked, both at a personal level and at the level of his or her Christian community, to re-transcribe 'the parable of the Good Samaritan in the communication of the suffering of the love of healing and the consolation of Jesus Christ' (*CL*, n. 53).

b. In the world of health and health care the presence and the action of people who are trained and qualified at a spiritual, pastoral and professional level is increasingly necessary.

c. We should promote coordination and practical cooperation between the various associations that act in the health-care world and health care, overcoming the risk of forms of personal interest or an exaggerated interest in efficiency, so as to open up to a sense of community and of belonging to the Church.

d. We should appreciate more the 'World Day of the Sick' as a itinerary of education in Christian communities and as a stimulus and opportunity for dialogue and proposals in the health-care world and in civil society.

One thing is certain: only through a shared commitment and with a renewed hope rooted in that spring that is the Lord Jesus, the physician of bodies and souls, together and at all levels, can we contribute to pastoral care in health and to an integral care of health which educates and places the person at the centre of things and looks at the other, especially if sick and suffering, with the heart of God. ■

The Twentieth World Day of the Sick

11 February 2012

MESSAGE OF THE HOLY FATHER BENEDICT XVI
ON THE OCCASION OF THE TWENTIETH WORLD DAY OF THE SICK
(11 FEBRUARY 2012)

"Stand up and go; your faith has saved you" (Lk 17:19)

Dear Brothers and Sisters,

On the occasion of the World Day of the Sick, which we will celebrate on 11 February 2012, the Memorial of Our Lady of Lourdes, I wish to renew my spiritual closeness to all sick people who are in places of care or are looked after in their families, expressing to each one of them the solicitude and the affection of the whole Church. In the generous and loving welcoming of every human life, above all of weak and sick life, a Christian expresses an important aspect of his or her Gospel witness, following the example of Christ, who bent down before the material and spiritual sufferings of man in order to heal them.

1. This year, which involves the immediate preparations for the Solemn World Day of the Sick that will be celebrated in Germany on 11 February 2013 and will focus on the emblematic Gospel figure of the Good Samaritan (cf. *Lk* 10:29-37), I would like to place emphasis upon the "sacraments of healing", that is to say upon the sacrament of Penance and Reconciliation and that of the Anointing of the Sick, which have their natural completion in Eucharistic Communion.

The encounter of Jesus with the ten lepers, narrated by the Gospel of Saint Luke (cf. *Lk* 17:11-19), and in particular the words that the Lord addresses to one of them, "Stand up and go; your faith has saved you" (v. 19), help us to become aware of the importance of faith for those who, burdened by suffering and illness, draw near to the Lord. In their encounter with him they can truly experience that *he who believes is never alone*! God, indeed, in his Son, does not abandon us to our anguish and sufferings, but is close to us, helps us to bear them, and wishes to heal us in the depths of our hearts (cf. *Mk* 2:1-12).

The faith of the lone leper who, on seeing that he was healed, full of amazement and joy, and unlike the others, immediately went back to Jesus to express his gratitude, enables us to perceive that reacquired health is a sign of something more precious than mere physical healing, it is a sign of the salvation that God gives us through Christ; it finds expression in the words of Jesus: *your faith has saved you*. He who in suffering and illness prays to the Lord is certain that God's love will never abandon him, and also that the love of the Church, the extension in time of the Lord's saving work, will never fail. Physical healing, an outward expression of the deepest salvation, thus reveals the importance that man – in his entirety of soul and body – has for the Lord. Each sacrament, for that matter, expresses and actuates the closeness of God himself, who, in an absolutely freely-given way, "touches us through material things … that he takes up into his service, making them instruments of the encounter between us and himself" (*Homily*, Chrism Mass, 1 April 2010). "The unity between creation and redemption is made visible. The sacraments are an expression of the physicality of our faith, which embraces the whole person, body and soul" (*Homily*, Chrism Mass, 21 April 2011).

The principal task of the Church is certainly proclaiming the Kingdom of God, "But this very proclamation must be a process of healing: 'bind up the broken-hearted' (*Is* 61:1)" (*ibid.*), according to the charge entrusted by Jesus to his disciples (cf. *Lk* 9:1-2; *Mt* 10:1,5-14; *Mk* 6:7-13). The tandem of physical health and renewal after lacerations of the soul thus helps us to understand better the "sacraments of healing".

2. The sacrament of Penance has often been at the centre of the reflection of the Church's Pastors, specifically because of its great importance in the journey of Christian life, given that "The whole power of the sacrament of Penance consists in restoring us to God's grace, and joining with him in an intimate friendship" (*Catechism of the Catholic Church*, 1468). The Church, in continuing to proclaim Jesus' message of forgiveness and reconciliation, never ceases to invite the whole of humanity to convert and to believe in the Gospel. She makes her own the call of the Apostle Paul: "So we are ambassadors for Christ, as if God were appealing through us. We implore you on behalf of Christ, be reconciled to God" (*2 Cor* 5:20). Jesus, during his life, proclaimed and made present the mercy of the Father. He came not to condemn but to forgive and to save, to give hope in the deepest darkness of suffering and sin, and to give eternal life; thus in the sacrament of Penance, in the "medicine of confession", the experience of sin does not degenerate into despair but encounters the Love that forgives and transforms (cf. John Paul II, Post-Synodal Apostolic Exhortation *Reconciliatio et Paenitentia*, 31).

God, "rich in mercy" (*Eph* 2:4), like the father in the Gospel parable (cf. *Lk* 15:11-32), does not close his heart to any of his children, but waits for them, looks for them, reaches them where their rejection of communion imprisons them in isolation and division, and calls them to gather around his table, in the joy of the feast of forgiveness and reconciliation. A time of suffering, in which one could be tempted to abandon oneself to discouragement and hopelessness, can thus be transformed into a time of grace so as to return to oneself, and like the prodigal son of the parable, to think anew about one's life, recognizing its errors and failures, longing for the embrace of the Father, and following the pathway to his home. He, in his great love, always and everywhere watches over our lives and awaits us so as to offer to every child that returns to him the gift of full reconciliation and joy.

3. From a reading of the Gospels it emerges clearly that Jesus always showed special concern for sick people. He not only sent out his disciples to tend their wounds (cf. *Mt* 10:8; *Lk* 9:2; 10:9) but also instituted for them a specific sacrament: the Anointing of the Sick. The *Letter of James* attests to the presence of this sacramental act already in the first Christian community (cf. 5:14-16): by the Anointing of the Sick, accompanied by the prayer of the elders, the whole of the Church commends the sick to the suffering and glorified Lord so that he may alleviate their sufferings and save them; indeed she exhorts them to unite themselves spiritually to the passion and death of Christ so as to contribute thereby to the good of the People of God.

This sacrament leads us to contemplate the double mystery of the Mount of Olives, where Jesus found himself dramatically confronted by the path indicated to him by the Father, that of his Passion, the supreme act of love; and he accepted it. In that hour of tribulation, he is the mediator, "bearing in himself, taking upon himself the sufferings and passion of the world, transforming it into a cry to God, bringing it before the eyes and into the hands of God and thus truly bringing it to the moment of redemption" (*Lectio Divina,* Meeting with the Parish Priests of Rome, 18 February 2010). But "the Garden of Olives is also the place from which he ascended to the Father, and is therefore the place of redemption … This double mystery of the Mount of Olives is also always 'at work' within the Church's sacramental oil … the sign of God's goodness reaching out to touch us" (*Homily*, Chrism Mass, 1 April 2010). In the Anointing of the Sick, the sacramental matter of the oil is offered to us, so to speak, "as God's medicine … which now assures us of his goodness, offering us strength and consolation, yet at the same time points beyond the moment of the illness towards the definitive healing, the resurrection (cf. *Jas* 5:14)" (*ibid.*).

This sacrament deserves greater consideration today both in theological reflection and in pastoral ministry among the sick. Through a proper appreciation of the content of the liturgical prayers that are adapted to the various human situations connected with illness, and not only when a person is at the end of his or her life (cf. *Catechism of the Catholic Church*, 1514), the Anointing of the Sick should not be held to be almost "a minor sacrament" when compared to the others. Attention to and pastoral care for sick people, while, on the one hand, a sign of God's tenderness towards those who are suffering, on the other brings spiritual advantage to priests and the whole Christian community as well, in the awareness that what is done to the least, is done to Jesus himself (cf. *Mt* 25:40).

4. As regards the "sacraments of healing", Saint Augustine affirms: "*God heals all your infirmities*. Do not be afraid, therefore, all your infirmities will be healed … You must only allow him to cure you and you must not reject his hands" (*Exposition on Psalm 102*, 5; *PL* 36, 1319-1320). These are precious instruments of God's grace which help a sick person to conform himself or herself ever more fully to the mystery of the death and resurrection of Christ. Together with these two sacraments, I would also like to emphasize the importance of the Eucharist. Received at a time of illness, it contributes in a singular way to working this transformation, associating the person who partakes of the Body and Blood of Christ to the offering that he made of himself to the Father for the salvation of all. The whole ecclesial community, and parish communities in particular, should pay attention to guaranteeing the possibility of frequently receiving Holy Communion, to those people who, for reasons of health or age, cannot go to a place of worship. In this way, these brothers and sisters are offered the possibility of strengthening their relationship with Christ, crucified and risen, participating, through their lives offered up for love of Christ, in the very mission of the Church. From this point of view, it is important that priests who offer their discreet work in hospitals, in nursing homes and in the homes of sick people, feel they are truly "'ministers of the sick', signs and instruments of Christ's compassion who must reach out to every person marked by suffering" (*Message for the XVIII World Day of the Sick*, 22 November 2009).

Becoming conformed to the Paschal Mystery of Christ, which can also be achieved through the practice of spiritual Communion, takes on a very particular meaning when the Eucharist is administered and received as Viaticum. At that stage in life, these words of the Lord are even more telling: "Whoever eats my flesh and drinks my blood has eternal life, and I will raise him on the last day" (*Jn* 6:54). The Eucharist, especially as Viaticum, is – according to the definition of Saint Ignatius of Antioch – "medicine of immortality, the antidote for death" (*Letter to the Ephesians*, 20: *PG* 5, 661); the sacrament of the passage from death to life, from this world to the Father, who awaits everyone in the celestial Jerusalem.

5. The theme of this Message for the Twentieth World Day of the Sick, "Stand up and go; your faith has saved you", also looks forward to the forthcoming Year of Faith which will begin on 11 October 2012, a propitious and valuable occasion to rediscover the strength and beauty of faith, to examine its contents, and to bear witness to it in daily life (cf. Apostolic Letter *Porta Fidei*, 11 October 2011). I wish to encourage sick people and the suffering always to find a safe anchor in faith, nourished by listening to the Word of God, by personal prayer and by the sacraments, while I invite pastors to be increasingly ready to celebrate them for the sick. Following the example of the Good Shepherd and as guides of the flocks entrusted to them, priests should be full of joy, attentive to the weakest, the simple and sinners, expressing the infinite mercy of God with reassuring words of hope (cf. Saint Augustine, *Letter* 95, 1: *PL* 33, 351-352).

To all those who work in the field of health, and to the families who see in their relatives the suffering face of the Lord Jesus, I renew my thanks and that of the Church, because, in their professional expertise and in silence, often without even mentioning the name of Christ, they manifest him in a concrete way (cf. *Homily*, Chrism Mass, 21 April 2011).

To Mary, Mother of Mercy and Health of the Sick, we raise our trusting gaze and our prayer; may her maternal compassion, manifested as she stood beside her dying Son on the Cross, accompany and sustain the faith and the hope of every sick and suffering person on the journey of healing for the wounds of body and spirit!

I assure you all of a remembrance in my prayers, and I bestow upon each one of you a special Apostolic Blessing.

BENEDICTUS PP XVI

From the Vatican, 20 November 2011,
Solemnity of our Lord Jesus Christ, Universal King.

Keynote Address by Archbishop Zygmunt Zimowski on the Occasion of the Twentieth World Day of the Sick

ST CHARLES BORROMEO SEMINARY, WENNEWOOD, PENNSYILVANIA
SATURDAY, FEBRUARY 11, 2012

H.E. MSGR. ZYGMUNT ZIMOWSKI
President of the Pontifical Council for Health Care Workers, the Holy See

Your Excellencies, Reverend Fathers and all you health care workers. It is indeed a great honor for me to be here with you today, to celebrate this Twentieth World Day of the Sick, in the Archdiocese of Philadelphia. I would like to express my heartfelt gratitude to Archbishop Charles Chaput, for warmly welcoming the suggestion to celebrate this day with you, and at such a short notice working around the clock to make this event possible. I thank those who have worked closely with him, making all the necessary arrangements, especially the Auxilliary Bishop, Most Rev. John McIntyre, and Prof. John Haas, President of the National Catholic Bioethics Center, and Consultor of the Pontifical Council for Health Care Workers. My gratitude goes also to all those who have been working behind the curtains for the success of this event.

I have the joy and honor of conveying to you the Blessing of the Holy Father Pope Benedict XVI, who on learning about my intention to celebrate the World Day of the Sick in Philadelphia asked me to give his regards to the Archbishop, the bishops, clergy and religious and all the faithful under their care. He also asked me to bless you on his behalf. I also bring to you greetings from the Pontifical Council for Health Care Workers and the eternal City.

I propose to share with you a few reflections on the World Day of the Sick, Pope Benedict XVI's teaching on healthcare in his three Encyclicals, *Deus Caritas est, Spe Salvi and Caritas in Veritate*, and lastly the Message of the Holy Father for the Twentieth World Day of the Sick.

1. Why Celebrate the World Day of the Sick

In response to a petition made by the Pontifical Council for Health Care Workers, Blessed John Paul II instituted the World Day of the Sick on May 13, 1992. In his letter to Cardinal Fiorenzo Angelini,[1] then President of the Pontifical Council, he established that it be celebrated each year on February 11, the liturgical commemoration of Our Lady of Lourdes. This initiative is, among others, an invitation to the universal Church to devote a special day of the year to praying, reflecting and sharing the conditions of those suffering in spirit and body.

It is to be remembered that on the same date, February 11, 1984, John Paul II chose to publish the Apostolic letter *Salvifici Doloris*, concerning the Christian meaning of human suffering. Similarly, on the same date February 11, 1985, he established the Pontifical Council for Health Care Workers. Thus he explains that it was meaningful to set the same date for the celebration of the World Day of the Sick. "In effect, with Mary, the Mother of Christ, who was standing by the cross, we pause before the crosses of man today (*Salvifici Doloris*, 31)."[2] Moreover, "Lourdes, one of the most beloved Marian sanctuaries for the Christian people, is at once a place and symbol of hope and grace, in the sense of the acceptance and offering of salvific suffering."[3]

Till then, the Day of the Sick had already been held for several years in some countries. Its extension to the universal Church represented a significant step forward in the efforts to increase awareness of and promote the initiatives it calls for. He therefore instructed the Pontifical Council for Health Care Workers to make the institution of this important day known to all those responsible for pastoral care in health in the Conferences of Bishops, in the international and international organization working in the vast field of health care, so that in keeping with local needs the whole People of God may participate in its celebration: priests, religious and the lay faithful.

The reasons for the celebration of the World Day of the Sick are multiple; however, the Pope emphasizes six in particular:[4]

1.1 To Increase the Awareness of the People of God and Civil Society

The World Day of the Sick has the objective of sensitizing the People of God and consequently the various Catholic healthcare institutions and civil society itself to the need to ensure best possible care of the sick.

a) Making the People of God Aware

Caring for the sick and suffering is one of the largest fields in the Church's pastoral action, since it embraces all age groups. Moreover the domain of health care is increasingly being expanded by the extraordinary progress

in medical science and technology and its application in the prevention, diagnosis, treatment and rehabilitation of human ailments, as well as the increase in life expectancy and the socialization of medicine.

Today, medical science recognizes the interaction between medical care and moral, spiritual and religious assistance to the suffering. It must therefore be acknowledged that the expansion of the field of medical action ought to be accompanied by a corresponding growth of pastoral care in health, involving the whole Church community.

Unfortunately this reality is still felt and experienced in an insufficient manner. In order to have this clear we could ask ourselves a few questions. How many local Churches have an up to date record of Catholic medical facilities? How many Conferences of Bishops have a commission for pastoral care in health and a Bishop in charge?

The number of priests and religious in places of suffering and care has diminished due to the crisis of vocations. Consequently there is also a lack of pastoral workers in health, which lowers the capacity to provide religious assistance to those who ask for it. This is being exacerbated by the introduction of the day hospital and home care, with their impact on health ministry.

Furthermore, many schools of theology and major seminaries do not provide training in pastoral care in health. Some parishes are not used to maintaining a census of their own sick people, nor do they have planned assistance for them (Cf. CIC, can. 529 § 1), they delegate it to the good will of individuals, yet the healthcare ministry is an integral part of pastoral attention as a whole. There is urgent need to work for increased awareness of the healthcare ministry within the People of God.

b) Making Civil Society Aware

Oftentimes when the Magisterium of the Church calls the attention of public officials to subjects like birth control, abortion, euthanasia and genetic manipulation, it is accused of unwarranted interference. Such an accusation is due to ignorance of the Church's inalienable right to intervene so as to enlighten and guide her members and be a witness to the truth before the world in questions concerning the moral and spiritual order.

The laity are called upon to mediate, be the channels and defend the position of the Church in the civil domain and secular society. Such action translates into increased awareness.

Catholic associations of those active in health care (physicians, pharmacists, nurses, social workers, volunteers) are called upon to increase the awareness of civil society, using their recognized social rights (conscientious objection, mass media). They are to positively influence legislation in the healthcare field.

1.2 To Help the Sick Find Value in Suffering

The sense of impotence, of solitude and later on abandonment is a source of tremendous suffering for the sick. In the face of the mysterious problem of pain and suffering, Christianity does not propose either stoic resignation or hopeless fatalism, but it offers, in the Person of Christ, God made man, the key to reading the human condition. "At one and the same time Christ has taught man to do good by his suffering and to do good to those who suffer. In this double aspect he has completely revealed the meaning of suffering." (*Salvifici Doloris*, 30).

In the parable of the Good Samaritan (Lk 10:33) our Lord invites us to draw near to those suffering as the first and obligatory step to helping the sick person find value in suffering.

We can find value in suffering by looking at the experience of Christ, who took suffering on himself, out of love, so that man would not die but have eternal life (Jn 3:16). To do good by suffering refers to Christ's choosing pain as a tool of redemption, he overcomes the destructive power of suffering and turns it into a moment of grace, an instrument of salvation. Moreover "in bringing about redemption through suffering, Christ has also raised human suffering to the level of the Redemption. Thus each man, in his suffering, can also become a sharer in the redemptive suffering of Christ."[5]

Pastoral care in health ought to help the sick people discover the possibility they have to offer their suffering to God and to the brothers and sisters.[6]

1.3 To Involve Dioceses, Christian Communities and Religious Families in the Pastoral Care of the Sick

The Church is one of the largest institutions engaged in the field of health policy and care, particularly in numerous developing countries, because in following the example of her Divine Founder, she always gives priority to the poor, the suffering and sick among those to whom she announces the Gospel.

The organization and promotion of pastoral care in health is favored in the Church by the homogeneity of its internal structures all over the world. Moreover there is unity of doctrine, ideals and pastoral orientation, with a corresponding substantial unity in instruments for action.

Most dioceses, parishes, mission stations have health institutions in their territory. Many priests, religious, permanent deacons and laity are involved in the health care ministry. Numerous Religious Families have assistance to the sick as a specific charism or include it as one of their main activities. An organic involvement of all these institutions would have far reaching effects in making the People of God and civil society aware of the problem of assistance for the suffering.

Also the cooperation among Bishops responsible for Pastoral Care in Health within Conferences of Bishops and Major Superior of religious institutes, as well as heads of secular institutes working in health, is a necessary premise for raising awareness. Thus the celebration of the World Day of the Sick constitutes an initial moment of this converging effort.

1.4 To Foster Valuable Commitment by Volunteers

Volunteers are recognized for a special capacity to mobilize the whole social community and promote an authentic culture of solidarity. Contemporary health care which risks being excessively technical, institutionalized and dehumanized can be completed in a valuable way by the active charity of volunteers. Alongside their good will and resolve to help those in need, there is currently a growing professionalism, which becomes indispensable in sectors of special delicacy and complexity.

Involving volunteers in a more valuable way means also working on their legal recognition and guarantees, providing them with a minimum number of instruments to work effectively. Dioceses, parishes and religious institutes have a large part to play in encouraging volunteer work.

1.5 To Recall the Importance of the Spiritual and Moral Formation of Health Workers

Health care workers are the first and principal mediators of the Church's pastoral action in health. This makes their spiritual and moral formation particularly important, so as to empower them in their ministry to the sick. This formation is even more necessary today when the number of chaplains (priests) and religious in nursing has diminished.

The celebration of the World Day of the Sick will not live up to its aim if it is not capable of involving Catholic health workers, above all physicians, paramedics, nurses, and administrative personnel at healthcare facilities. The respective national and international organizations and associations must commit themselves to promoting this awareness.

1.6 To Recall the Importance of the Religious Assistance to the Sick

Religious assistance to the sick who directly or implicitly request it is always urgent, especially in cases of terminal patients. It is therefore painful to observe that at the time of a drop in priestly and religious vocations, some of the first places where the presence of priests and religious has diminished have been healthcare facilities.

The celebration of the World Day of the Sick ought to include the vocational dimension. Pastoral care in health is a serious commitment by the Church and it has to enter into the priorities of her overall pastoral care. It is a true, profound concrete and credible witness to charity.

Healthcare facilities are the most frequented temples in the world. They are used by all people irrespective of their age, sex or religious affiliation. They offer opportunities of ecumenical encounter and collaboration in the name of true charity. Thus the celebration of the World Day of the Sick ought to promote this dimension too.

2. Health Care in the Three Encyclicals of Benedict XVI

Caring for the sick has always been an integral part of the Church's mission. Consequently Pope Benedict XVI places the world of suffering at the centre of his magisterium. In each of his encyclicals he touches on the topic as a great challenge for the contemporary world.

2.1 Deus Caritas est

In the first Encyclical *Deus Caritas est* the Holy Father highlights "caritas" in the health care institutions of the Church and the principle of subsidiarity (n.28). The Pope observes that caring for and healing the sick is Christian charity in action. This practice of charity is as essential to her as the ministry of the sacraments and preaching of the Gospel (n. 22).

Benedict XVI stresses that "love – *caritas* – will always prove necessary, even in the most just society. There is no ordering of the State so just that it can eliminate the need for a service of love. Whoever wants to eliminate love is preparing to eliminate man as such" (n. 28). He then reminds us that "there will always be suffering which cries out for consolation and help. There will always be loneliness. There will always be situations of material need where help in the form of concrete love of neighbor is indispensable" (*ibid.*). In brief we can say that every person, besides the care of the state, needs: loving personal concern.

It is therefore indispensable that the State "in accordance with the principle of subsidiarity, generously acknowledges and supports initiatives arising from the different social forces and combines spontaneity with closeness to those in need. The Church is one of those living forces: she is alive with the love enkindled by the Spirit of Christ. This love does not simply offer people material help, but refreshment and care for their souls, something which often is even more necessary than material support" (*ibid*).

It has to be remembered that the Church's charitable activity has to be marked by a certain distinctiveness. It is not just about meeting the needs of the moment. "We are dealing with human beings and human beings always requires something more than technically proper care. They need humanity. They need heartfelt concern" (n. 31). Consequently, besides the necessary professional training, care givers "need a 'formation of the heart': they need to be led to that encounter with God in Christ which awakens their love and opens their spirits to others. As a result, love of neighbor will no longer be for them a commandment imposed, so to speak, from without, but a consequence deriving from their faith, a faith which becomes active through love (cf. *Gal* 5:6)."

2.2 Spe Salvi

In the second Encyclical *Spe Salvi*, Benedict XVI makes a strong affirmation concerning our relationship with the suffering. He affirms that the "true measure of humanity is essentially determined in relationship to suffering and to the sufferer" (n. 38). I wish to quote here the words of the Ho-

ly Father in which he also exhorts us to have compassion towards the sick and suffering.

"A society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through 'com-passion' is a cruel and inhuman society… Indeed, to accept the "other" who suffers, means that I take up his suffering in such a way that it becomes mine also. Because it has now become a shared suffering, though, in which another person is present, this suffering is penetrated by the light of love. The Latin word *consolatio,* "consolation", expresses this beautifully. It suggests *being with* the other in his solitude, so that it ceases to be solitude. Furthermore, the capacity to accept suffering for the sake of goodness, truth and justice is an essential criterion of humanity" (*ibidem*). The disciples of Christ and particularly health care workers have a big role to play in this *consolatio*.

2.3 Caritas in Veritate

In the third Encyclical *Caritas in Veritate*, Benedict XVI, among other things, teaches on the respect for human life and the development of peoples. The Encyclical follows in the tradition and teaching of *Populorum progressio* on the mission of the Church, which includes as its necessary implication the promotion of integral human development, that is, one that promotes the good of every man and of the whole man; authentic human development concerns the whole of the person in every single dimension (*Caritas in Veritate*, nn. 11, 18).

Benedict XVI particularly underlines the link between life ethics and social ethics, already present in *Humanae Vitae*. He therefore reiterates the teaching of John Paul II affirming that: "a society lacks solid foundations when, on the one hand, it asserts values such as the dignity of the person, justice and peace, but then, on the other hand, radically acts to the contrary by allowing or tolerating a variety of ways in which human life is devalued and violated, especially where it is weak or marginalized" (*EV*, 93). Such a society does not promote authentic human development, for it attends to some dimension of the person and undermines others.

Respect for life and its protection from conception to its natural end cannot in anyway be detached from questions concerning development, especially in health policy and service delivery. Today poverty still provokes high rates of infant mortality in many regions, but in other parts there are practices of demographic control through the promotion of contraception and even the imposition of abortion. Legislation contrary to life is becoming widespread, creating an anti-birth mentality, with frequent attempts to export this mentality to other countries. "*Openness to life is at the centre of true development*. When a society moves towards the denial or suppression of life, it ends up no longer finding the necessary motivation and energy to strive for man's true good." (*Caritas in Veritate*, n. 28).

Secondly, if authentic development has to promote the good of every human person, then it becomes difficult to reconcile economic, scientific and technical progress with the persistent inequities in the access to health care services, which is a fundamental human right. Many poor and marginalized people do not have access to the medicines and other life-saving technologies due to the inaccessible costs or a poor healthcare infrastructure. Moreover, even in the rich countries themselves there are wide gaps in access to health care. In the face of such situations of penury and injustice, the Church has a mission of truth to accomplish, so as to promote a society that is attuned to man, to his dignity and to his vocation. *Caritas in Veritate* invites all Christians and people of good will to recognize and confront the evils of our day, especially in the fundamental sector of health.

The issues raised by the Holy Father in these Encyclicals with regard to health care, give us more reason to promote the celebration of the World Day of the Sick, so as to increase awareness, defend the culture of life and foster the best possible care for our suffering brothers and sisters.

3. Reflections on the Message of Pope Benedict for the Twentieth World Day of the Sick

In the message for the Twentieth World Day of the Sick, the Holy Father Benedict XVI lays emphasis upon the "sacraments of healing", which as we know are Penance and Reconciliation, Anointing of the Sick and the Eucharist received as viaticum.

3.1 Stand up and go your faith has saved you

"Stand up and go; your faith has saved you" (Lk 17:19), this is the theme of Pope Benedict XVI's Message for the 20th World D*ay of the Sick.* In this year's message the Holy Father highlights the importance of faith during illness. Faith he says draws the sick person close to the Lord. "He who in suffering and illness prays to the Lord is certain that God's love will never abandon him, and also that the love of the Church, the extension in time of the Lord's saving work, will never fail."

The four evangelists testify to the fact that apart from preaching, Jesus' main activity consisted in healing people from sickness and infirmities. The healing mission of Jesus was a visible sign of God's special care for those who are sick and suffering.

Sickness, says the Pope, "is a sign of evil in the world and in man, whilst healing shows that the Kingdom of God is near. Jesus came to defeat evil at its root; his healing anticipated his victory, which came with his Death and Resurrection." For this reason, "the decisive underlying attitude with which to face sickness is faith "in God's love, which radically defeats evil" (Benedict XVI, *Angelus, Sunday, 5 February 2012*).

Suffering and illness have always been among the greatest problems confronted in human life. "In illness, man experiences his powerlessness, his limitations,

and his finitude. Every illness can make us glimpse death" (*CCC* 1500). We know from experience that illness can be very destructive, it can lead to feelings of isolation, discouragement, despair, mental depression and even to a feeling of abandonment by God.

How do we react to evil's attack? Normally we respond by following the right treatment. Thank God, medical research is continuously making progress, offering hope to many sick people. Secondly, "the Word of God teaches us that the decisive underlying attitude with which to face sickness is faith. Jesus said it repeatedly to the people he healed: 'your faith has saved you,' (*Mk*, 5:34-36). Even when facing death, faith can do what is humanly impossible. Faith in what though? In God's love."

Even when healing does not occur and suffering continues, such faith can "make a person more mature, helping him to discern in his life what is not essential so that he can turn toward that which is" (*CCC* 1501). In other words it provokes a search for God and a return to Him. The trial moment becomes a moment of grace, a moment of spiritual awakening. This has been the experience of many saints (St. Francis of Assisi, St. Ignatius of Loyola).

Thus Benedict XVI, encourages "sick people and the suffering always to find a safe anchor in faith, nourished by listening to the Word of God, by personal prayer and by the sacraments."

3.2 Following the example of Christ

Christ's preferential love for the sick continues to draw the special attention of Christians towards those who suffer in body and soul and is a source of tireless efforts to comfort them (CCC 1503). By so doing Christians express an important aspect of their Gospel witness, following "the example of Christ, who bent down before the material and spiritual sufferings of man in order to heal them."

Sickness is a typical human condition, "which shows us our lack of self-sufficiency and our need for others. In this sense and paradoxically, sickness can be a healthy moment to experience the attention of others and pay attention to others" (Benedict XVI, *Angelus, Sunday, 5 February 2012*).

As Blessed John Paul II rightly affirmed, "the suffering, which is present under so many different forms in our human world, is also present in order *to unleash love in the human person,* that unselfish gift of one's "I" on behalf of other people, especially those who suffer. The world of human suffering unceasingly calls for, so to speak, another world: the world of human love; and in a certain sense man owes to suffering that unselfish love which stirs in his heart and actions. The person who is a "neighbor" cannot indifferently pass by the suffering of another: this in the name of fundamental human solidarity, still more in the name of love of neighbor." (*Salvifici Doloris*, n. 29)

Caring for the sick is the responsibility of the whole Church. All baptized Christians should share in this mutual charity, by doing all they can to help the sick return to health. We all have the responsibility to be concerned and helpful to the sick members in our family, in our community. It is our duty to use all the means that may help the sick, both physically and spiritually (cf. *General Introduction to the Pastoral Care of the Sick*, nn. 32-33).

"Heal the sick!" The Church has received this charge from the Lord and strives to carry it out by taking care of the sick as well as by accompanying them with her prayer of intercession. She believes in the life-giving presence of Christ, the physician of souls and bodies. This presence is particularly active through the sacraments" (*CCC* 1509). In the sacraments Christ touches the sick in order to heal them.

The sacraments express and actuate God's closeness to us. In them God touches us through material things, which he takes up and uses as instruments of the encounter between us and himself.

3.3 The Sacrament of Penance

Like the father in the parable of the prodigal son (Lk 15: 11-32), God in his infinite mercy reaches out to his children and calls them to the joy of forgiveness and reconciliation. Through the encounter with the merciful and loving Father in the sacrament of Penance the "time of suffering, in which one could be tempted to abandon oneself to discouragement and hopelessness, can thus be transformed into a time of grace so as to return to oneself, and like the prodigal son of the parable, to think anew about one's life, recognizing its errors and failures, longing for the embrace of the Father, and following the pathway to his home."

It has to be remembered that reconciliation with God also leads to other reconciliations, which repair relationships that were broken by sin – relationships with God and the brethren.

It is therefore important that sick people be helped to respond to God's gift of full reconciliation and joy.

3.4 The Sacrament of Anointing of the Sick

Pope Benedict XVI denounces the practice of treating the Sacrament of Anointing the Sick as "almost a minor sacrament". This sacrament he says "deserves greater consideration today both in theological reflection and in pastoral ministry among the sick."

This concerns the misconception and habit of administering the sacrament almost exclusively when a sick person is close to death (*Extreme Unction* or Last Anointing). This praxis has to be changed, so that the sign of God's medicine, which offers strength and consolation, may find its proper place not only within hospitals and other places of care and assistance, but also become part of the ordinary care that pastors solicitously offer in their parishes, to those who are sick or elderly, with the participation of the families and the parish community.

This sacrament of healing confers sanctifying grace, which comforts and strengthens the soul of the sick person. God's grace quiets anxiety and dissipates undue fear of death; it also points beyond the illness towards the definitive healing, the resurrection.

Moreover, by eliminating anxiety and inspiring confidence in God, Anointing of the Sick may enhance the recovery of bodily health by the sick person.

The Sacraments of healing are and indeed "precious instruments of God's grace, which help the sick person to conform himself ever more fully to the mystery of the death and resurrection of Christ."

3.5 Eucharistic Communion

Together with the Sacraments of Healing the Pope emphasizes the importance of the Eucharist. He observes that the sacraments of healing have their natural completion in the Eucharist. This is particularly true when the Eucharist is received as Viaticum at a time of illness. It contributes in a singular way to working out the transformation initiated by the other sacraments, that is, "associating the person who partakes of the Body and Blood of Christ to the offering that he made of himself to the Father for the salvation of all."

The sick person thus unites his own suffering to that of Christ for the salvation of the brothers and sisters. It is elevated to a precious sacrifice on the altar of the Lord and the sick person participates in the mission of the Church. This conformation to the Paschal Mystery can also be achieved through the practice of spiritual Communion.

Secondly, given the assurance of the Lord himself, "Whoever eats my flesh and drinks my blood has eternal life, and I will raise him on the last day" (*Jn* 6:54), Viaticum is "medicine of immortality, the antidote for death."

Thus the Holy Father invites the whole ecclesial community, parishes in particular, to guarantee the possibility of frequent Holy Communion to people who because of poor health or their age cannot come to the place of worship. Priests who work in hospitals and nursing homes have a great responsibility to reach out to the sick with these signs and instruments of Christ's compassion.

Conclusion

Jesus in his ministry proclaimed God's concern for the whole person, soul, mind and body. He came that all "may have life and have it to the full" (Jn 10:10). In his ministry he sought to free people from anything that would hinder them from having this full life. In the healing miracles of Christ, "reacquired health is a sign of something more precious than mere physical healing, it is a sign of the salvation God gives us through Christ."

The Church has always recognized the close ties between physical and spiritual healing, and has used the sacraments to heal "lacerations of the soul." Through these sacraments the Church follows "the example of Christ, who bent down before the material and spiritual sufferings of man in order to heal them."

"He who in suffering and illness prays to the Lord is certain that God's love will never abandon him, and also that the love of the Church, the extension in time of the Lord's saving work, will never fail." It is our responsibility as a Church to be true effective instruments of God's compassion to our sick and suffering brothers and sisters.

Notes

[1] Cf. John Paul II, *Letter to Cardinal Fiorenzo Angelini to Institute The World Day of the Sick*, Vatican City, May 13, 1992.

[2] John Paul II, *Letter to Cardinal Fiorenzo Angelini to Institute The World Day of the Sick*, n. 3.

[3] *Idem*.

[4] Pontifical Council for Pastoral Assistance to Health Care Workers, *World Day of the Sick: Why to Celebrate It, How to Celebrate It*, Vatican Press, Vatican City 1992, pp. 11-33.

[5] *Salvifici Doloris*, 19.

[6] Cf. John Paul II, *Redemptoris Missio*, 78: "I therefore urge those engaged in the pastoral care of the sick to teach them about the efficacy of suffering, and to encourage them to offer their sufferings to God for missionaries. By making such an offering, the sick themselves become missionaries."

TOPICS

'And give the physician his place, for the Lord created him'

Humanity in the Elderly

‘And give the physician his place, for the Lord created him’ (Sir 38:12)[1]

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Today, those who should bring health suffer, paradoxically, from what some people call ‘sick health care’.[2] The medical world is suffering[3] because contemporary medicine is in crisis.

Starting with the situation of the world that provides care, and in particular, the medical world (1), I will advance three possible theses that will equally be three philosophical (2), Biblical (3) and Christian (4) supports. Behind the question of medical malaise, another one emerges that is positive: what kind of Catholic doctor should there be for today’s world?

1. The Contemporary Situation: Suffering Medicine

Suffering comes both from our – dualistic – dominant (in the two meanings of the term!) model of medicine and from the dissatisfaction that has risen from the alternative – humanistic and holistic – models.

a. The dualistic model

1. Some characteristics

The medicine that is practised today is characterised first and foremost by a certain vision of the sick body: measured or quantified; analysed and fragmented; normalised; invaded (reference is made to ‘invasive methods’); and passive.

It is characterised by a certain vision of the medical doctor: he or she is the person who knows (he or she knows about the illness better or more than the patient), who can (he or she has the power to diagnose and to heal in the case of a patient who has been made powerless by his or her condition), and who is the only person who acts (medicine and what is done are the sole causes of healing).

2. *Assessment*

To assess a model of this kind in a solely negative way would be unfair. Quantification, analysis and invasion are methods and instruments that open up to scientific knowledge and the dominance of technology. They have allowed the advent of a truly rigorous medical science and the striking successes that we know about, such as the fact that numerous epidemics have been weakened or the impressive distancing of pain.[4] The Fathers of the Second Vatican Council were happy at the fact that man ‘has extended his mastery over nearly the whole of nature and continues to do so’.[5]

The fact remains that this model is at one and the same time dualistic and domination – the domination of nature by man, the domination of the spirit by the body with the inevitable consequence of the domination of the patient by the medical doctor. On the one hand, it generates an institutional structure of a paternalistic kind. But not without excesses. Paul Ricœur spoke about a difference not of nature but of degree between contemporary medicine and medicine that resorts to torture: ‘the participation of such medical doctors is not an aberration’ but ‘is the extreme pole of a continuous gamut of compromises’.[6] On the other hand, this model nourishes the omnipotence of the medical doctor who erects himself or herself into being the prime and total cause of healing. This is attested to by the exchange that takes place within a hospital. A doctor writes in his medical report: ‘I delivered the child of Mrs Unetelle’. On coming out of the general anaesthetic ‘the young mother reminds him, rightly, that it was she who gave birth to the child and not him’.[7]

b. The humanistic model

Faced with the dualist model, the first reaction is to strengthen the tie and inject the human aspect into it.

1. Some aspects

The contemporary world is increasingly resisting a hierarchical and paternalistic vision of the relationship between a medical doctor and his or her patient and is replacing it with a model that is more based on dialogue. Today, reference is often made to the humanisation of medicine and of its institutions.[8] As the philosopher Dominique Foldscheid observes: ‘*true medicine* is in the end the medicine of the person. To treat always means to treat *someone*’.[9]

For that matter, as is demonstrated by the works of Jackie Pigeaud, in the past there have been numerous physicians, belonging to a great humanistic tradition, who spontaneously lived listening and generous self-giving. According to the University of Nantes, the fracture began in the nineteenth century,[10] perhaps, paradoxically, when medicine became a profession.[11]

Catholic medical doctors were especially affected in this field and tried to reconcile the dualistic model with the humanistic one. For example, some sought to exit from the purely technical aspect and to discern in the healing deed a sacred reality.[12] Indeed, the healing deed, whether carried out by a physician or a nurse, concerned not a thing but a body which, being human, was ‘a body of words’,[13] a personal body which had meaning; the sacred is what saved meaning: ‘when a human being actuates a relationship with the sacred, he or she affirms that this world is a place of meaning’.[14]

2. *Assessment*

How can one not delight in a more human and symmetrical relationship between a patient and his or her medical doctor? Nonetheless, although important, this seems to be not very effective. This rejection of the reduction of the body of the sick person to an instrument belongs more to the or-

der of the prescriptive than the effective. This is what a cancer patient declared: 'The day has not yet arrived when the conversation between a patient and a surgeon can take place between equals'.[15]

In addition, today we are increasingly realising that this humanism must involve not only the patient but also the medical doctor. The crisis of trust also affects the one who heals. An article by Prof. Didier has the following significant title: 'Protecting Patients and Being Protected Against Them?'[16] Hence the question posed in another article: 'How can we exit from the mutual distrust that can enter into the relationship between a patient and a doctor? Indeed, 'the relationship between a patient and a doctor has become by nature a matter of a contract, with an obligation, for the doctor, no longer of means but of results. Doctors see that they have imposed upon them numerous duties whose impact cannot be assessed at that moment, at a financial, organisational or juridical level. The application of judgements, which for the most part is rooted in the mass media or in opportunistic considerations, is perceived as a permanent threat by doctors'.[17] As one medical doctor told Édouard Zarifian, a professor of psychiatry at the University of Cannes, 'before I had patients to be treated, now I have customers to satisfy'.[18] Without speaking about the particular case of medical doctors who, as in countries such as France, are by now asked to be managers, in addition to having to face up to various administrative difficulties.

Lastly, and above all else, this suffering indicates a deeper crisis. The Catholic doctor perceives a spontaneous distrust of the model that will be described in the next sub-section, that is to say the holistic model; he is tempted to articulate the mechanistic and humanistic model without realising the contrast that exists between the first, which gives value to domination, and the second, which emphasises reciprocity. In a more general way, the calling into question of the previous model is basically only partial: it is opposed to domination and to an overly exterior view of the sick body, but it does not take into account other aspects such as, for example, the mechanistic axiom of a body reduced to what is measurable, passive, detached from the mental dimension and ahistorical. It is right that the conversation where the patient is told of a cancer diagnosis takes into consideration the human factors (speaking in a brightly lit room, giving the news on a Friday evening, etc.) but this humanisation, that is to say this integration of the mental dimension (which should involve the spiritual aspect as well), does not concern either diagnosis nor treatment. Struck by the gravity of a cancer pathology and the urgent need for effective therapeutic protocols, researchers invest very little in more fundamental studies which would link the origin of cancer not only to the body (the genetic factors, immunity diseases, etc.) but also the soul, to which it is closely connected,[19] and more than in any other living being.[20] The body, declares Prof. Sicard 'is increasingly absent from medicine, it is present only if it offers objective parameters, images or figures'.[21] Humanising, therefore, is not enough, the action of treatment should also be reconsidered. Discernment must lead to this point.

c. The holistic model

Faced with the violence of the dualist model and the insufficiency of the humanist response, another thesis has emerged over recent decades. This model, which I call holistic,[22] is becoming increasingly important.

1. Some characteristics

In opposition to the dualistic and mechanistic model, here the sick body is no longer measured and analysed but considered as a whole, in its links with other bodies and also with the totality of the universe (hence the adjective 'holistic' which comes from the Greek, *holè*, 'all'). In the same way the body is no longer seen as a passive reality but, instead, is honoured in its curative resources which are at times amazing.

As regards the medical doctor, in addition to criticism which is at times strong with respect to the institution and also the claims of this very 'pro-active' medicine, we have witnessed the appearance of a new concept: self-healing. The total organism of the patient contains in itself everything that is necessary for healing.

2. Assessment

We must be happy about this recognition of the role played by nature and a human organism restored to its cosmic fraternity and its inventiveness,[23] as well as the limit imposed by medical omnipotence.

However, today we strongly run the risk of moving from the omnipotence of human reason to the omnipotence of nature. The omniscience and omnipotence of the medical doctor is replaced by the body of the patient who knows and can do everything. In addition, this humiliation of medicine does not pay tribute to its nobility and generosity which is borne witness to by innumerable figures who, as I have observed, have flourished down the centuries and who the medical world still honours today. For that matter, too reactive and often nourished by resentment, the holistic approach inherits the same unilateral nature of the medicine it opposes: contraries appear to belong to the same category.

Lastly, in addressing the holistic model a certain number of Catholic doctors accept anthropological practices and conceptions – for example of an esoteric character – which are incompatible with their faith. Incarnation is not reincarnation.

d. A summing up

This first part of my article has briefly outlined the history and the subject. Often the models that have been proposed oppose each other in the name of their reciprocal limitations. These preclusive oppositions take a bipolar form: dualism versus monism; mechanism versus holism; paternalism versus contract theory, etc.[24] One cannot deny that in the past medical practice has at times humiliated sick people; today we run the risk of humiliating medical doctors. An authentic medicine, which is respectful of its mission, involves not opposing or condemning these different perspective, but, instead, integrating them with discernment. I thus propose three pathways in this sense.

2. Integration in a philosophical approach

This first proposal appeals to reason, and more precisely philosophical reason, alone. It concerns the Catholic medical doctor who, according to the title of a famous encyclical, is called to unite *fides et ratio*. I will confine myself to two notions or rather to two pairs of notions: one is traditional and the other is contemporary.[25]

a) *The 'metaphysical' model: the physician, a minister of health*

A valuable teaching of Aristotle (384-322), the first great biologist of the history of humanity, who was himself the son and grandson of physicians, was systemised by a medieval philosopher, who was also of notable greatness, St. Thomas Aquinas (1225-1274).[26] The latter posed the following question to himself, which is of surprising contemporary relevance: which (where) is the principal cause of healing when a man is sick, in the physician or in the patient (naturally helped by the physician)?

To answer this question, the Angelic Doctor had recourse to the analogy of teaching. To teach John mathematics, should one know mathematics or John? There have been two great tendencies in pedagogy: granting too much to the teacher, granting too much to the person taught. The truth, we have said, lies not in choosing (and thus in excluding) but in integrating. For this reason, St. Thomas appeals to a distinction between two types of causality elaborated by the Philosopher: the principal cause (*causa perficiens*) and the dispositive cause (*causa disponens*). The person who is taught and the teacher are both indispensable, but in a *hierarchical* way. And more precisely: the pupil or the student is the principal cause of learning; the teacher, the art of teaching, is the adjutant or dispositive cause. Indeed, it remains exterior to the process of learning, proposing to the pupil knowledge and instruments, organising signs so that the mind acquires knowledge. However, the authentic teachers were not autodidacts but, first and foremost, disciples. Although second, the teacher is not secondary in anything. St. Thomas makes clear, for that matter, that only he who possesses science 'underway' can teach, that is to say teach in a complete way: the communication of knowledge assumes that the source has something to transmit.

In the same way, a medical doctor cannot but help a patient to recover. There is not only the aspect of psychology (today for example the importance of the placebo effect or of the wish to recover is recognised, and the same may be said, inversely, of the hopelessness or discouragement of the patient), but also that of the body itself. The body of the patient is always wiser than the wisest of physicians. But sometimes it is weaker than the physicians and thus needs their service.

Let us keep this valuable distinction: the patient is the principal cause of healing, the art of medicine is the dispositive cause, also called the ministerial cause. The truth does not lie either in the unilateral affirmation of the 'omnipotent doctor' of dualistic medicine (which survives in humanistic medicine) or in the symmetrical assertion of the 'omnipotent patient' of 'holistic' medicine, but in the conjugation, or rather in the hierarchical articulation, of these two causalities, thus of the partial truths defended by these three models of medicine.

This first explanation allows various teachings to be arrived at:

– A holistic vision that gives greater importance to the patient of the medical doctor is closer to the truth than the dualistic vision. The contemporary crisis of medicine allows a proclaiming of this happy awareness.

– The fact remains that the medical doctor is not in the least put to one side, because he or she plays an indispensable role. Indeed, the role that he or she plays is appreciated anew. Lastly, the fact that he is a dispositive or adjutant cause does not justify the mediocrity of a medical doctor ('I am not the total cause of the healing, therefore my knowledge must not be total') or contempt of the patient. Just as a teacher must possess his or her science 'underway', so a medical doctor can help the therapeutic process in an effective way only if he or she possess complete medical competence, even though it can be perfected.

– This integrated vision opposes the omnipotence of the paternalistic vision and the resentment of the holistic vision to allopathic medicine.

b. The personalist model. The patient-object and the patient-subject

This 'metaphysical' vision, however interesting and adequate it may be, appears a little abstract, impersonal and cold to those who are less expert in philosophy. It should not be replaced or corrected but, instead, completed by a more personalist vision (which, in its turn, needs a metaphysical approach in order to provide an objective foundation to the relationship between a medical doctor and a patient and the kind of causality that is involved). I will here appeal to the distinction appreciated by phenomenology between the body as a subject and the body as an object. Various pairs of notions allow this difference to be identified in a better way: the body-subject is known from within; the body-object is known solely from without; the body-subject is tested; the body-object is measured; the knowledge of the body-subject is singular, but that of the body-object tends to the universal.

I will illustrate this distinction with reference to a famous medical example. On 13 May 1981, in St. Peter's Square in Rome, John Paul II collapsed, the victim of an assassination attempt by Ali Agça. Taken urgently to the Gemelli Polyclinic, he stayed there for a month. He had an excluding colostomy which subsequently required a restoration of continuity as regards the intestines. But an infection caused by a herpes virus brought forward the hospitalisation of the Supreme Pontiff. Once he had recovered from the viral infection, the question arose of the second operation. The doctors wanted to postpone it, but this was not the wish of the Pope. He then summoned what in a smiling way he called his 'Sanhedrin' ('what has the Sanhedrin decided for me?') and he explained to them: 'don't forget that you are the doc-

tors and I am the patient and that I have made you take part in my problems as a patient, and above all this problem: I wanted to return to the Vatican only if I was completely recovered; I don't know what you think but for my part I feel very well, even if we assume that the analyses say the contrary. I completely feel that I can take another operation'.[27]

This episode is rich in teachings. I will take just one. The previous Supreme Pontiff had refused to oppose 'on the one hand the knowledge and the expertise of medicine', in other words the objective knowledge about the human body, and 'on the other what the person knows about himself', that is to say the subjective knowledge of the human body. Before being the *object* of the diagnostic and therapeutic activity of the physician, the patient is the *subject* of his or her illness. Furthermore, if these two forms of knowledge enter into conflict ('even if we assume that the analyses say the contrary'), priority must be given to the knowledge that the patient has of his or her state'.[28]

It was thus out of personal experience that John Paul II affirmed in a very fine address given to sick people and to the medical world during his visit to France in 1986: 'The personnel providing care does not only have technology to offer but a warm devotion that comes from the heart, concern for the dignity of persons. Try not to reduce the sick person to an *object* of care but, instead, make him the first companion in a war that is *his* war'.[29]

This is something the English language knows well. As regards a pathology it makes a distinction between 'disease', the illness-object, the biomedical dysfunction, and 'illness', the illness-subject, the personal subjective experience, and as regards treatment, 'curing', the healing-object, the biomedical therapeutic process, and 'healing', the healing-subject of which the person is the protagonist.

From this distinction between the (sick)-subject body and the (sick) object body a medical doctor must in his or her turn draw more than one teaching.

– The patient must have confidence in the objective knowledge that the personnel who provides care and treatment, and in particular the medical doctor, have about his or her body.

– In his or her turn, *and even more*, the medical doctor should pay attention to the knowledge that the patient has of his or her illness. The personalist approach rediscovers, but at a subjective level, the hierarchy of the patient and the medical doctor: numerous patients, above all chronic patients, know about their illness much better than their medical doctor in the name of the principle that follows: the knowledge of a medical doctor is at one and the same time external and general; that of the patient is experienced and singular. This hierarchy pre-supposes, however, that the patient learns to know himself or herself, that he or she enters an authentic emotional and somatic intelligence, and stops fleeing from his or her illness.

– Even though they are asymmetrical, these two forms of knowledge are complementary. They should lead to a pact or to an alliance. The patient-subject opens up to compassion, the patient-object appeals to competence.

c. A summing up

These two approaches, the one metaphysical and the other personalist, are both valid. They allow a primary assessment of the three models. They both demonstrate how much the patient takes pride of place.

However, this conclusion raises some difficulties. One cannot deny the nobility of the medical profession or reduce the tie with the patient to a contract. How can one reconcile the primacy of the patient with the nobility of the curative art?

These approaches, for that matter, do not say everything, in particular about the humanistic model and the suffering that is present in he or she who treats.

Indeed, experience demonstrates that these approaches oscillate and constantly seek a point of balance that cannot be found: how can one give enough listening to the patient-subject, albeit basing oneself on that expertise that allows diagnosis? The synthesis is absent. A third term is required that attracts and binds these two terms which are always tempted to become absolutes to the disadvantage of the other.

In addition, have we not integrated at a philosophical level two central assertions of the unitarist (monist) approaches: the body in its relationship with the cosmos; the capacity for self-healing of our organism or rather that somatic-mental-spiritual totality that is man? We detach ourselves only with difficulty from a dualistic vision which is directly derived from the Cartesian mechanism and painfully lacks a philosophy of nature by which to integrate the part of truth contained in the holistic vision.

Lastly, nothing is said to us about a specifically religious vision to which the humanistic approach cannot be reduced. Now the Bible, whether the Old Testament or the New Testament, has resources that are able to illuminate the other questions raised here.

3. Integration from a Biblical perspective

I will concentrate on a rightly famous text in Sirach that concerns medicine (Sir 38:1-15). In some important verses it offers us an especially balanced and always topical vision of medicine.

a. Between two extremes

The historical and sociological context of this text is also of an amazing modernity. Indeed, at the time of Jesus Ben Sirac there were two opposing conceptions of medicine.

The first had an *exaggerated appreciation* of the art of medicine.[30] The successes achieved by the physicians of Alexandria led it to identify salvation with the healing that these physicians achieved and to distant patients, as well as those who provided care and treatment, from God. Medicine was believed in, in the same way as God was believed in.

The second, in contrary fashion, *devalued* medical practice or rather resort to treatment. The reason advanced for this was of a technical character. Illness was a punish-

ment of God who sent it to punish man for his sins. To appeal to a physician, therefore, was in contrast with the plan of God. In the Book of Enoch, a spiritual work but also apocryphal (it is does not form a part of the canonical texts), written a little times after Ecclesiastes, the bad angels are accused of having communicated diagnostic and therapeutic knowledge to men.[31]

As we can see, the first vision of the art of medicine (Alexandrine medicine) has a relationship to the second (the despising defence of the Book of Enoch) which is like the relationship that dualistic medicine has with holistic medicine. Indeed, a re-reading of the history of medicine could demonstrate that the contemporary bipolarity was present in all epochs and finds its own paradigmatic figure in the tandem of Hippocrates and Galen.

Now, Ben Sirac is located between these two extremes, seeking to save their truthful parts – a generous and integrative approach which in itself constitutes an entire programme.

b. The answer of Ben Sirac

1. The right place of the physician

The passage from chapter 38 of Sirac recognises first of all the importance and also the nobility of the work of a physician. The *sign* of this is that he must be honoured: 'honour the physician as he must be honoured (v. 1); according to the Hellenic tradition to which this book of wisdom, Sirac, which was written in Greek, belongs, tribute is only given to the person who is worthy of praise and is virtuous.[32] Thus a physician, according to this book of wisdom, is a virtuous man. The *cause* of this honour is to be found in the function of medicine: this mission is to re-establish health which, as the same work tells us, is a possession of great value (cf. Sir 30:14-16). But there is more. To he who takes his faith in God as a pretext to belittle the physician, the text declares: 'he too was created by the Lord'. Thus it is the very creative presence of God that comes after a certain fashion to save this profession which runs the risk of being belittled. God acts in its favour. This is the truth and the nobility of the Alexandrine position, which is that of contemporary medicine: mechanistic, allopathic, and today overly denigrated.

It is normal, therefore, that the physician should have 'his head held high' (v. 3). But how can one ensure that he who has his 'head held high' does not become, as is said colloquially in French, a man with a 'big head', that is to say feels that he is important? Ben Sirac does not ignore the risk of being big headed, in other words of being proud,[33] something that threatens a physician. This is the truth of the distrust that is present in the Book of Enoch and the criticisms that holistic medicine directs at the dominant model. In our epoch the temptation of vanity has grown notably because of the innumerable advances of diagnostic and therapeutic medicine. One example may be given out of many: reproduction is increasingly dominated to the point that reference is made to the 'manufacturing of children'. How can this pride be avoided? The answer of Holy Scripture is always pertinent: the ultimate source of healing is not to be found in man but in God. This is why Sirac adds: 'From on high comes healing' (v. 2). Medical power is a participation, as I will observe below. As in the case of political power, the power of healing is delegated: 'You would not have any power over me if it were not given to you from on high' (Jn 19:11). It is normal that a physician 'holds his head high': to restore health is no capacity of little import. But it is at least equally important that a physician should constantly remember that what is he is admired for comes from God. Cardinal de Lubac said that when he thanked him ('*Gratias tibi*': 'thanks to you'), he added within him '*et Domino*" ('and to the Lord').

2. The right place of the patient

This passage from Sirac offers us a balanced presentation of the point of view of the physician It also allows us to place the healing nature in man and outside man in its right place. On the one hand, it gives a place to the patient because it asks him or her not to ignore illness: 'My child, when you feel ill, don't ignore it' (v. 9). It would be anachronistic to identify this not taking note of illness with stress: this advice recognises, however, the importance of a good approach on the part of the patient. Ecclesiastes adds at verse 38 'purify yourselves, wash your hands, clean your heart of all sin' (v. 10). This does not mean that every illness is the consequence of contemporary sin but, rather, that it is certainly the consequence of original sin which has its roots in each man and as a consequence that a contemporary mistake cannot but be reflected sooner or later in the equilibrium of a human being. Lastly, Ben Sirac alludes to the cosmos though the 'pharmacist' who prepares 'medicines' (v. 7).

On the other hand, we have also seen the risk of absolutising this nature within the framework of the holistic model. But, no more than the physician, the patient is not the principal cause of the cure. He or she, too, indeed, must pray: 'when you are sick…pray to the Lord and you will get better'. The text, therefore, limits the power of the physician.

More in general, atheism for the Bible is a false problem. Man is a religious being made for the infinite and nothing less. The question, for man, is not, as a consequence, that of choosing for or against God but choosing between the true God and false gods, whom Holy Scripture calls idols. Now, behind the dual model, dualistic and holistic, pushed to the extremes, are concealed and at work two idolatries: that of reason and that of nature.[34] For example, scientism is not so much atheistic as a worshipper of science.[35] 'There are two divinities', wrote the Austrian philosopher Ludwig Wittgenstein, 'the World and my independent Self'.[36] Once again, the exit from the lethal oscillation is worked from on high, thanks to divine mediation.

As a consequence, faith in transcendent and provident God does not allow only a stabilising of the precarious balance between the two poles of the act of treatment – the patient and the physician – but also to a conjoining of the dual idolatry that threatens it: that of reason and that of nature: 'The Catholic physician', Pius XII

observed, 'does not divinise nature and medicine; he does not see them as absolutes but sees in them a reflection of the grandeur and the goodness of God and subordinates himself entirely to His service'.[37]

c. Systemisation: the triangle of God, the physician and the patient

Let us now take up in a systematic way the conclusions to which this Biblical text lead. The Book of Sirac invites or orders no longer two actions, that of the patient and that of the physician, but three, adding the action of God. Rejecting the logic of 'either or', it conjoins them in an integrative logic of 'and, and'. Let us make clear again that this conjunction must not be understood as a juxtaposition but as an ordering.

1. The curative action of God comes first. That is why He does not hesitate to attribute to Himself the title of 'physician': 'I am the Lord, He who heals' (Ez 15:26). And we see that this is also what happens with Christ.

2. Then comes the action of the patient. This activity is indeed placed second. At a specific level, three acts are prescribed for the patient: praying, not ignoring his or her illness, and if the remedies are not sufficient, calling the doctor.[38]

3. Lastly, the man of the art of medicine intervenes: 'Let the physician *then* pass' (Sir 38:12). The action of the physician is thus doubly subordinated: to God and to the patient.

How, then, should we understand the relationship between the action of God and the action of the man who heals? As in the second part, one could call into play a dual metaphysical and personalist grammar.

1. Classical metaphysics explains this arrangement by appealing to the difference between first cause and second cause[39] which the *Catechism of the Catholic Church explains in the following way*: 'The truth is that God is at work in all the actions of his creatures is inseparable from faith in God the Creator. God is the first cause who operates in and through the secondary causes: 'For God is at work in you, both to will and to work for his good pleasure' (Phil 2:13; cf. 1 Co 12:6)'.[40] Applying this distinction to medicine, we must therefore state that God is the first cause of healing and that the physician and the patient are the second causes. This is what is meant in a figurative way by the rightly famous words that Ambroise Paré loved to repeat: 'I bandaged and God healed'. Uniting this analysis to the doctor/patient system, we could propose the following synoptic table:

Causes of healing		
First causes	**Second** causes	
God	**Principal** cause	**Dispositive** cause
	The patient	The physician

2. The link between the curative action of God and that of the physician can also be interpreted in the personalist lexicon of participation[41] or (hierarchical or subordinated) cooperation. The Magisterium of the Church has observed this on a number of occasions. I will confine myself to two quotations. The first, from Pius XII, interests us even more because it cites the passage from Sirac: 'this is the grandeur of your task, gentlemen, to be true collaborators of God in the defence and the completion of His creation. It is in this sense that Holy Scripture says to the physician 'God created him' (Sir 38:1). He created him as an instrument of His mercy, to sweeten the woes of our brethren, as a guide and adviser to teach them wisdom, as a depository of the science of man and his charitable goodness. The physician is a benefit of God, and by this title, he has the right not only to being honoured an esteemed by men, but also to their acknowledgement and their trust'.[42] The second is from John Paul II: 'To you, surgeons, specialists in laboratory research and general practitioners. God offers the honour of *cooperating* with all the strength of your intelligence in the work of the creation which began on the first day of the world'.[43]

d) Consequences

From this (inclusive) primacy of God in His being and His action, the Book of Ecclesiastes draws some practical consequences with realism.

A medical doctor has the duty to pray for his patients: 'In their turn indeed they will pray to the Lord'. This prayer even comes before the other acts that he has to engage in for his patients. But this prayer does not at all exclude his skills because reference is also made to the 'science of the physician' (Sir 38:3,6). Yet prayer and work, oratory and laboratory, means making permanent an exaggerated emphasis on the extrinsic, the opposition of grace and nature.

For his or her part, the patient must first of all address God. Indeed, calling the medical doctor before praying to God is seen by the Bible as being a grave sin. 'In the thirty-ninth year that Asa was king, he was crippled by a severe foot disease; but even then he did not turn to the Lord for help, but to doctors (2 Chronicles 16:12). This is why Sirac describes the right attitude of he who receives care in two stages. 1. Turn to God and pray to him: 'My child when you feel ill, don't ignore it' (v. 9). Indeed the subject of an illness is not an organ but the person. 'My skin has a rash', but also 'I have a rash' and 'I a suffering from a rash'. A person is not first and foremost his or her body but, rather, a being with a relationship with his or her Creator. 'Let's return to the Lord! He has hurt us, but he will be sure to heal us' (Hos 6:1) 2. Then look for a man of the art of medicine: 'And give the physician his place, for the Lord created him' (Sir 38:12). Although the physician is the secondary cause he is not secondary; if he cooperates with the God, the role that he or she receives from this is real. God does not dispense with second causes and honours us by making us take part in His providential governance.

Lastly, let us draw a lesson from the point of view of the relationship between the physician and the patient. Indeed, a part of con-

temporary suffering comes from guilt. Giving exaggerated value to curative power, man has divinised himself and no longer knows how to respond to the excessive expectations that he has generated. Let us express this, smiling, with the words of *Oscar et la dame rose*. Oscar – that little modernised prince who has become a ten-year-old child, struck by an incurable cancer at a terminal stage and who lives in a universe without meaning – tells his medical doctor who is treating him: 'Listen, I will speak to you frankly because I have always been very correct at a medical level and you have been impeccable at the level of illness. Give up this air of guilt. It is not your fault if you are obliged to give people bad news, illnesses with Latin names that cannot be cured. Calm down, relax. You are not God the Father. It is not you who commands nature. You are only a *repairer*'.[44] In his vocabulary of a child who has become wise, Oscar enunciates the difference between the first cause (God 'who commands nature') and the second cause, and furthermore one of only a dispositive nature (the physician is 'only a repairer').[45]

e. Weighing up

The words employed for the title of my paper, 'The Lord created him [as well]' (v.1),[46] is intertwined with the dual curative action, placing it in a hierarchy: that of the Lord who is the first, as is indicated by the added 'as well'; that of the physician whom God has created and whom he makes take part in His healing mission. Between the two intervenes the therapeutic action of the patient which also draws efficacy from divine causality. The truth of the two (objective and holistic) positions is thus stability.

Does not such an interpretation lead to a pejorative vision of the role of a physician? As only this, it occupies the last post, but the phrase 'as well' makes him an 'acquired relative' who is often reduced to a 'tolerated relative'…

Indeed, the phrase that begins the passage from the Book of Ecclesiastes on medicine is often translated as 'The Lord created him as well'. This is the translation (in Italian) of the Jerusalem Bible that I have adopted. In reality, two versions of this text exist: the first, in Greek, from which our Bible was translated, and the Hebrew version which is the original and the 'authoritative' text.[47] The passage that I am trying to clarify varies notably whether one refers to the Hellenic version or the Hebrew version. Indeed, the first speaks about the creation whereas the second employs the verb *halak* which means 'to choose' or 'to put to one side'. It thus affirms that the physician has been chosen by God. In the same way, having recourse to a physician, far from going against the design of God, in contrary fashion participates in it. After a certain fashion, God chooses the physician from amongst men in order to allow him to take part in the mysteries of the creation. The art of medicine is not just another profession amongst many but a vocation in the etymological sense of the term: Good chooses and calls. The two versions, therefore, propose complementary readings of the role of a physician: the Greek one calls him to humility (to a sense of receptivity)[48] and the Hebrew one to his appreciation.

However deep the Old Testament reading of medicine may be, it does not say everything. On the one hand, we have not yet seen how Holy Scripture assesses the humanistic model. On the other, an approach of this kind remains partially abstract. How can these different poles be arranged at a practical level? Although it is first, the divine action seems far away and encounters difficulty in inspiring the daily action of a physician (and also of a pharmacist). Another approach thus seems necessary in order to understand how the divine action informs and animates from closer to hand the action of the person providing treatment (and that of the patient).

4. Integration into the Christian perspective

The Gospels introduce two novelties: the model of the physician in Jesus, the pathway through his Spirit.

a. The exemplariness of Christ the physician

A physician, who is baptised and a disciple of Christ, is called to follow him (cf. Mt 16:24). As a physician, he or she is called to follow Christ the physician. Indeed, Christ presents himself as a physician: in his deeds – healing is very present in the Gospel because there are no less than twenty-five accounts of healing and five summarising tables – and in his words ('It is not the healthy that need a physician, but the sick' Mk 2:17).

The fact of being a physician does not only express the mission of Jesus but even more radically his *identity*. In one of the first post-apostolic texts, which goes back to the end of the first century, St. Ignatius of Antioch states in an amazing way: 'There is but one material and spiritual physician, generated and not generated, made God in the flesh, true life in death, born in Mary and from God…Jesus Christ our Lord'.[49] This rightly famous text is that much more worthy of note because it is also the first of Tradition to speak explicitly about the dual nature of the Saviour. Because he is at one and the same time man and God, the Messiah can come to save man from his sin and thus cure him of this mortal illness. As a consequence, to be a physician expresses the intimate identify of Jesus. The Fathers were not in error – I will take up this subject and expand on it below.[50] In thus establishing an intrinsic and mysterious link between the divine humanity of Christ and his healing mission, this apostolic Father invests the vocation of being a physician with an ontological importance and opens up an abyssal perspective on medicine.

Let us apply this consideration to what we could call the very soul of medicine in a Christian perspective. Jesus 'loved us unto death' (Jn 13:1). It is 'for us' that, out of free obedience to the Father, he became flesh from our flesh to help sick humanity. More precisely, faced with misery love takes on the form of mercy or compassion. The Saviour thus teaches us that the burning heart of the vocation of a Christian physician is love. This is what an entire sub-section

of the Catechism of the Catholic Church entitled 'Christ the Physician'[51] states.

This development is affirmed, unexpectedly, in the article on the sacrament of the anointing of the sick. Let us read a few passages from it: 'Christ's compassion toward the sick and his many healings if every kind of infirmity (cf. Mt 4:24) are a resplendent sign that 'God has visited his people' (Lk 7:16) and that the Kingdom of God is close at hand…His compassion toward all who suffer goes so far that he identifies with them: 'I was sick and you visited me' (Mt 25:36)…Moved by so much suffering Christ not only allows himself to be touched by the sick, but he makes their miseries his own: 'He took our infirmities and bore our diseases' (Mt 8:17; cf. Is 53:4). This rich paragraph indicates a progression in compassion and identifies three levels: the compassion for the patient in his or her person; the compassion of Jesus who is seen in the sick person; and the taking on of the misery of the patient.

When speaking about compassion, we here touch upon a fundamental experience of every medical doctor and his or her vocation: medicine, we could say, is love of compassion which has become reason, the affective has become the effective, spontaneous empathy has become a pondered act of care.[52] This is why medical doctors often identify with the parable of the Good Samaritan (to the point that in Western languages the phrase has become proverbial). This parable intertwines the love that draws near, the competence that gives rise to effective deeds, and the patience that allows nature to run its course.[53]

The deeds and the words (*acta et verba*) of Christ thus teach the Christian physician that the incandescent origin from which he or she must irradiate all of his or her work is love. Here lies the challenge of Catholic medicine in the twentieth century: putting charity at the centre of things – and charity in its fullness, that is to say holiness. The health-care personnel 'should show the face of love in its most sublime expression'[54] said Paul VI.

Let us, finally, draw from this a consequence. Above we asked ourselves about an intrinsic tension of the medical act: how to reconcile this primacy of the patient and this nobility? We can now answer that question. This tension is the same tension of the condition of Christ who is at one and the same time Lord and teacher (cf. Jn 13:13; Col 2:10) and the servant of everyone (cf. Mk 10:45), as is borne out by the episode of the washing of feet. The Fathers of the Church summed this up in a paradoxical formula 'To reign is to serve'.[55] We are thus once again referred back to the primacy of charity. Indeed, this is the first of the fifteen characteristics that St. Paul attributes to it: 'charity is patient' (1 Co 13:4).

For that matter love takes a triple form: of God, of oneself and of the other (the sick, the suffering). 'Love the Lord your God with all your heart…Love your neighbour as you love yourself' (Mt 22:37,39). This, I believe, is the exit route from medical malaise: the expression of the triple love of God, of self and of the patient. To be rightly understood and experienced, one should appeal to the other theological and moral virtues of the medical doctor. Let one thing be said: the purpose of medical care and treatment is service to the sick; for a Catholic medical doctor, *agape* is thus to be identified with the love of Christ who identified with each suffering person. But this giving to the other is only possible if the medical doctor knows how to care for himself or herself: how can he or she ask of the other in a credible way what he or she does not live personally? Lastly, these two loves, of oneself and of the patient, renew themselves, take concrete (visible) form, but they also find their equilibrium[56] in love of God.

b. The help of the Holy Spirit

The Holy Spirit pours into our hearts that compassion which Christ the physician reveals to us is the burning heart of the vocation of the physician (Rom 5:5). What Jesus expresses outside us (as a model to follow), the Spirit *impresses* in us (as an effective force). Indeed, Jesus is he who never ceases to obey the Spirit who pushes him: the evangelist St. Luke emphasises this 'pneumatic' way in particular. The Hebrew term 'Messiah', translated into Greek by 'Christ': does this not perhaps mean 'the anointed one', that is to say he who has received the anointing of the Spirit? Christians are children of God. As a consequence, what Christ lives totally, his disciples receive in part in order to be led by his Spirit (cf. Rom 8:14). A physician who follows Christ the physician lives by his Spirit of compassion, of love and of service (the deaconate).

In addition, a Christian physician has always been and is, today more than yesterday, subject to various dramatic tensions. The concrete difficulty that the physician encounters lies in living requirements that are apparently contradictory and conflicts that are often insoluble in human terms:

1. Compassion (that is to say listening to suffering) and the need for truth. This is particularly true as regards bioethics. At times, I would venture to say, witness to truth refers back to its etymology: martyrdom.

2. The need for care and leaving things go in the face of what escapes the medical doctor. This is true, I have observed in this article, as regards every illness (the patient knows this more than the physician) but in particular when faced with great suffering and even more with the drawing near of death.

3. Self-giving with the right level of care for oneself. This takes place in particular today when, after neglecting the wellbeing of the medical doctor too much, concentration is placed, as a reaction, on the suffering of he or she who provides care and treatment, to the point of running the risk of forgetting that the purpose of care is the health of the person who is cared for. Medical practice is never without self-abnegation.

To keep together these three needs that are in tension, we need a superhuman force: the Holy Spirit.[57] The created Gift offers us those created gifts, the theological virtues: the need for truth thanks to faith; accompanying in agreement and abandonment, thanks to hope; self-giving, at times to forgoing things, but also with a just renewal, thanks to charity.

Once again this is not a matter of opposing these three approaches or of juxtaposing them but of ordering them beginning with their core which is *agape*. Let us see this with reference to the first and to the last: charity and faith, in other terms love and truth, compassion and competence. Love is at the centre and truth qualifies it: true love and love that gives good, which is truth. Just as, according to the title of the last encyclical, '*Caritas in veritate*', charity envelopes truth and truth qualifies charity, so, in the Christian medical doctor, the compassion of Christ is the soul that gives life to his or her activity. But this charity is not a passive compassion. It wants good, in particular that good to the utmost that is the safeguarding of innocent life from conception until death, from the man without a face to the man without a voice.

c. A Trinitarian model

The New Testament does not abolish the Old Testament but completes it (cf. Mt 5:17). The teachings of Sirac 38, especially on the participation of the art of medicine in the creative work of God, are thus pre-suppositions of the Gospel. Now, it is usual to attribute the creation to the Father.[58] Participating, through his science and his art, in the healing action of the Father, following Christ the physician with compassion and moved by the Spirit of love, a Christian medical doctor is thus configured to the Trinity.

5. Conclusion

At the beginning of this article I observed the crisis that is currently afflicting medicine and the suffering of those who provide care and treatment. We are not defenceless in the face of this generalised malaise.

The model that I have proposed is not exclusive but integrative. This is a matter of thinking together (and have interact) the medical doctor and the patient in a hierarchical way: the first as a minister or adjutant cause and the second as a principal cause. This pre-supposes the dual mediation of mature – we have seen that we are waiting for a new reflection in this field – and of God – we have also seen that the Bible has a great deal to teach us about the art of medicine as participation in God the physician and about what the burning heart of the medical act should be: the compassionate charity whose model is given to us by Christ and whose strength is given to us by the Spirit.

I am not saying that 'faith becoming operative in charity' (Gal 5:6) is the only solution to the contemporary crisis of medicine. This would mean falling into fideism. However, as I have sought to demonstrate, God is not an accidental partner or a partner who is exterior to healing and to the curative act. It is of vital importance, therefore, to think in a new way about the relationship between God, man and the nature of medical practice.

I will end this paper of mine in an exhortation to ensure that the formation of the Catholic medical doctor of the third millennium ceases to be only technical and only ethical. As is the case with the model proposed above, it must be integral and integrative. Let us end this medical training reduced to the mere acquisition of a knowledge and a know-how. Knowing how to be and even more having to be, which is a duty to love, constitute an essential component of care, that is to say its heart, which should not be left to the mere private consideration of each practising medical doctor. Let it be made clear again that the training of a Catholic medical doctor involves a fourfold mission:

– intellectual and technical training (competence);

– moral formation (education in virtues);

– psychological formation (self-knowledge, self-esteem and healing): the medical doctor must learn to take care of the whole of himself or herself, and do the same with his or her patient;

– spiritual formation (which contains conversion, but also catechesis, that is to say theological formation).

Is this not what perhaps Pope Pius XII said in 1956: 'A physician should consider first and foremost man in his entirety, in the unity of his person, that is to say not only his physical state but also his psychology, his moral and spiritual ideal and the place that he occupies in his social environment'.[59]

Notes

[1] This article was first given as a paper to the international conference of Catholic doctors held in Lourdes, 6-9 May 2010. I have deliberately conserved its oral form.

[2] http://societe.blogs.liberation.fr/laplumeetlebistouri/2007/03/la_malsant_des_.html

[3] Two statistics from many: 'According to the recent survey of the CNOM which goes back to 2003, 14% of deaths of practising private doctors were due to suicides, as against 5.6% in the population as a whole… In 2007, according to research carried out by the Regional Office of Île-de-France, 53% of medical doctors said that they felt threatened by burn-out' (Le Quotidien du Médecin, 24 March 2010).

[4] The philosopher Michel Serres observed, by way of a comparison, that at the time, even though he was the man most surrounded by physicians in the Kingdom of France, King Louis XV cried out every day because of pain.

[5] Second Vatican Council, Pastoral Constitution on the Church in the modern world *Gaudium et spes,* n. 33, § 1.

[6] Paul Ricœur, "Préface", Commission médicale d'Amnesty International e Valérie Marange (dir.), *Médecins tortionnaires, médecins résistants. Les professions de santé face aux violations des droits de l'homme,* Paris, La Découverte, 1989, pp. 5-10, taken from *Lectures 1. Autour du politique,* series 'La couleur des idées' (Paris, Seuil, 1991), pp. 398-403, quotation p. 398.

[7] Jean Monbourquette, *Le guérisseur blessé* (Montréal, Novalis, 2009), p. 72.

[8] Cf., for example, Bernard Häring, *Perspective chrétienne pour une médecine humaine,* translation by. André Divault (Paris, Fayard, 1975) ; Lucien Sève, 'La personne, concept éthique d'intérêt public', Laennec, 44, n. 5 (June 1996).

[9] Dominique Foldscheid, 'La médecine comme praxis: un impératif éthique fondamental', Laval théologique et philosophique, 52/2 (June 1996), p. 508.

[10] From the outset, with Hippocrates and Galen, 'Western medicine was born first and foremost as a general discourse about man and his relationship with the world. It specialised only subsequently'. According to Péigeaud, the fracture began in the nineteenth century: 'We still find in Laennec the same problems and the same descriptions that are present in Hippocrates. During the course of history, physicians read the Greek texts, commented on them or translated them'. But in 1870, with Claude Bernard and then Louis Pasteur, this tradition was lost ' (interviewed in Le Monde des livres, Friday 26 September 2008, p. 10).

[11] 'Medicine became a profession only after 1892. The positive consequence of this was institutionalisation; a consequence that was perhaps more negative and which granted to medical doctors a monopoly of the treatment of illness' (cf. Philippe Adam and Claudine Herzlich, Sociologie de la maladie et de la medicoe, series '128', Paris, Nathan Université, 1995).

[12] Jean-Marie Gueulette, 'Le geste de soin est-il un geste sacré?', *Études,* n. 4083 (March 2008), pp. 341-350.

[13] *Ibid.,* p. 349.

[14] *Ibid.,* p. 350.

[15] Ramon Sanchez, *Au-delà des maux. La mémoire du corps*, written in collaboration with France-Marie Chauvelot, Paris, Sarment, 2001, p. 131.

[16] Le Monde, 29 January 2004, p. 17.

[17] Patrick Choutet and Béatrice Birmelé, 'Malade : un métier ? Utilisateur ou acteur du système de santé?', *Le Supplément. Revue d'éthique et de théologie morale*, n. 239 (June 2006), pp. 105-116, quotation p. 109.

[18] Édouard Zarifian, *La force de guérir* (Paris, Odile Jacob, 1999), p. 71.

[19] 'Corpus et anima unus', officially translated into 'unity of soul and body' (Second Vatican Council, Pastoral Constitution on the Church in the modern world *Gaudium et spes*, 14, § 1).

[20] On how the human being can be more unified than the luving world cf. the vibrant defence of Gustav Siewerth, *L'homme et son corps*, translated by. Robert Givord, series 'Credo', Paris, Plon, 1957. Cf. Pascal Ide, 'Une anthropologie du don. Lecture de Der Mensch und sein Leib de Gustav Siewerth', Nova & Vetera, in press.

[21] Didier Sicard, *Hippocrate et le scanner. Réflexions sur la médecine contemporaine* (Paris, DDB, 1999), p. 157.

[22] The holistic medicine described here is seen in its reactive form, that is to say excluding the mechanistic model, and not in the moderate and integrating sense suggested by its etymology.

[23] Cf. the works by Gabor Csepregi, for example *Le corps intelligent,* translated by Pierrot Lambert (Série "Essais", Québec, Presses de l'Université Laval, 2008).

[24] A typical example is given by the various typologies proposed by the reference work of François Laplantine, *Anthropologie de la maladie. Studio etnologico dei sistemi di rappresentazioni eziologiche e terapeutiche nella società occidentale contemporanea, series* 'Science de l'homme' (Paris, Payot, 1986).

[25] It would be possible to appeal to other philosophical concepts. For example the concept of narrative identity, elaborated by Paul Ricœur (cf. *Soi-même comme un autre,* series 'L'ordre philosophique, Paris, Seuil, 1990, 5ème et 6ème études), inspired fertile medical approaches, such as, for example, that on dementia (cf. Thierry Collaud, 'Que devient la personne dans la démence?', series *L'humain et la personne, Colloque de l'Université de Fribourg* (Switzerland), 7-9 November 2007, François-Xavier Putallaz and Bernard N. Schumacher [éd.], préface de M. Pascal Couchepin, Paris, Du Cerf, 2009, pp. 115-130).

[26] Cf. Q. D. De Veritate, q. 11, a. 1 (saint Thomas d'Aquin, *Questions disputées sur la vérité. Question XI. Le maître,* trad. et notes par Bernadette Jolles, series 'Bibliothèque des textes philosophiques', Paris, Vrin, 1983). For details cf. Pascal Ide, "Health: Two Idolatries", Paulina Taboada, Kateryna Fedoryka Cuddeback and Patricia Donohue-White (eds.), *Person, Society and Value: Towards a Personalist Concept of Health,* series 'Philosophy and Medicine' n. 72 (Lancaster, Kluwer Academic Publishers, 2002), pp. 55-85.

[27] André Frossard, *"Non abbiate paura!"*. André Frossard dialoga con Giovanni Paolo II (Paris, Robert Laffont, 1982), pp. 355-356. 'In the ultimate analysis, comments Prof. Tresalti, health-care director of the Gemelli polyclinic, who operated on the Holy Father, he tries to convince us that in the relationship between medical doctor and patient, he should not be the oracle who allows his decisions to come down from on high. These decisions should be taken in shared agreement since although on the one hand there is the knowledge and expertise of medicine, on the other there is what the person and knows and knows about himself. We know this, but sometimes we forget about it' (*ibid.,* p. 365).

[28] This opposition between objective statistical rules and experienced normality reminds us of the central thesis of the classic work by George Canguilhem, *Le normal et le pathologique* (Paris, p.u.f., 1966).

[29] Giovanni Paolo II, *Discorso sulla sofferenza, Viaggio apostolico in Francia, Lione, Cattedrale di San Giovanni, 5 ottobre 1986*. My emphasis.

[30] Ceslas Spicq, *L'Ecclésiastique, Louis Pirot and Albert Clamert, La Sainte Bible* (Paris, Letouzey et Ané, 1943), p. 756.

[31] Cf. *Livre d'Henoch,* VIII, 3-4; LXIX, 8-12, *La Bible Écrits intertestamentaires*, André Dupont-Sommer and Marc Philonenko (eds.), series 'Bibliothèque della Pléiade' (Paris, Gallimard, 1987), pp. 479 and 546.

[32] Cf. Aristotele, *Etica a Nicomaco*, L. I, 5, 1095 b 26 ; L. VIII, 2, 1159 a 22.

[33] St. Thomas Aquinas, in line with St. Gregory the Great, speaks with pride as a 'tumor mentis', in the literal sense, the spread of cancer in the mind (Somme de théologie, IIa-IIae, q. 158 a. 7 arg. 3).

[34] One could present this choice in another way: the absolutisation of man (his reason) to the point of atheism; the absolutisation of nature to the point of pantheism. The dilemma is then the following: the affirmation of finitude (man in his reason and freedom) to the point of despising the infinite; the affirmation of the infinite to the point of despising the finite. Christ is 'synthesis' without confusion or separation from God or from man, from the infinite and from the finite. Only Christian monotheism thus allows an exit from the dual temptation of atheism and pantheism, which the law and the overturning of the same error.

[35] This is one of the central theses if the works of Fr. Georges Cottier on atheism. This eliminates God so as to worshipman better,. Tgus 'a certain scientism…argues that technical reason is able to work the divinisation of man' (Vous serez comme des dieux, Saint-Maur, Parole et Silence, 2008, p. 110).

[36] Ludwig Wittgenstein, *Carnets 1914-1916*, translation, introduction and notes by Gaston Granger (Paris, Gallimard, 1971), p. 142.

[37] Pio XII, *Radiomessaggio al VII Congresso internazionale dei Medici cattolici*, 11 September 1946.

[38] It will be observed this triplicity of acts themselves specified by their triple object – God ('Prays'), the patient ('do not become bitter'), and the medical doctor ('call the doctor') – reflects in a fragmentary way (the everything of the fragment) the three subjects whose acts are here articulated: that of God, that of the medical doctor, and that of the patient.

[39] For a simple and brilliant analysis cf. Charles Journet, *Entretiens sur la grâce* (Paris, Saint-Augustin, Suisse, Saint-Maurice, 21985, 2e entretien), p. 38-59. Foran in-depth and technical analysis cf. Louise-Marie Antoniotti, 'La présence des actes libres della créature à l'éternité divine', *Revue Thomiste*, 74 (1974), pp. 5-47.

[40] *Catechism of the Catholic Church*, 8 December 1992, n. 308. Cf. all of the section entitled 'Providence and Secondary Causes' (n. 306-308).*

[41] For a systematic approach cf. Hans Urs von Balthasar, *Phénoménologie della vérité. La vérité du monde*, translated by Robert Givord, series 'Bibliothèque des Archives de Philosophie (Paris, Beauchesne, 1952), part 4: 'La vérité comme participation'. There is another translation: *La Théologique. I. La vérité du monde,* translated by Camille Dumont, series 'Ouvertures' n. 11 (Namur, Culture et Vérité, 1994).

[42] Pio XII, *Ai congressisti della Società nazionale di gastroenterologia*, p. 186.

[43] Giovanni Paolo II, *Discorso all'Associazione Medica Mondiale,* 29 October 1983. My emphasis. In the address already cited we also find the following passage: 'I encourage you to continue courageously with your research, to treat with the greatest competence, to combat illness in all its forms and also its causes, whether natural or human. All of this is a part of the plan of God who gave man the intelligence and the ability to progress in discoveries about the human organism and place their fruits at the service of man. As defenders of human life, you are cooperators with God' (Giovanni Paolo II, Discorso sulla sofferenza. My emphasis.

[44] Éric-Emmanuel Schmitt, *Oscar et la dame rose* (Paris, Albin Michel, 2002), p. 92. My emphasis.

[45] Wemay adds that the text of Sirach and more in general the Old Testament gave rise to a valuable model of understanding: the therapeutic alliance (cf. its initiator: William F. May, *The Physician's Covenant,* Philadelphia, The Westminster Press, 1983). It completes the models of service, contract and cooperation.

[46] Or in a dynamic way: 'And give the physician his place, for the Lord created him (Sir 38:12).

[47] For example, in the abstract cited above, Pius XII quotes Sir 38:1 in the Greek version, but he comments on it in the Jewish sense. Indeed, the Hebrew text was written by Jesus Ben Sirac about 180 BC. 'Now', explains one exegete, 'this text that St. Jerome knew has disappeared for more than ten centuries. We know only a translation in Greek carried out in Egypt, by the son of the author shortly before 132 BC, and a Syriac version. At the end of the last century, in a building in Cairo, fragments in Hebrew were discovered corresponding to two-thirds of the text. Subsequently these discoveries were confirmed by other fragments found by the side of the Dead Sea, in the grottos of Qumrân and at Massada, a fortress that fell into the hands of the Romans in 73 AD. This, however, raised numerous problems for critical texts because of the large differences that exist between the various versions. The Hebrew text of Sirach 38 is not, fortunately enough, notably different from the Greek version'. Whatever the case, in general 'it is legitimate to consider this [Hebrew] version as being authoritative' (Maurice Gilbert, 'L'Ecclésiastique quel texte ? quelle autorité?', *Revue Biblique*, 94/2 [1987], p. 233-250).

[48] Cf. Jean-Louis Chrétien, *"L'humilité libératrice" et "L'humilité selon saint Bernard", Le regard de l'amour* (Paris, DDB, 2000), pp. 11-31 and pp. 33-54.

[49] St. Ignatius Of Antioch, *Letter to the Ephesians,* 7, 2, translated by Pierre-Thomas Camelot, Les écrits des Pères apostoliques, series "Foi vivante2, Paris, Le Cerf, 1990), p'. 160.

[50] Cf. Pascal Ide, *'Le péché, maladie de l'âme'*, series Le Mystère du mal. Péché, souffrance et Rédemption, edited by Marie-Bruno Borde, series 'Recherches Carmélitaines' (Toulouse, Éd. du Carmel, 2001), pp. 411-430.

[51] *Catechism of the Catholic Church*, 8 December 1992, nn. 1503-1505.

[52] Cf. the developments in Cristiano Arduini, *La razionalità dell'agire del medico e*

il ruolo delle virtù, series 'Sophia. Epistême' n. 6, Padova, Facoltà Teologica del Triveneto (Ed. Messaggero Padua, 2009), pp. 131-156: 'Specificità della compassione medica'.

[53] The Good Samaritan uses not only vegetal means such as oil and wine but also, and this is often forgotten, the means of movement, his horse.

[54] 'Discours au Comité national italien pour 'la journée du médecin', 18 October 1969, La documentation catholique, 7 December 1969, n. 1552, p. 1060.

[55] Cf.. Second Vatican Council, Dogmatic Constitution on the Church *Lumen gentium*, n. 36.

[56] Like the oscillation between the primacy of the patient and the primacy of the medical doctor, self-love and love for neighbour encounter difficulties in harmonising with each other.

[57] Let us remember that the Holy Spirit breathes within the Church, whose visible limits it is not our task to delineate, and that she teaches us through her Magisterium, the good news of life, the Gospel of life.

[58] This is what is stated in the first article of the Creed: 'I believe in the Almighty God the Father, creator of heaven and earth' Cfr. S. Thomas d'Aquin, *Somme de théologie*, Ia, q. 45, a. 6, ad 2um.

[59] Pio XII, 'Discorso ai membri del Comitato esecutivo dell'Unione internazionale contro il cancro e a un gruppo di oncologi riuniti in giornate di studio', 19 August 1956, *Documents de sa Sainteté Pie XII* (Saint-Maurice (Switzerland), Saint-Paul, 1956), pp. 475479, quotation p. 478. One should quote the whole of this discourse: 'Whatever the case, the medical doctor has the obligation to engage in an authentic mediation where the factors of a human kind are considered much more than the others'. In addition, the medical doctor cannot conceal from himself technology alone: 'Science…here disappears in the face of a broad and disinterested under standing that is sensitive to all the imponderables o fan affective kind, which an overly rigid spirit does not grasp'.

Humanity in the Elderly

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This paper was born from one of the problems that most characterises our Western communities: the growing number of elderly people who are not autonomous. And given that they are many in number, and do not generate interest or mean anything, we must clearly admit that we do not know what to do with them. We increasingly exclude them – or they exclude themselves – from the most vital activities of our communities and we create for them a kind of marginal culture, with their old people's homes, their social clubs and their rites of journeys and entertainment.

Our social consciousness, which is more interested in external appearances than in interior reality, always strives not to alter or not to be overly compromised, not to be moved, and so we are not concerned about 'internal experiences', unless some terrible evil, such as drugs, AIDS, lack of public safety or youth delinquency, assaults our communities. It follows from this that the spiritual deterioration and the desperation of grandparents who are not autonomous do not appear to be relevant.

Our social consciousness is struck by things that have a 'high visibility', like the large monuments, the large squares and the abundance of medical resources, much more than by things that have a 'low visibility', such as personal treatment.

In a home for elderly people who are chronically ill, for example, the personnel, although they are caring and affable, seem to have an attitude of indulgent superiority towards elderly people, whom they see as disoriented children in need of care, to whose confusion special attention should not be paid, whereas their physical needs are assiduously attended to.

Old people's homes are directed towards the body and not towards the mind. The mind of elderly people obstructs the true purpose of an institution which is to provide medical care and treatment, food and asepsis. Everything that is asked for rationally by elderly people is given to them as rapidly as possible, work is actively engaged in and they are rarely talked to with severity. At the same time, the personnel seem to have a minimal understanding of the mental characteristics of an infirm and elderly person.

In an institution for poor people who depend on insurance, the director discovers whether an elderly person has been washed or not, but not whether the person who has done so has taken a little more time to wash him or her, treating him or her as a human being and not as an inanimate object. Given that to dedicate too many minutes to a human being means that an assistant loses time and cannot reach his or her 'quota' of patients, they are washed as though they were worthless objects, with a violation of their intimacy, because there is not enough time to move the screen or change the bed linen so as to respect the modesty of the patient.

Elderly people pass the last periods of their lives in long periods of anxiety and silent memories, mixed with outbreaks of rage or petulance in their relationships with other people, watching television or receiving visits from family relatives. At the same time, elderly people hold out their hands to those who can attend to them in a personal way and if they could they would keep them so as to talk to them without end. There is a wish for communion but little real ability to achieve it.

Thus, the most important general characteristic of a healthy community *concerns the place that elderly people have within it. In our communities they must have a place that is worthy of them.*

In my paper I will speak about culture but above all about individuals. I will try, with reference to nine characteristics, to connect culture and the individual. I will concern myself, above all else, with defining well those elements that mean that a culture and its communities can be open, caring and personalising.

1. Personalising and Communicating

A community is that part of the social fabric that is located between the individual – in this case an elderly person – and society. The two extremes – the elderly person and the world – can make a community unilateral.

At one extreme would be narcissistic, isolated and self-absorbed – indeed purely subjective – communities. *Two examples* may be given of them. *The first is the so-called 'solitude in two'*, where couples close themselves up in their own homes even more than isolated individuals, widows/widowers or singles. The often jealous, manic, tyrannical attachment that they have to each other leads them to create a void around them. *The second example is those 'old people's homes'* which are marginalised and isolated from the social fabric and in which elderly people vegetate and pass their time in a monotonous way waiting for the next meal.

At the other extreme would be those chaotic and confused communities in which the individual loses himself or herself and dissolves his or her own identity in the global reality of the world. One survey has revealed, for example, that one elderly person in every three, living in the wider community, has no social relationships, never receives a letter or a visit, and does not know anybody.

1.1 A healthy community must first of all personalise

Here I was struck by the comment of an elderly lady who, in an old people's home, had received a bunch of flowers. She told me: "I do not know the people who sent it to me – they are from a club to which my son and daughter-in-law belong, they do not know me – and so I received it because of my son and my daughter-in-law. All those people who do me good do it because of other people, not for me. A whole host of people send me postcards and do things for me, but they are friends of my husband or my son; they are not my friends". Although the feeling that one is not loved may be a personal peculiarity of that elderly lady, I believe that one is dealing here with a rather general feeling in our culture.

First of all, people have placed a high standard of living in the place of their own authentic selves; thus they do not cultivate the self but a standard of living. In addition, we perceive that our culture does not provide us with a way of assessing with certainty our individuality, and we find ourselves forced to assess it through external things or by obtaining qualifications.

We also lose our friends who seem to abandon us without any apparent reason or who simply go away, so that a personal community does not exist in which our true identities can be reflected. It follows from this that it is difficult for us to believe that we are worthy of live, independently of the fact that our parents may have loved us.

These underlying conditions become worse during old age because many of the people that elderly people loved have died or many of the people who surround them are younger people who as a consequence see them as extraneous, strange and boring. There is therefore no role to perform and these people become elderly people who are not autonomous.

1.2. A healthy community, secondly, must relate to people and communicate

One should at this point say that elderly people feel lonely because in reality they are alone. Society is not interested in them since they now consume less as compared to other social groups. They look for autonomy in distraction and chatting, and few act so as to go on being useful. An elderly person usually thinks that he or she has no role in post-modern society, that the only thing that he or she can do is to rest and enjoy life. What in principle does not seem to be a bad thing can be transformed into a trap of tedium and ugliness.

From this one clearly deduces a *first* fundamental and *general* aspect of a healthy community that is able to integrate elderly people: *strengthening to the utmost its members – including elderly people – in the strong integration of a shared project*.

And we can right away give the community a task: 'The purpose of a community, of every authentic community, lies in personalising the individual – in this case the elderly person – allowing him or her communication with the wider community'.

2. Affiliating, Belonging, Being Faithful

The phenomenon of the community, in our Western world, must be located in its context. And this context, faced with the wider community, has a general difficulty: many of the concerns of people as regards acceptance and conformity derive from a lack of affiliation, of belonging and of fidelity to our society, which means that a *personal community* is something that is so uncertain that people must take advantage of every resource possible in order to assure that they are not alone.

Filiation, in contrary fashion, is important given that it is known that the most effective protection for elderly people is the protection that is assured to elderly parents by the love of their children.

For this reason, the goals of care for elderly people are not social or merely therapeutic action. They must involve, amongst other things, the prevention of the break up of the family and keeping an elderly person in his or her home for as long as possible.

These goals must be laid down very early. Reheim has emphasised the correspondence between the happiness of youth and the happiness of old age. In the further development of the personality, the importance of the way in which a child was treated is known about.

When a child is not rewarded in his or her alimentation, protection

and tenderness, in him or her there grows rancour, fear and even hatred. Once he or she has become an adult, his or her relationships with other people are aggressive, and in all certainty he or she will abandon his or her parents when they are able to look after themselves.

When, on the other hand, parents nourish well and cuddle their children, they make them become happy, open and benevolent individuals. When they inculcate in their children feelings of belonging, they ensure that when their children become adults they develop altruistic feelings and in particular feel attached to their parents, recognise that they have duties towards them, and carry out these duties.

If such is the case, one should reflect on what has happened in our Western societies which can be explained with reference to the following data. One survey shows that 92% of elderly people say that they are respected and loved by their children whereas only 63% say that children in general love and respect their parents. Evidently, in many of these answers either the elderly person is lying to himself or herself or his or her pride is at work, and to such an extent as to not want to admit to himself or herself that he or she is alone or neglected.

On the other hand, it has been demonstrated that: amongst elderly people who are economically weak, his or her familial relationships do not improve his or her state of mind; amongst those who are well off friends are more important than the family; and the rather close presence of brothers, sisters and cousins etc. may not be helpful to the elderly person in his or her life.

However there is no more tender image than a child in the arms of his or her grandfather as he tells him or her a story. And there thus emerges a second healthy aspect of a community: *its capacity for affiliation, its matrix of belonging and a sufficient time to structure faithfulness*.

3. Values and Impulses

A community today – if it wants to be a healthy community in which elderly people can live – must act as a *place of refuge* in the face of a culture that works by impulse.

3.1. Our culture is moved by *impulses*: related to fulfilment, competence, earning and mobility, and by those related to satisfaction and a higher standard of living. Impulses such as hunger, thirst, sex etc. arise directly from the chemistry of the body, whereas those of expansion, competence, fulfilment and so forth are generated by culture. Despite this, we yield to these last just as we yield to hunger and sex.

In this kind of very impulsive culture how can elderly people survive? How can they survive when: at a psychological level, elderly people conserve: their vocabulary, general information and common sense; whilst, in contrary fashion, they lose: abstract reasoning, learning, memorisation, speed of reaction and assimilation, attention, concentration, and the organisation and structuring of their vital spatial field. And it is specifically these characteristics which make some aspects of the psychological lives of elderly people rigid; when their interests and attraction to risk decrease it becomes difficult to control their emotions, something that gets worse with age and this means that an elderly person, like a child, controls his or her impulses badly; when between the age of sixty and seventy anxiety increases, which makes elderly people more vulnerable to change and because of this they take refuge in the consumption of alcohol and anti-anxiety pills; and when, for reasons that are both physical and psychological in character, they are more sedentary; and when it is known, indeed, that greater age is matched by greater resistance to changes, that new ideas are adopted slowly, when they are not rejected. Is it because of all this that this part of the population is deemed to be very conservative?

An apparent tranquillity in the face of death, side by side with a wish to prolong life, is connected to this culture which, in operating by impulses, stresses only survival and does not know how to prepare the mind for the final journey.

One should confess that this liberation from impulses does not create problems. How can a community address the vigorous impulse of its members and yet absolve the task assigned to it as regards this period of life? How can it liberate primary emotions without unleashing chaos? There are cases of children who are alcoholics, of adolescents who are drug addicts, and of young people who have 'no respect'. How can one allow impulses to be offloaded and at the same time provide sufficient peace and quiet because these people, like elderly people, need slower rhythms and have the right to exist?

3.2. For this reason, faced with what is held to be a 'wild' development of the most immature and unconscious (impulses and desires) parts of us and our culture, there exists nostalgia for another kind of need which we could call *values*. A moment must arrive where people live in tolerance and there is a capacity for living together in society, freedom and participation like never before, but, inexplicably, we do not see all of this as a realisation of values.

And thus the third psychological characteristic of a healthy community is to be a place of refuge where other kinds of solicitations can be operational, which we may call values, such as love, goodness, tranquillity, contentedness, entertainment, frankness, honesty, decency, rest and simplicity. Because only starting with these values can elderly people have a place, a meaning and usefulness.

4. Strengthening the Individual

A community – if it wants to be a healthy community in which elderly people can live – must want, be able and know how to *protect its members* from what, more specifically, destroys them: the indiscriminate and voracious invasion of desires.

The existence of a vast potential of human needs has always been recognised but after modern industrial culture, with its capacity to produce almost everything, the time has come to open the curtain on infinite needs.

Desires and consumption are destroying the most fundamental thing of the Indo-European, Islamic and Jewish tradition, namely the system of control of impulses, inasmuch as the desire for a million things cannot take place without stimulating yearning for everything.

Indeed yesterday I was able to see this represented on a stall in the underground. An advertising poster read: 'All your Desires' and underneath it was 'All your Presents'. It was signed: '*El Corte Inglés*'.

If we allow ourselves to be transported by our desires, if the only valid and palatable cultural model is that of satisfying them, we understand that this means the marginalisation of those people who 'are irritating' because they have deteriorated or simply because they are old.

In this sense, we must dare to affirm that behind many requests for a place in an old people's home, or behind that elderly person who spends months if not days in the various homes of his or her children, there is the sensation that this elderly person is irritating and impedes the comfortable satisfaction of our desires. And, in contrary fashion, we should state simply that we do not like to see, to feel and to live with an elderly person.

Certainly, this is connected with change. An intact human being is physically and mentally healthy. In this health figure sight, reasoning, hearing and continence. But a deteriorated person is mad, blind, deaf or incontinent. The more a person has deteriorated, the more other people strive to distance themselves from him or her. Some handicaps, such as incontinence, for example, are more repulsive than others. Naturally enough, not everyone draws away from such people and probably the more problematic an intact person is, the greater will be his or her tendency to keep distant those people who have handicaps. It is difficult to imagine that a person who has received love and who has been fortunate will draw away so rapidly from a being with a handicap, as much as a person who life has been a series of privations and humiliations.

Thus the tendency of healthy people to draw away from people with handicaps is connected to their *experience of privation* and degradation in their own lives.

But this drawing away must also to a certain extent be related to *fear* of people with handicaps. People who are afraid of people who have handicaps will very probably draw away from them more than those people who do not fear them.

Lastly, we may suppose that if a deformed person – a hunchback, for example – *has something to give* – human warmth or presents – people will feel less inclined to reject him or her.

All of this can be expressed in what appears to be a kind of law of deformation and marginalisation: 'the tendency of healthy people to draw away from people with handicaps is determined by the level and nature of the handicap, of the level of handicap of healthy individuals and by their fear of the deformed person, and by the resources of that person'.

Faced with the current crisis of the 'new poor' and the future crisis when they are elderly, a negative stereotype of old age will appear: ageism, gerontophobia and a practical state of loneliness and illness, of immobility and hopelessness, of restriction of freedom and poverty, and of unhappiness and fear of death: a 'grey panorama' this was defined as being yesterday by the representative of EUROLINK-AGE, Margaret Batty. Thus Mauriac is right to state that 'an elderly person exists only through what he or she possesses: given that he or she does not possess everything, he or she is thrown in the garbage can; and at this advanced age one can only choose between admission to a home and fate'.

A healthy community, where elderly people have their proper place, must dedicate itself immediately to the task of protecting its members because to be a slave to impulses pre-supposes a weakening of the self. The identity of the self – above all when it does not reach the high standards of the cultural models – is impoverished because desire and consumption impose on people the forgoing of their personal needs.

Today, the fourth characteristic of a healthy community very closely concerns systems of defence. Whereas down history, human communities established themselves in forests and deserts with the aim of obtaining food and protection, at the present time a healthy community should also find a way by which to meet these inevitable needs and protect itself from others that are superfluous. A healthy community should teach its members to know how to transform certain impulses into higher goods and defend them against the invasive opinion which holds that the sacrifice of impulses does not guarantee the achievement of rewards on earth or in heaven.

5. A Capacity for Emulation

A healthy community – as I have already pointed out – is able to provide its members with a sense of belonging, a place of shelter, the strengthening of individuality and operational defences against all dangers, both ones that are internal and ones that are external.

In addition, it should be able to have sufficient vitality to educate its members and to be able to offer them projects and tasks.

In our society we can observe the *erosion of the capacity for emulation*, the loss of the capacity to take another person as a model. Instead, in a competitive culture, a person envies all the good that may befall another person. One need only know that someone has something good to begin to feel depressed or envious or both these things together. In a competitive culture the success that someone obtains in some regards constitutes a defeat for another person, even when this success does not have anything to do with him or her. Envy kills emulation at the roots.

We live in a society that worships everything that is young. For this reason its idols are speed, struggle, strength, nerves, sexual potency, political, ideological or simply mental rebellion, and, as a consequence, image. For this reason, it is believed that elderly people are a silly thing.

For the 'Pepsi generation' an elderly person is a complainer; he or she is capricious, a trickster, depressed and decrepit, and lives in

an ivory tower. Engaged in airing his or her sweaty clothes, useless, and unable to assimilate the new, he or she looks backwards with nostalgia and anger. He or she is an individual without gender or sex; he or she is tired, paranoid, neurotic and unpleasant.

But the relationship of children, young people and adults to elderly people is vital. For this reason, I was happy to hear yesterday that in an old people's home there are 'children volunteers'. Their authority (as regards the elderly people) is based upon duty or the respect that they inspire; the day that children, young people and adults free themselves from these feelings, elderly people will have no power.

A *capacity for emulation*, however, is a cultural aspect which it is extremely important to conserve, and this for various reasons:

1. Because culture depends, whatever the case, on these potentialities inasmuch, in large measure, it is through the vigorous potential inherent in the emulation of these qualities that man possesses and are maintains the moral qualities of the community, and man has relied upon this mechanism to educate the new generations.

2. Covery, in emphasising that an elderly person maintains the fundamental characteristics of his or her personality and adapts them to new situations, states that in our epoch it is necessary to retrieve old age because in the near future not only will there will an ageing of the population but also an increase in the very old and not autonomous compared as compared with the number of young-old people. This is an increase that will be in parallel with a decrease in supports for the family, given that there will be an increasing number of singles and couples without children

3. When disappointment and suspicion are joined to a feeling of having been betrayed, populations find that they are without models to be imitated and communities suffer a grave crisis of identity.

A healthy community, so that within it is achieved an emulative choice that is morally solid must, as a fifth characteristic, have sufficient faith in itself to be able to present its own educational projects with a certain ingenuous optimism that is able to affect the will of its members.

6. Love and Authority

Nowadays, in our culture, *dependence* has acquired a special significance because in every community it places a brake on impulses; and the desire to be independent rarely means something more than the wish to do something that pleases us. The anxiety or anger of those of advanced age is thus seen as 'unjust', 'absurd' or 'backward'. Today, the demand for independence often possesses a sort of unreflecting egoism which is light years from its ancient meanings.

Thus everyone admits the difficulty of having an elderly person in the nuclear family: there is no room for the elderly, one cannot look after them because both the husband and the wife work, and in addition they take away time and spaces for independence and freedom, and disturb the children.

This implicit philosophy is what fosters the proliferation of admissions and old people's homes. For this reason, keeping in mind the humanity of the elderly, we should ask ourselves: do elderly people wish to go to an old people's home? What are the reasons that force them to go such a place? And if there is no other remedy, what is their life like there?

All research demonstrates that 74% of elderly people put up resistance to going to an old people's home and 15% accept the idea because they are invalids.

There are four principal reasons why elderly people ask to go to an old people's home.

1. First of all, an insufficiency of resources. In large institutions three quarters of them depend on welfare whereas those who have a pension prefer small private institutes.

2. An inability to find accommodation and problems in dealing with this problem.

3. Family reasons. Children refuse to take in an elderly person or decide to get rid of him or her.

4. Lastly, elderly people need medical assistance.

In general, elderly people go to an old people's home in their local area, either as poor people or by paying a part of their pension. There are elderly people who spend all their time going from one home to another; between homes they wander and drink. Some people reject infirm elderly people; others accept them, even though they are young.

But when speaking about individuals and personalisation, it is interesting to know here how elderly people experience this.

One can understand how entering an old people's home constitutes a drama for an elderly person. The psychological shock is especially strong in women, who are more rooted in their homes. They emit signals of anxiety and they tremble. Gradually, many become resigned. At times, it seems, the old people's home restores to an elderly people the enjoyment of life; he or she feels less isolated, he or she makes friends: through a kind of emulation, he or she takes more care of himself or herself. However this happens rarely.

A statistic of Dr. Pequinot indicates that amongst elderly people who are admitted to a home: 8% die within eight years; 28.7% die during the first month; 54.4% die during the first year, and 65.4% die during the first two years.

This means than over a half of them die during the first year of their stay. The conditions of life in old people's homes are not the only factors at work; amongst elderly people it is chan ge, whatever form it may take, that causes death. Rather, one should be concerned at the fate of those who survive. In large measure one can sum up this fate in a few words: abandonment, segregation, dementia and death.

Most of them have difficulties in dealing with community life. Discontented, anxious, and closed up in themselves, they are locked up together without any kind of social life being organised for them. The subject and the contents of this symposium – 'The Formation of Animators for Elderly People' – are therefore welcome! Their susceptibility, their vengeful tenden-

cies which are at times paranoid, produce frequent reactions of conflict. All the pathological processes to which old age is subjected accelerate in old people's homes.

In trying to understand these people one should remember that they are not simply elderly people but elderly people in an *institution*, separated from their families and their friends, except during visiting hours, and that who looks after them is paid to do so. It is certainly the case that in many instances it is better for them to be cared for by people motivated by a pecuniary benevolence and not a family that has no benevolence at all. Despite this, the choice can be hard and constitute a reason for grave tension which people who because of their age are not equipped to deal with it well. The difficulties inherent in being elderly in our culture are increasing, even in conditions of pecuniary benevolence, the needs for the order, routine and profits of a institution, which exercise all their power of coercion. We may say, without fear of error, that some people would not be in an old people's home if they could choose, something, naturally, that they cannot do, because of their debilities, their illnesses, money, the inability of their families to take care of them and an absence of a wish to do so, behind which, and because of which, old people's homes proliferate in number. For many elderly people, not even the care of these homes can eliminate the 'bitterness, fever and irritation' that accompany elderly people in our society.

The thirst for independence, behind which, and because of which, old people's homes proliferate in number, has been formed by the philosophy of permissiveness in the upbringing of children and the consequent erosion of the capacity for gratitude towards elderly people in a culture directed towards impulses.

The obsession with independence of many young couples is connected with an anxiety about not having anything or not being at times capable of self-esteem. In this context, independence, keeping a distance from other people, is an expression of a fear of becoming lost and subject to the control of another person through love, friendship, gratitude or intellectual dominion. In this context, it is not strange that elderly people do not find space for themselves.

A healthy community should know how to overcome this malevolent spell which has it that love is a tie, friendship is dependence, and gratitude is servility. The seventh characteristic of a healthy community lies in the art of conjoining love with authority.

7. The Meaning of Life and Spiritual Meaning

I believe that what is happening in our Western communities is the result of a deep spiritual crisis. One needs to have audacity to affirm that the gravest thing that has taken place in our communities is that the ability to think and act with a framework which has a hierarchy of spiritual values, the existence of s unifying core thanks to which man is directed in life, is about to be destroyed in our society. We are condemned to a praxis of wellbeing and consumption and thus we do not have this core of spiritual unification which gives meaning to our lives.

It is particularly difficult to find in our culture the meaning of life and the meaning of elderly people. Only some people – the best, the strongest or the most fortunate – have been able to achieve this eighth stage of Erokson: 'Only the individual who has taken care of things and people and has adapted to triumphs and to the disappointments inherent in the fact of being generated by other human beings or of products and ideas can accede to the maturation of a the full integrity of the self. This integrity is the accumulated security of the self in relation to order and meaning. It is a post-narcissistic love of the human self as an experience that transmits a certain order of the world and spiritual meaning however much has had to be paid for this. It is the acceptance of one's own and unique life cycle as a thing that had to be and necessarily did not allow any replacement: it thus means a new and distinct love for one's parents. It is camaraderie with the organisational forms of remote epochs and with distinct activities, just as they are expressed in products and the simple sayings of such times and activities. Whoever perceives the relativity of the various lifestyles that have given meaning to the human endeavour, he or she who posses integrity is always ready to defend the dignity of his or her own lifestyle against all physical or economic threats. Inasmuch as he or she knows that an individual life is an accidental coincidence of a unique life cycle with a single fragment of history; and that for him or her every human integrity is maintained or collapses with this unique style of integrity in which he or she participates. The style of integrity developed by his or her culture is thus transformed into a 'patrimony of his or her soul', the seal of moral paternity of himself or herself. In this final consolidation, death loses its character of being oppression.

The lack or the loss of this accumulated integration of the self is expressed in fear of death: one does not accept the unique lifecycle as the essential of life. Hopelessness expresses the feeling that the time that remains is short, too short to undertake another life and to try alternative pathways towards integrity. The malaise of his or her concerns hides hopelessness, most of the time in the form of a thousand little sensations of malaise that are not the same as great remorse.

In order to draw near to integrity or to experience it, the individual must learn to follow the bearers of images in religion and politics, in the economic order and in technology, in aristocratic life, in the arts and in the sciences. Thus the integrity of the self implies a rational integration that allows participation by consent and the acceptance of the responsibility of leadership.'

Today the tragedy of old age is the radical condemnation of the whole of a mutilating system which does not supply to the vast majority of people who belong to it any reason for living. The work and the difficulties dissimulate this absence which emerges at the moment of retiring. It is much graver than apathy.

For this reason, people who are not autonomous cannot speak

about the present because they have nothing to do; they can only comment on their roles in the past and as soon as they become bored they also draw away from each other. Past lives dedicated to doing what they did not want to do, but which they had to do; jobs which required neither study nor thought nor speculation, and which did not prepare them for old age, when there is nothing to do. We have here once again an omnipresent irony: this time it involves narrating the roles performed by men who no longer have a role, except that of *acquiescent internment*, and of speaking about the pleasures of travelling for men who will never travel.

Once he has become old a worker has no place on earth because in reality he or she has never been granted a role. Simply he did not have time to realise this. When he understands this, he falls into a kind of brutal hopelessness.

With all of this, and this is the seventh characteristic of a healthy community, it is very important to bear in mind the fact that without a solid moral and spiritual foundation no political activity can aspire to success in a society that is as demoralised as ours is.

8. Generosity, Tenderness and Compassion

Sooner or later in the life of man there appears a shadowy line – old age, which we traverse with a shiver and which makes us think that the gardens of Eden, the enchanted reason of our youth, have passed.

But the real evil of growing old is not the weakening of the body but the indifference of the soul; the doubts that assault us when we see things and beings as they are and one enters the age of why: why leave? Why work? Why struggle? Why live?

To know how old a person is not the same as asking him or her how much he or she feels old; the data on the birth certificate is objective and inexorable, but a state of mind can be recovered because nobody is as unfortunate or as old as he or she thinks.

Without a self man is nothing. But in contemporary society the self dies a little every day. Surrounded by the visible expressions of a high standard of living, a man usually gradually forgets that he is alienated from his self. For this reason, with his socially modelled defect narcotised today's man can only just tolerate the weak and failures, the elderly and the mad, because they are the expressed consciousness of the fact that his self is also constantly immolated. Unable to rebel, he is prepared by small doses of humiliation and sick people remind him of his failure and his slow deterioration; for this reason he distances them and he excludes them.

For our subject – humanity in the elderly – one should reflect on how this kind of culture which is so intolerant and emptying can respond to the so-called collective of 'risk'.

1. Those who are more than eighty-five years old; Akthar (1973) tells us that four out of five of these people are incapacitated and require a certain kind of help.

2. Those who live in situations of loneliness and social isolation, who are separated or without a family.

3. Those who have been deprived of something in general; the elderly women who has lost her husband but also the elderly women who has lost a child and social support.

4. Those who live 'by charity' and do not receive welfare support, help from the community or the local council.

5. Convalescents and those who have recently been discharged from hospital and who in their homes do not receive adequate assistance.

6. Those who have recently had to change their address and are without roots, since elderly people very much note change and have great difficulties in adapting to a new situation.

7. Those who live in areas of underdevelopment, poverty and acute poverty in large cities, with fear about acts of vandalism, theft and violence.

And very concretely at the moment of observing the generosity, the tenderness and the compassion of our culture, we cannot form an idea of this by touching on the button of what this society does for its 'most marginalised' elderly people.

1. The situation of the '*homeless, who are often mentally ill*' who are the new marginalised people of the third millennium and who are gradually increasing in number.

As regards these people, the first step in a common approach is that of the policy of the 'revolving door': this involves making the elderly person enter without many difficulties and making him or her exit rapidly with a diagnosis and treatment, without being concerned about whether he or she will be monitored or whether social or health-care resources exist to achieve this. This rapid coming and going in hospitals, old people's homes or psychiatric hospitals means that the sick person, or his or her family, grows tired and does not go to the centre involved; rejection of admission of the sick person by the health-care staff is also more easily obtained.

Often elderly people sleep in the streets, in underground stations or in parks, covered by newspapers, and they die numbed by the cold. Within this group of 'homeless' marginalised people the percentage of sick elderly people is very high. At times they are alcoholics. Today the image of these people has become rather frequent in our European 'super-capitals' and this shows to us the cruelty of society towards elderly people, without it being realised that all of us could go through this same condition.

2. Equally illustrative here is the cruelty of another kind, a *cruelty* that is personal: I am referring here to the *ill-treatment of elderly people*.

If a person it truly autonomous it is unusual for him or her to be ill-treated. A lower level of autonomy is matched by a greater likelihood of ill-treatment.

The most visible form of ill-treatment is, logically, that of a physical kind, which takes place with greater intensity the less the elderly person is autonomous. Tying elderly people down, for example, is relatively frequent, even in specialised centres. Physical con-

tainment can be used, but it should not be abused.

Psychological ill-treatment is overly known about and goes from despising elderly people to ignoring them, to the point of insults.

It is better not to speak about financial and/or material ill-treatment: it is known that in the case of elderly people, in addition to receiving a low pension this is 'administered' by the family.

As regards the ill-treatment of elderly people we must know:

1. That looking after an elderly person, above all when he or she is losing autonomy, is stressing for his or her family; and a stressed family can generate bad treatment which begins with bad nutrition.

2. That the ill-treatment of elderly people comes, mostly, from their children, or more specifically from those who are 'married and have children', and rarely from the grandchildren.

3. That at times when this ill-treatment is of a psychological character it is unconscious. There is a form of ill-treatment which is particularly discouraging: that which is produced within the couple…

4. Lastly, the ill-treatment can be institutional: it is that of medicine which is directed towards technical progress, or of old people's homes, which are directed towards profit-making.

All of this is an alarm bell because however much we progress in solidarity, democracy and care for the weak we can never manage to achieve the paradises that are promised. Through the tremendous suffering of two world wars, Europe learnt to forgo its utopian dreams and now we at least know to what our extent our natural frailty does not allow us to play with prefabricated models of man and the social fabric.

As regards all of this, I believe that a well established community should foster something which is very vital, even though it is not mentioned: repairing. If the evil of the world is so tenacious and if we have to admit with Camus 'that we cannot go forward without causing injury to someone', it is very important for the best men and women of the community to dedicate themselves to the task of repairing. A community, and let us say this frankly, needs *these saints* who with generous self-giving return to give spiritual meaning to daily life and become a model of that to which our hearts aspire to internally.

People who repair because we have to admit that in many communities today the salient characteristics in addition to impulsiveness and the struggle for dominion are a lack of 'engagement', incoherence and a lack of concern for tenderness. These will be unhealthy communities which, beneath a patina of hyper-sensitivity, conceal their fundamental weakness.

A healthy community should, as an eighth characteristic, be tolerant with its weakest and non-autonomous members, giving ample space to tenderness, generosity, goodness and compassion.

9. Celebrating

In all cultures, opportunities for social *climax* require demonstrations of emotion, almost by decree. Arrivals and departures (counting amongst these birth, which is an arrival, and death, which is a departure) are some of the occasions for celebrations. Initiations are as well: the first word spoken, the first steps, birthdays and illness. Social climaxes are ritualised.

Every decay of a ritual constitutes a decay of culture, and communities that do not celebrate are usually emotionally impoverished communities. One of the first things that happens when a community begins to decompose is that the ceremonial systems disintegrate; this leads to internal disorganisation, to the loss of values and to interpersonal atomisation.

But celebrating, too, in the case of elderly people, has its problems. Celebration in elderly people and with elderly people has its own special connotations:

9.1. First of all, every celebration has an important ingredient of evocation and memory; during ageing what produces most disturbances *is the loss of memory*. Elderly people, when they no longer recognise their family relatives, do this because their memories have been emptied, even though they continue to have the ability to engage in involuntary acts connected to lesser aspects of it.

9.2. Secondly, every celebration is an event and elderly people are excluded or do not adapt to the present.

9.3. Thirdly, every celebration has a dynamic sense that looks to the future, and the elderly person can only contemplate death and this is a taboo for our communities that are alienated in consumption and atrocious satisfaction.

Taking these conditions together it is not strange that an elderly person excludes himself or herself or that he or she is excluded from the 'celebrations of life'. And it is not strange, in addition, that when the ties that unite them to their culture are broken elderly people are provided with other types of celebration and entertainment which are more connected with the interests of those who programme them than with the authentic interests, desires and needs of elderly people themselves. I am thinking, here, of tourism for elderly people, carnivals and parties.

And, as regards celebrations, it will be necessary to explore another dimension: an apparent tranquillity in relation to death, side by side with a desire to prolong life, is linked to a culture which, in placing emphasis upon survival, does not prepare the mind for death. Since sensuality and appearance also have a pre-eminent place in this culture, decay and death seek to disappear from sight and consciousness. It is logical that the anxiety provoked by obsolescence, by fear of death, is in contrast with the persistent celebratory symbols of sensuality and appearances. Hence all that agitation about 'celebrations' and 'parties' that are organised around elderly people. At times they are more connected with our anxiety than with their real interests.

A healthy community, and this is the ninth characteristic, must provide settings and opportunities to express at an emotional level important events. Amongst these there is also old age, illness unto death itself. Celebration, in addition, with them and for them.

10. A Question

How can elderly people realise their humanity in the concrete limitations of our culture?

10.1. *First of all*, one is dealing here with a specific task of an elderly person who must above all else safeguard his or her utility, autonomy and dignity.

Ortega states that old age should be experienced according to the parameters of the young: 'To feel young in a world of old people one should have the capacity to smile and have optimism; with friendship, faith in Man and men, love, idealism, generosity, enthusiasm (which comes from *enthousos*, to fill oneself with God), the search for ideals, rebellion, a desire for self-assertion and the need for change'.

An elderly person – and I stress the point – if he or she wants to feel young in a world of old people must laugh easily and have understanding in the face of changes. Sexuality passes by way of carnal love and possession to being tenderness and forgoing. How wrong are certain sexologists! Youthful enthusiasm is transformed into open experience for everyone and, as a consequence, into wisdom. Rebellion will be prudence and lastly, serenity will be peace and perseverance.

An elderly person, if he or she does want to prostitute his or her own identity or alienate it in a thousand tasks that the society of consumption proposes or him or her – and we should not forget that businessmen are discovering that the 'elderly' person is a very appetising customer – should live more by values: generosity; disinterested and sincere friendship with others; love or dedication to others in freedom; love for truth and enthusiasm, that is to say faithfulness to certain principles and the capacity to fill oneself with God, to become enthusiastic in the face of the good, the beautiful, the just and the true; and the capacity to be amazed by the new, that is to say to conceive of things, to imagine, to change and daydream.

Thus the line to follow is: live, love, work, learn, think, give, laugh, try, persevere and dream because today is the first day of rest of your life.

10.2. Secondly, this is the task of everyone. Principally by helping elderly people to recover their own subjectivity, keeping them in our affections and restoring to them illusion. Emotion does not really die if one only gives it an opportunity. Poor, sick, old, depersonalised people, those tied to a bed in an unhospitable old people's home, maintain a spark of hope. This ability to evoke emotions is a primordial endowment of a cell and dies with it. The self is a spiritual manifestation of this capacity of man.

I never tire of saying that *all life is emotional life*, with the golden and grey components of th thought of Margaret Batty. By a complete emotional life I mean when one admits the whole of the impressive gamut of human feelings: love and hatred, envy and reparation, emulation and jealousy, selfishness and generosity.

To admit the subjectivity of the elderly assumes, in that movement itself, admitting that the capacity to hate probably lasts as long as the capacity to love. If, at the doors of death, the ability to love still exists,one can say the same about hatred, and this must mean that *how and what* to hate are lessons that are learnt early and well.

I will give an example of this. In a old people's home that one pays for that I know Mrs Pérez has conserved the *capacity to wound*, just as Mrs Gómez has conserved the capacity to hate. The first, therefore, must be very careful because otherwise she would not know how to wound so well. If it is true that the value that an idea or a feeling has for a culture can be measured by the space of time in which a body that is dying lives, then, given that the capacity to love, hate and wounding seems to last as long as mental acuteness, culture must have a very high view of them. Amongst the elderly women of this old people's home there is no love but there is a great deal of hostility. Here love is visitors, between two and four in the afternoons on Tuesday, Thursday, Saturday and Sunday and between six and seven on Monday, Wednesday and Friday. It is something that the elderly women limit to their families and friends, and they offload onto other people their ill humour.

In this old people's home the visitors are counted as though they were beads on a rosary and this is what people who are drawing away from life *must* do. "They are many people who come to visit me, but few come to see you" is an envious comparison that raises the rank of Mrs Pérez while it lowers, at the same time, the rank of Mrs Gómez: *the impulse to fulfilment aims at the heart of death itself*. Thus this impulse which we, too, have learnt, persists, with love, hatred and the ability to wound, until the end of life, because our culture greatly esteems it.

I do not know whether Ihave managed to explain myself. In this old people's home we encounter people who are so old that they have to be tied to their chairs, who await the arrival of death at any moment, and yet despite this fact in them culture is alive – indeed more than alive – as alive as their breathing. It is almost as if the culture had been imprinted into them. It is a sort of *instinct*; the most banal details, the most subtle motivations that are imprinted in them continue to palpitate and to be vigorous, even when people, the bearers of this culture, are at the doors of death and even *perception itself is going away*.

I will finish with a nostalgic observation of Professor Joaquín Garcia Roca. If today, sometimes, some of the greatest of us cannot restore, as was the case in traditional cultures, the place of experience and wisdom because one is dealing with a place that is occupied by computers and artificial intelligence, then we should try to find a significant place in the emotional story of our communities. Because if for our affections elderly people do not exist, it will be easy to justify the fact that they are eliminated. And let us not forget that timid but persistent propaganda is already being engaged in to promote euthanasia.

Testimonies

The Casa de Belén Centre:
Putting Everything on Life

The Archdiocese of Chicago
Long Term Care Facilities:
Pastoral Considerations

Sister Maria Benedetta Frey:
a Witness to Suffering for Love

The Casa de Belén Centre: Putting Everything on Life*

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What is its Mission?

The 'Casa de Belén' was created in 1995 as a response by the Daughters of Charity and by the Autonomous Community of Madrid to the care needed by children with AIDS and children who, because of their physical, mental, health-care and family condition, could not be integrated into those various settings which are normal for children This house is open to boys and girls in need and who are without appropriate resources for their lives and their development, as long as it can give them the most suitable response to their needs. It has 10 children between the ages of 0 and 6 and it is a centre which is linked to the national health service.

The 'Casa de Belén' is a 'home for children' which is happy, conceived of for them, and where a normal daily life is offered as a health-inducing factor for their quality of life; it is, that is to say, the lives of children that characterise its organisation and directs the resources that are used. In this home they pass their lives, they are looked after when they fall ill, and as much as possible their admission to hospital is avoided. And they also die in this home, always surrounded by affection.

The 'Casa de Belén' is a 'family home', a place of encounter, of life, of joy, of happiness, of hope and of pain of children and adolescents. No human event that gives meaning to the life of human beings is concealed there.

The 'Casa de Belén' is a 'place of Life' because the 'Lord of Life' was, and is, very generous with those who live there and are looked after there. The rhythms are adapted to the capacities of each child even when his or her life expectancy is short. The children are also educated through a specific education, with the integration of those who have grave problems at the level of movement, etc.

What Principles Shape it?

The 'Casa de Belén' is above all else:

A *project open to love* which stakes everything on a fragile life, a life that is apparently without a future and without means, and often fleeting; on that life that is perceived in the daily experience day after day of handicap, illness, deterioration; on that life that we touch in a child who needs everything, who shows that he or he has a unique ability to bring out in us the most beautiful thing that God gives us. To all of this we pay constant attention so as to perceive what a child needs and to learn the unique language of each child and his or her rhythms. And they, in their turn, teach us to open ourselves to our limitations.

A *socio/health-care project* directed towards nursing care, with an educational style, the management of social resources, and a project that is lived pastorally.

A *Catholic project* that respects the creeds of everyone. Here there have been children of believing families and non-believing families, Catholics and Muslims, who have together followed the same pathway. Children are truly those who throw those bridges across which passes that daily relationship which produces the miracle of learning to provide assistance in especially painful situations.

A *project that speaks to and calls on* many people, both inside and outside the home, and which always surprises. Every day has its novelty and each person who arrives goes away different, because the attraction that is exercised by this project calls into question his or her life.

Aims and Objectives

The primary aim of the 'Casa de Belén' is that the sick or invalid children who are received into it should become happy, should grow, should develop harmoniously, and fall sick and die in peace. To achieve this, the following objectives are established:

Coverage of the basic needs of the children: food, rest/sleep, hygiene, movement, psycho-affective security, and health care.

Making available to them a space and a joyous kind of life that is serene and safe, and that contributes stability to their development and helps to create or develop in them that fundamental trust which they need to be happy, taking into account their limitations, their frailties and in many cases their brief lives.

Accompanying and directing the educational process of children according to their capacities.

Organising and planning all the actions inside and outside the Church, taking into account the personal and familial characteristics of each child.

Normalising the lives of children and their participation in the various spheres of socialisation: school, games in the park, the neighbourhood, friendships etc.

Accompanying, starting with life, the process of mourning that many children experience or will

experience in losing or having lost a father or mother, or both parents, or family relatives or their companions.

Providing them with basic social/health-care care that will assure them an adequate level of physical, mental and social well-being.

Avoiding hospital admission in those situations where the home can take care of the child.

Ensuring that the children die in the home and accompanying them during the process of death.

Accompanying their families, facilitating their healing process so that they accept realities without guilt or fears and become integrated where this is possible into the care and treatment of their children; respecting the rhythms of each person so that if the child dies they have had the experience of having cared for their child until the end of his or her life.

Accompanying in a Christian and pastoral way the child and the team, attending to the transcendent dimension.

Who Makes up the 'Casa de Belén'?

The 'Casa de Belén' is made up of a group of people who every day stake what they have on the lives of children, renew their preference for the weakest and without care, and see their action as a responsible and supportive service. This group is made up of:

The Community of the Daughters of Charity. Their task of assistance and evangelisation with less favoured children has become an important responsibility of their Order. Their dedication is exclusive and they deal with managing and directing the home, the nursing staff, the coordination of education, and the volunteers.

Naturally enough, the children themselves. They are the subjects of our action and the authentic reason which gives meaning to our work and to the project itself. All of those children who have been to the home, forty-four children in all, had a short life expectancy; however in the majority of cases they lived for more time than was originally expected thanks to the care and treatment that was provided, and to the enormous personalisation of the attention that was paid to them. At the end of 2009, of these forty-four children, fourteen had died in the home, five died in hospital, one in his family; another six had returned to their previous homes, nine had been transferred to other centres, three were welcomed by families that were not their natural families, and six remained in the home.

The friends of the home. These are volunteers of various ages who want to perform tasks involving service, who are committed to giving time and affection to the children, who involve themselves in their families and take part in the celebrations of the home. These are 'authentic confidants' who identify and communicate the changes that take place in the children. The *godparents through baptism* have a special importance who supplement the family when it is not there.

Some *lay health-care professionals*, as well, have joined this project of supportive service by creating the 'basic team that works with those who own the home'. In particular, we should refer to the paediatricians – one of these has been present ever since the foundation of the home – and the nurses. The medical doctors perform essential work before the arrival of a child and until his or her departure. They work with other medical doctors and coordinate the treatment prescribed in other health-care centres; in the same way they attend to the formation of the personnel of the home.

The parents are accompanied every moment by the team responsible for treatment which wants to avoid the parents having any feeling of guilt. The principal objective is that the parents are involved in the care and treatment provided to their children and gradually free themselves of their fears. Helping them in the process of mourning after the death of their child is indispensable.

The priest, who has been present in this project ever since the foundation of the home, helps people to discover the work and presence of God in the 'Casa de Belén'. Always near to life during the moments of pain, suffering and death of the children, he directs and helps people to discern the moral decisions to be taken in the face of difficult situations. He also accompanies the parents in addressing and experiencing the hard realities of the infirmity, illness and death of their children.

Which Values Sustain the 'Casa de Belén'?

In the home are experienced and cultivated certain values which are fundamental cornerstones in understanding this project and which in addition direct all of its activity.

Service to life, the whole of life and the lives of everyone. 'Yes, life dawned; and it is as eyewitnesses…' (1 Jn 1:2). For this reason, we appreciate life, we serve life and we celebrate life. The tabernacle of the chapel – which is the centre of the home – reminds people every day: 'I am the Life'. In this society which idolatrises physical health and creates lifestyles that destroy man and profoundly wound the healthy growth of children, the home wants to be a 'healing community', a place of truth that is able to welcome in an affectionate and attentive way, and wants to demonstrate that following Jesus is one of the healthiest ways to live life, illness and death itself. The days pass with Life being placed in the most frail lives, without any kind of discrimination. Life is celebrated every day, enjoying everything that brings health and life: joy, welcome, simple and competent service, thinking of, being with, receiving from, journeying with, being concerned about, offering ourselves to; in effect, enjoying loving and allowing ourselves to be loved.

It is has been shown that this service to children humanises all of us and as a consequence it is a factor working for the human enrichment of society.

The Healing Power of Love. 'The kindness of God…dawned on us (Tit 3:4)

Children need a mother, a father, uncles and aunts, grandpar-

ents, cousins, neighbours…When these are faraway or do not exist, the children have to have relationships with other people in order to grow, that is to say the sisters, the staff that works in the home and accompanies them. They constitute a welcoming group that forms a network of human relationships, which is a basis in the maturation of every child and which brings together our people allowing the children to be enriched and to enrich others. The children are experts in giving and receiving love, they generate in us tenderness and compassion. Love – made up of affection, welcoming, nearness and care – is able to prolong their lives, improve their health and make them a little more happy. Love changes our outlook and allows us to discover the human being that is in every human being, beyond his or her small or large head, his or her inability to speak or stand, his or her short or long life. Love for the children gives us a new way of feeling and of listening, and a new vision of human beings.

The Dignity of Children

Each child is unique and never to be repeated, he or she is a sacred story, he or she is the loved child of God.

The relationship that is established, which at times is not easy because of an apparent absence of communication that is experienced in entering into contact with these children, gives us a profound outlook which enables us to love them as they are, beyond their physical features or their mental states, and makes us recognise that each of them is a loved child of God, and unique. And it is in this way, starting from the communication of love, that one discovers the true dignity in all its dimensions of his or her being. Those who work in the home or come to visit it, when they encounter the beauty and the harmony of its interior, the cleanliness, and the order, perceive how important these children are for us, children who are so frail and defenceless, as well as the need to respect them and defend them.

The Leading Role of the Children

The children are our teachers, they teach us and they evangelise us.

At the 'Casa de Belén' one must be ready to put to one side what one knows and learn every day. There are languages that the children do not understand and we have to learn from them. They teach us how to love them, educate them, and care for them, starting from the small actions of every day: making them eat, washing them, making them move, making them drink, their medicines, dressing them, speaking to them, kissing them, hugging them, singing, laughing, crying, welcoming them, discovering, listening to them, accompanying them, cooking, ironing for them…Actions of our daily lives that acquire a distinct meaning. The insecurity provoked by their illness breaks all planning because, when you least expect it, a child falls ill and then that planning has to be adapted to new needs. There have been days when it was rather difficult to be organised and take care of certain children in the home and accompany others to hospital. Their instability forces us to live without security, in uncertainty or at times in urgency, and this is not easy, because it tests our strength of mind and our community feeling.

Normalising Daily Life

One must bear in mind the level of development and the needs of every child. Most of them are behindhand as regards their development at the level of the mental government of movement and a lack of harmony can be observed between their corporeal dimension and their mental maturation. We work as though the children were to live for ever, even though we know that they will soon die. In no case does illness or deterioration limit the life prospects of the children. Oxygen, tube feeding, aerosols etc. do not exclude them from swimming in the swimming pool, from walking in the streets, or from exercises to help their movements. The garden is equipped with what is needed for these activities. They come and go from the centres for rehabilitation, for stimulation, etc., and when their age allows them they attend school in colleges, in special education centres or centres for education. We are convinced that in trying to normalise every situation of health or illness, one can help many to integrate diversity.

Coordinated and Organised Team Work. 'Sharing with all whatever gift each of you has received, as befits the steward of a God so rich in graces' (1 Pt 4:10)

In this project which is already a palpable reality we Daughters of Charity live various things as being positive: the fact that we come from various places of service (colleges, homes, old people's homes, hospitals), that we have various professional experiences (teachers nurses, auxiliary workers, personnel that help elderly people, people engaged in general services), and that everything enriches us so that we can give the love and the care that we are ready to give.

We who form a part of the 'Casa de Belén' place at the service of the children the gifts that we have received and we work at a multiprofessional level for the supplementing and the defence of their social, educational and healthcare needs, on various fronts and in various contexts: the commission for protection and coordination of the centres they come from, centres for family support, centres for primary assistance, swift care, colleges, rehabilitation centres, hospitals, palliative care, environmental resources, etc.

The Value of a Child. A child makes our lives great. And God made Himself a child

To enter the 'Casa de Belén' one has to be ready to 'make oneself very little' and encounter the greatness of God. The children who live there are different from those that we usually care for; they are special, with various pathologies limitations or absences, and one can clearly see that each one of them requires very personalised care. We are joyful about very small successes and

we work day after day, overcoming tiredness and repeating constantly: "you can do it", "take this or that", "take things out" etc., day after day, because we do not know if we will succeed or what our help can achieve.

Dying in the Home

We help the children to die with dignity and in peace in our home, accompanied, without useless pain or suffering. We ensure that they die in the company of people they love (family relatives, educators voluntary workers…), with their things (toys, ties, etc.) and we encourage these people that they love to express the pain, affection and emotion that they feel because of their loss.

Accompanying in Mourning. Open to hope

When faced with the imminent death of a child, a whole process of accompanying him or her is set in motion in which his or her companions, educators, voluntary workers and family participate… we are convinced that this care for so many fragile and vulnerable lives gives good hope that they will go on to a Life that never ends. Hope does not stop at what is not observable through experience but looks for what is to come, what is promised in Christ. Nothing here is definitive, neither our little joys or sufferings nor the successes or failures. Everything is penultimate, it is what we leave behind us, it is living by looking at things as they should be one day. It is running the risk of a journey whose end is not known but which is promised. It is living in and towards Easter, with what it implies at the level of the dynamism of death and life.

The Cross: a Source of Life. 'By his wounds you have been healed' (1 Pt 2:24)

The 'Casa de Belén' invites people and provides the opportunity to welcome suffering and death in life day by day, knowing that Christ has preceded us, is alive, and promises us that he is living with these very little creatures. This is not a theory but healthy living with these realities, receiving the love that they bear and facilitating their normalisation to the utmost, as though these children were going to have a very long life. This way of doing things poses us questions, and makes it credible to say today that God does not want the innocent to suffer – He wants them to live. There is no cross without resurrection, and the encounter with this life gives meaning to the Cross of Life which is renewed with every celebration of Easter

The Important Activities of the 'Casa de Belén'

Welcoming the children. In the home the history of the child is analysed before his or her arrival and one assesses whether the child can be admitted. This involves numerous personal contacts and a prior study of various documents which are handed over when the child arrives.

Caring for each child in a specific way. When the child comes to the home a care plan is established in which all the dimensions of his or her person, as well as the specific circumstances of his or her process, are considered. This is a matter of creating a family environment which can express and find a response to his or her needs, wishes, fears, joys, pain, successes, frustrations, caprices; in definitive terms, being able to learn, according to what he or she is capable of, forms of healthy living with others, the enjoyment of happy moments, and experiencing of imminent death in peace, knowing that he or she is not alone.

Celebrating all the events of the life of the home and in particular accompanying the child at the level of his or her spiritual needs: 1. The baptism of these children, paying great attention to the godparents who receive and accept the mission of looking after, protecting and accompanying the pathway of the child so that he or she feels loved and is happy; 2. first communion, with prior preparation; 3. the birthday of each child, with a special party; 4. Christmas, which is marked every year by a specific theme which acts as guidance so that there emerges the 'new child' that each child bears within himself or herself and which so often he or she conceals or eliminates; 5. the magic of giving a present on the feast of the Wise Kings; 6. Holy Week and Easter, when emphasis is laid upon crucial moments in the life of a Christian and the true meaning of his or her faith and hope; 7. the moving departures of the children when they are transferred to another centre or go back to their families; and 8., lastly, a fundamental act that afflicts and leaves a mark on those who are present: the departure of children who die. This celebration is at one and the same time profoundly human and simply religious, and all the people of the home who can, or who want to, take part in it. Death is not hidden because it is a part of life.

Looking to the Future

We have shared with you our itinerary. Perfection is not in our hands, we know that we must start afresh every day, but it is worth it. Convinced of the fact that a serene smile is a window that allows people to see the wellbeing of a human being, we want to go on working so that the children who live in the 'Casa de Belén' are happy, and that if they do die they do not die alone but die in peace and accompanied. We hope that there will continue to be families who welcome these children, volunteers who visit them and are happy with them, godparents who accompany them; in definitive terms, people who love them and who are not extraneous to their humanity, which is of the utmost fragility and vulnerability.

[*] This text was originally published in the book *Pediatria e Bioetica* and is reproduced here by kind permission of the publishers.

The Archdiocese of Chicago Long Term Care Facilities: Pastoral Considerations

DR. PATRICK GUINAN, M.D.
Catholic Physician's Guild of Chicago, U.S.A.

Introduction

Pastoral care for the sick has been the mission of the Church since the time of Christ who made healing miracles his most visible ministry. This continues in Catholic acute care hospitals under the supervision of the local ordinary and the guidance of the Ethical and Religious Directives. LTC facilities are not as carefully monitored either by the local church authorities or the Joint Accreditation Commission for Health Care Organizations.

LTC is protean in its expression. It can range from home care by the extended family to retirement communities, to convalescent and rehabilitation units, to hospice and finally to the traditional nursing home. Care can range from expensive to the stereotypical warehousing of Alzheimer's patients restrained in wheelchairs in TV dominated day rooms. LTC facilities occupy a gray area relative to financing, government regulation and social awareness. With the breakdown of the extended family the responsibility for elder care often falls on third parties.

The purpose of this investigation was to assess the LTC institutions in the Archdiocese of Chicago for the availability of the sacraments and Catholic pastoral support for their residents.

Methods

The current Kenedy Catholic Directory[1] was employed to identify the LTC institutions (there were 22) in the Archdiocese of Chicago. These were owned and operated by a variety of Catholic organizations, mostly orders of women religious. The largest group was under the direction of the Resurrection Health Care System. The types of questions asked are listed in Table 1.

Table 1 - Questionnaire Areas of Interest

1. Type of Facility
2. Number of Residents per facility
3. Catholic Population
4. Chaplains / Facility
5. Eucharistic Liturgy
6. Mass on TV
7. Sacrament of Reconciliation
8. Sacrament of the Sick
9. Spiritual Support
10 Level of Local Parish Involvement

The survey was conducted by questionnaires sent to the various institutions' directors as listed in the Kenedy Directory. Cooperation was excellent with 20 of 22 responses (91%). The two non-responders were senior citizen federally subsidized housing units managed by Catholic Charities that did not have an overt Catholic presence.

Results (Table 2)

1. *Type of Facility*: For the purpose of this study, the category of LTC institution was self-defined by the institution director. The majority of facilities were self-described as "Nursing and Rehabilitation." (TABLE 2) Of the 22 institution 18 were listed as nursing and rehabilitation, 2 as retirement, and 2 as residential.

2. *Number of Residents*: The average number of residents per institution was 197.

3. *Number of Catholic Residents*: While disclosure of religious affiliation was not required in most institutions. Those that did indicated a greater than 75% Catholic population.

4. *Chaplain or Pastoral Care Assistant/Facility*: There were 1.6 chaplains and pastoral care assistants per institution.

5. *Mass*: Mass was offered daily in 16 facilities, 3 times per week in 3 facilities and no masses were offered in 3 facilities. Communion was available in the resident's room daily except in 8 facilities where it was available only on some days.

6. *Mass on Room TV*: Available in 12 institutions

7. *Sacrament of the Sick*: Available in 20 institutions

8. *Sacrament of Reconciliation*: Available in 20 institutions

9. *Spiritual Support*: There were a wide variety of spiritual support options available. These included: prayer groups, grief and loss sessions, and end of life discussions. Ecumenical prayer was available for non-Catholics. Several institutions indicated that counseling was available for staff as needed.

10. *Local Parish Involvement*: Relatively little local parish involvement.

Discussion

Acute nursing care has been the mission of the Church from the time of Christ. In apostolic times deacons were tasked with the care of the sick.[2] The Church founded the first hospitals in the Byzantine Empire as well as facilities for orphans, lepers, travelers, and the elderly.[3] The tradition was carried to the New World by religious sisters who founded nursing homes for the elderly in addition to hospitals.

The fastest growing segment of our population consists of individuals 85 years and older. The

fact that the US population is aging disproportionately suggests that their problem may only worsen. In the United States, while there are 6,000 acute care hospitals, there are three times as many LTC facilities (18,000).[4] About 20% of these are administered by Catholic authorities, 22 in the Archdiocese of Chicago.

Spiritual care has recently become an accepted component of good medical practice, particularly for the elderly.[5] Pastoral care has long been a major aspect of Catholic acute care institutions.[6] This study has been an attempt to assess pastoral care in LTC institutions. The results of the study suggest that Catholic pastoral care is strong. There are chaplains and pastoral care assistants in all institutions except those federally assisted dwellings.

Mass and the sacraments (reconciliation and anointing of the sick)) are universally available (excepting in Catholic Charities federally funded residential facilities). For those bedridden this is often a TV mass. Pastoral care is self-sustained within the institutions because there is relatively little local parish involvement. There appears to be an increasing level of activities (including spiritual) for elderly residents, particularly in retirement communities, perhaps a reflection of the strong competition in the retirement living market.

In this regard, Catholic LTC facilities should have an advantage if they emphasize the catholicity of their programs. There is an increasingly disproportionate number of Catholics (given the baby boomer demographics) in the elderly population. Many, if not most, of these Catholics remember the joys of their Catholic youth home life, and schools.

Table 2 - Summary Table

1. Type of Facility	Nursing and Rehabilitation	17
	Retirement	3
	Residential	2
2. Residents	197 / facility	
3. Catholic Population	75%+	5
	50-75%	2
	>50%	1
	Question not asked	14
4. Chaplains or Pastoral Care Assistants per Facility		1.6
5. Mass	Daily	16
	3x/week	3
	None	1
6. Mass on Room TV	Yes	12
	None	2
	Unknown	8
7. Sacrament of the Sick	As Needed	20
	Not Available	2
8. Sacrament of Reconciliation	As Requested	20
	Not Available	2
9. Additional Spiritual Support	Prayer Groups	
	Rosary	
	Spiritual Conversation Groups	
	Grief and Loss	
	Ecumenical Prayer	
	End of Life/Advanced Directives	
10. Level of Local Parish Involvement	Very Much	3
	Somewhat	8
	None	4
	Unknown	7

Afterthought

The Archdiocese of Chicago Catholic LTC facilities get high grades in this study for providing good pastoral care. Their staffs and sponsoring institutions are to be commended.

However, there is a Catholic resource that could be more widely promoted. The administration of the sacraments is strong. But what about the "sacramentals" (remember them): the rosary, holy cards, crucifixes, holy water, etc. Many, if not most LTC facilities residents, grew up before Vatican II when sacramentals were omnipresent. In the past 40 years, that emphasis has diminished. Life can be lonely and isolated in a nursing home. To be reminded, with holy water or the rosary, of the joyful family and Church life of the resident's youth can be a source of peace and happiness.

Notes

[1] *The Official Catholic Directory*. National Register Publishing. New Providence, NJ. 2009.

[2] Guinan, Patrick. The Christian Origin of Medical Compassion. *NCBQ* 5:243-248. 2005.

[3] Guinan, Patrick. Christianity and the Origins of the Hospital. *NCBQ* Summer 2004. 257-263.

[4] Ouslander, Joseph. The American Nursing Home. In *Geriatric Medicine and Gerontology*. Eds: Taller, RC; Fillet, H; and Bockelhuber, JC. Church-Livingston, 1998, Ch 112: 1559-1565.

[5] Daaleman, Timothy. Spirituality, In *Hazzard's Geriatric Medicine and Gerontology*. 6th Edition. McGraw-Hill Medical, New York, 2009. pp. 395-397.

[6] Guinan, Patrick; Zabiego, Thomas; Zainer, Christine. Pastoral Care: The Chicago Study. *Linacre Quarterly* 77(2), May 2010. 175-180.

Sister Maria Benedetta Frey: a Witness to Suffering for Love

FR. GIANLUCA SCRIMIERI
Parish Priest of Fabro, the Diocese of Orvieto-Todi, Vice-Postulator, Italy

The Servant of God Sister Maria Benedetta Frey (born Rome 6.3.1836, died Viterbo 10.5.1913) is special because she lived in the Cistercian convent of Viterbo for fifty-two years, immobile in her bed and full of physical and moral suffering. From an early age she was marked by suffering and if she was able to face up to it this was because of the faith that she had received from her family. Everything that she learnt from the gospel, from the example of her family relatives, turned out to be valuable in understanding in her the call of God to the contemplative life in a closed convent (she entered in 1856) and the call of God to a life of suffering for the glory of the Lord, for the good of the Church, and for the sanctification of priests and seminarians. In Frey there was a *special call to courage and strength* (*Salvifici doloris*, n. 25). Down the centuries, the suffering of saints, who have offered themselves as victims, have certainly helped to make them faithful to Christ and to the Church. Sister Maria Benedetta was confined to bed by a progressive paralysis (1861) which gradually extended to the rest of her body, leaving her head and her right arm free. She accepted the will of God after a 'resistance' of the early years when she beseeched a miracle. Nourished by the Eucharist, by prayer, by adoration of the Eucharist and of the cross, she was able, through pain, to sanctify her moral and physical sufferings, offering herself as a 'victim'. Her bed was an altar and she herself was a victim. Every day she celebrated Holy Mass in her condition of being a patient like a lamb ready to live her long martyrdom and apostolate through prayer and suffering. To see the reflected sky she used a small mirror.

Her spiritual father was Father Bernardo Prelini, the Superior General of the Passionist Order, and for a short time Father Germano Ruoppolo, the spiritual director of Gemma Galgani. When she wrote a letter she began with the two words 'From the Cross'. In the crucifix Frey found he who suffers, to learn how one loves, how one can live transforming union, and how one gives one's life. During this long ordeal she was always affectionately close to every Pope, to priests and to seminarians, for whom she offered up her sufferings and to whom she offered advice. All the sacraments were celebrated in her room as well as a number of priestly ordinations. Amongst her visitors were distinguished figures such as Cardinal Merry del Val (the Secretary of State); Cardinal Pietro La Fontaine (from Viterbo, the Patriarch of Venice); Cardinal Boschi, Cardinal Cassetta, and Cardinal Macchi; Pope Pius X's secretary, Msgr. Bressan; Don Giuseppe Nascimbeni; Bartolo Longo; and, lastly, Don Luigi Orione. This last was helped by her to overcome a crisis at the beginning of 1912. Sister M. Benedetta took a strip of cloth from near her, held him by the hand, comforted him and said to him: "you should be a strip of cloth in the hands of Jesus and allow yourself to be led by divine Providence". She then prophesied: "When you found a congregation of women religious tell them that they should be like strips of cloth". Frey offered her life for the health of Pius X which had deteriorated in April 1913. When the health of the Supreme Pontiff recovered, the 'bound sister' went up to heaven on 10 May 1913. The Pope died on 20 August 1914, the feast of St. Bernard.

Sister M. Benedetta 'hid' souls in Jesus so as to defend them and make them rest in the Sacred Heart. She was very devoted to Baby Jesus to whom she entrusted everyone. This is what she wrote: 'I hope that from Baby Jesus comes all that fire of Divine Love that was possessed by all the saints and which with such a conflagration of love burnt everything that could be defective in their hearts. Yes, that divine fire purified them, made them beautiful and made them strong in their battles, courageous in their martyrdoms' (24/12/1897). 'We know very well that it is not we who work but Jesus, who uses the weakest people to do what he wants!' (19/11/1894). She wrote that 'holiness involves solely carrying out in everything the most holy will of God, the obligation of one's own condition' (17/4/1900). She had the charism of discernment, of healing, of prophecy and of comfort. Frey knew how to give meaning to life, to suffering, and to pain, because she strongly loved Christ. She wrote: 'My dear, our soul only finds peace in its centre which is God' (24/7/1885); 'Yes! Yes! We love Jesus, we suffer for Jesus, we work for Jesus and it is certain that we will go to heaven' (24/11/1882).

She was a 'living Host': for the building up of the Church, for the sanctification of priests, for the conversion of sinners and for the salvation of souls. She always invited people to accept every trial and to become holy. Through pain she evangelised and bore witness to Christ, sanctifying herself and other people; she did not choose euthanasia but preferred to follow the Cross. She left behind her a strong and contemporary message: human life is a gift of God, with its dignity that is worthy of

being lived (suffering is also a gift of God). We are not, therefore, in front of a person who 'resigned herself' passively but, rather, of a woman who was guided from on high to use her theological points of strength to be active so as to be of benefit to other people. Thus suffering unleashed an extraordinary force of humanisation for herself and for other people, almost a supplement of the soul which could be given. She was able to make her misfortune a 'grace and blessing' of the Lord to evangelise and to exhort people to achieve holiness (eternal salvation). Despite the fact that she was a martyr who was full of suffering, this did not prevent her from feeling loved by God and from loving. She understood, in definitive terms, that the love of God does not exempt us from all suffering but protects us in all suffering. And she preached this to other people.

Holiness is a vocation for all Christians and also for the sick, for whom it sublimates the capacity for suffering. The Christian vocation to holiness constitutes an essential element of life which the condition of illness does not eliminate, even though it apparently makes it more difficult.

There is a bibliography of Frey in which her virtues of faith and hope are emphasised: *Suor Maria Benedetta Frey. Testimone della sofferenza per Amore* (CVS, Rome, 2009). The preface is by Msgr. José L. Redrado, Secretary of the Pontifical Council for Health Care Workers. The postulator is Don Armando Aufiero of the Silent Workers of the Cross (*www.suorbenedettafrey.it-scrimgia@libero.it*). This Servant of God is prayed to for the gravely ill, for couples that have difficulties in procreating, for conversion and for the reconciliation of two individuals. ■

Program of the XXVII International Conference of the Pontifical Council for Health Care Workers

The Hospital, Setting for Evangelisation: a Human and Spiritual Mission

Vatican City, 15-17 November 2012

Thursday 15 November
History and mission

Morning Session

7.30 Celebration of the Holy Mass in St. Peter's Basilica presided over by
His Em. Card. Tarcisio Bertone
Secretary of State (the Holy See)

9.00 **Opening Address**
H.E. Msgr. Zygmunt Zimowski
President of the Pontifical Council for Health Care Workers (the Holy See)

9.30 **Greetings of the Minister of Health of Italy**
Hon. Renato Balduzzi

9.40 **Message of His Eminence Cardinal Jean-Baptiste Pham Minh Mân**
Archbishop of Thàn-Phô Hô Chí Minh (Vietnam); Member of the Pontifical Council for Health Care Workers

9.50 **Prolusion: The Hospital – Setting for the New Evangelisation**
H.E. Msgr. Salvatore Fisichella
President of the Pontifical Council for the Promotion of the New Evangelisation (the Holy See)

10.20 **The Role of the Hospital in International Health-Care Policies**
Dr. Anarfi Asamoa-Baah
Deputy Director General of the WHO (World Health Organisation) (Switzerland)

10.50 Break

Chairman: ***Dr. Patrizio Polisca***
Archiater of Pope Benedict XVI and Director of Health Care and Hygiene of the Governorate of the State of the Vatican City (the Holy See)

11.10 **Recommendations and Perspectives in Pastoral Care in Health in the Post-Synodal Apostolic Exhortation 'Africae munus' of Pope Benedict XVI**
His Eminence Cardinal Wilfrid Fox Napier, O.F.M.
Archbishop of Durban (South Africa); Member of the Pontifical Council for Health Care Workers

11.30 **The Hospital: Temple of Humanity and Crossroad of Peoples**
His Eminence Cardinal Willem Jacobus Eijk
Archbishop of Utrecht (Holland)

11.50 **The Holy Spirit in Saxia Hospital: History and Mission**
Prof. Gianni Iacovelli
President of the Academy of the History of Medical Art of Rome (Italy)

12.10 **The Historical Genesis of the Hospital**
Fra Pascual Piles Ferrando, O.H.
Former Prior General of the Hospital Order of St. John of God (Spain)

12.30 **The Centuries-Old Religious Role of the Sisters of Charity of St. Joan Antida Thouret in Roman Hospitals**
Sr. Nunzia De Gori, SDC
Superior General of the Sisters of Charity of St. Joan Antida Thouret (Italy)

12.50 **The Human and Spiritual Accompanying of Medical Students**
Prof. Benoît Lengelé
Professor of Human Anatomy at the Catholic University of Louvain (Belgium)

13.10 End of the Session

Afternoon Session

Chairman: ***H.E. Msgr. Valter Župan***
Bishop of Krk; Bishop Responsible for Pastoral Care in Health (Croatia)

15.00 **The Military Hospital and the Evangelisation of Peace**
Brigade General Vito Ferrara
Vice-director of the Department of Health of the "Arma dei Carabinieri" (Italy)

15.20 **Hospital Management Between Rationalisation and the Defence of the Right to Health**
Dr. Anthony R. Tersigni
President and Executive Director of the 'Ascension Health Alliance' Office (USA)

15.40 **Biomedical Research in the Hospital**
Dr. Ornella Parolini
Director of the E. Menni Research Centre, the Hospital Polyclinic Institute Foundation of Brescia (Italy)

16.00 **The Vocation of the University Hospital**
Dr. Sandro Caffi
Director General of the Integrated University Hospital Company of Verona (Italy)

16.20 Break

Chairperson: ***Prof. Kuo-Inn Tsou***
Dean of the Faculty of Medicine of the Catholic University of Fu Jen, Taipei (Taiwan); Consultor of the Pontifical Council for Health Care Workers

16.40 **Telemedicine: a Medical Reality that Calls on Ethics**
Dr. Giovanni Putoto
Head of Planning of Doctors with Africa CUAMM (Italy)

17.00 **Healing Spaces: The Science of Place, Spirituality and Well-being. Implications for the Hospital Environment and Health.**
Prof. Esther M. Sternberg
Research Director, Arizona Center for Integrative Medicine, University of Arizona, Tucson (USA)

17.30 **Round Table:**
Hospital Workers: Evangelisers of Life

The Administrator
Dr. Orochi Samuel Orach
Director of the UCMB, National Office for Pastoral Care in Health, Kampala (Uganda); Consultor of the Pontifical Council for Health Care Workers

The Medical Doctor
Dr. Daniela Terribile
Medical Director of Breast Surgery at the Agostino Gemelli University Polyclinic (Italy)

The Nurse
Sr. Alžbeta - Bc. Jana Galgóciová
Sister of the St. Elizabeth Congregation (the Republic of Slovakia)

The Volunteer
Ms. Anna Janowicz
(Poland)

The Chaplain
Fr. Werner Erhard Demmel
(Germany)

18.30 Discussion

19.00 End of Session

Friday 16 November
Ethics and humanisation

Morning Session

Chairman: ***H.E. Msgr. José Luis Redrado, O.H.***
Former Secretary of the Pontifical Council for Health Care Workers (Spain)

9.00 **Health Care Between Being and Acting: Balances of Charity**
Fra Mario Bonora, P.S.D.P.
President of the Don Calabria Sacred Heart Hospital of Negrar -Verona, and National President of ARIS (Religious Association of Socio-Healthcare Institutions) (Italy); Member of the Pontifical Council for Health Care Workers

9.20 **Humanisation and Fairness in the Care Provided by Health-Care Institutions**
Prof. Enrico Garaci
President of the Higher Institute of Health Care of the Higher Council of Health Care (Italy)

9.40 **The Hospital: Bioethical and Biopolitical Problems**
Prof. Francesco D'Agostino
Full Professor of the Philosophy of Law and the General Theory of Law at the University of Tor Vergata (Italy)

10.00 **The Hospital as the Custodians of Life**
Prof. Riccardo Marana
Director of the Paul VI International Scientific Institute for Research into Human Fertility and Infertility for Responsible Procreation - I.S.I. at the Agostino Gemelli University Polyclinic (Italy)

10.20 **Ethical Committees in Hospitals Today**
Prof. John M. Haas
President of the National Catholic Bioethics Center, Philadelphia (USA) Consultor of the Pontifical Council for Health Care Workers

10.40 Break

11.00 **Round Table:**
Catholic Hospitals in a Changing World

Chairman:
S.E. Msgr. Protase Rugambwa
Adjunt Secretary of the Congregation for the Evangelization of Peoples (the Holy See)

AFRICA
H.E. Msgr. Joachim Ntahondereye
Bishop of Muyinga, Bishop Responsible for Pastoral Care in Health, Burundi (Burundi); Consultor of the Pontifical Council for Health Care Workers

ASIA
H.E. Msgr. Bernard Blasius Moras
Archbishop of Bangalore (India); Member of the Pontifical Council for Health Care Workers

NORTH AMERICA
H.E. Msgr. Robert J. McManus
Bishop of Worcester; Bishop Responsible for Pastoral Care in Health (USA)

CENTRAL AND SOUTHERN AMERICA
H.E. Msgr. Sebastián Ramis Torrens
Bishop of Huamachuco; Bishop Responsible for Pastoral Care in Health (Peru)

EUROPE
H.E. Msgr. Edoardo Menichelli
Metropolitan Archbishop of Ancona-Osimo, National Ecclesiastical Assistant of the A.M.C.I. (Italian Association of Catholic Doctors) (Italy)

OCEANIA
H.E. Msgr. Donald Sproxton
Auxiliary Bishop of Perth; Bishop Responsible for Pastoral Care in Health (Australia)

12.30 Discussion

13.00 End of the Session

The spirituality and deaconate of charity

Afternoon Session

Chairman: ***H.E. Msgr. Emery Kabongo***
Emeritus Archbishop-Bishop of Luebo and Canon of St. Peter's Basilica in Rome (the Holy See)

15.00 **The Hospital Chapel: a Beating Heart of the Mission of the Church for the Sick**
Fra René Stockman, F.C.
Superior General of the Brothers of Charity (Belgium)

15.20 **The Vocation of Consecrated Life and Charismatic Witness in Places of Care**
Mother Laura Biondo, F.S.C.
Superior General of the Daughters of St. Camillus of Lellis (Italy)

15.40 **Home Care for the Sick**
Dr. Konstanty Radziwill
President of CPME (Standing Committee of European Doctors) (Poland)

16.00 **The Hospital Chaplaincy**
Fra Benigno Ramos Rodríguez, O.H.
Superior of the Community of the Tiberine Island of the Brothers of St. John of God (Italy)

16.20 **The Human and Spiritual Training of Hospital Volunteers**
Dr. Salvatore Pagliuca
National President of UNITALSI (Italian National Union for Transport of the Sicks to Lourdes and International Shrines (Italy); Consultor of the Pontifical Council for Health Care Workers

16.40 **Spiritual needs of patients with chronic diseases in a secularized society**
Prof. Arndt Büssing
Professorship on Quality of Life, Spirituality and Coping; Center for Integrative Medicine; Faculty of Health, Witten/Herdecke University (Germany)

17.00 Break

Chairman: ***Fr. Salvatore Pignatelli, M.I.***
Director of the Medical Centre of Ouagadougou (Burkina Faso)

17.20 **The Mission for the Suffering of the 'Merciful'**
Dr. Manuel de Lemos
National President of the Union of the 'Merciful' (Portugal)

17.40 **The Humanitarian and Missionary Role of the Order of Malta**
H.E. Balì Gr. Cr. D'Obb. Barone Albrecht von Boeselager
Grand Hospiteller of the Sovereign Military Order of Malta (Germany); Member of the Pontifical Council for Health Care Workers (the Holy See)

18.00 **Some Projects of the 'Good Samaritan' Foundation' for Hospitals in Cooperation with Other Bodies**
• Donation from General Electric of ultrasound machines and formation medical personnel in the health district of Butembo, North Kivu, Democratic Republic of the Congo
• Donation by Gilead of antiretroviral drugs for the HIV/AIDS Response Program of the Bishop's Conference of Tanzania

18.45 **Conclusions and Recommendations**

Msgr. Andrea Pio Cristiani
Founder of the 'Shalom' Movement (Italy) Consultor of the Pontifical Council for Health Care Workers

Fr. Jacques Simporé, M.I.
Rector of the St. Thomas University, Ouagadougou (Burkina Faso); Consultor of the Pontifical Council for Health Care Workers

19.00 End of the Proceedings

Saturday 17 November

8.00 Celebration of the Holy Mass in St. Peter's Basilica

10.00 Meeting of reflection and prayer by Health Care Workers on the occasion of the Year of Faith, Paul VI Hall.

1. Introducing by H.E. Msgr. Zygmunt Zimowski
2. Reading of the Word of God
3. Comment by His Eminence Cardinal Angelo Comastri
4. Pause for Reflection
5. Testimonies
6. Final Prayer

Holy Father's address is expected.