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Saturday, 22 November 2014 the Lord Called to Himself Cardinal Fiorenzo Angelini

CARDINAL FIORENZO ANGELINI

- Born in Rome on 1 August 1916
- Ordained a priest on 3 February 1940
- Consecrated a Bishop on 29 July 1956
- Created a Cardinal of the Holy Roman Church at the consistory of 28 June 1991
- President of the Pontifical Council for Health Care Workers, 1985-1996
- National Ecclesiastical Assistant of the Association of Italian Catholic Doctors, 1959-1999
- Baccelliere in philosophy
- Doctor in theology
- Extraordinary reader at the St. Thomas University of Manila
- Gold medal for merit for public health care in Italy, 1961
- Gold medal for social merit in the fight against tuberculosis, 1961
- Gold medal for blood donation, 1966
- Extraordinary Professor of Medical Deontology at the El Salvador University of Buenos Aires, 1969
- Gold medal of the World Health Organisation for studies and activities against social di-

seases especially in developing countries, 1973
- Member of the Academy of Sciences of New York, 1983
- The 'Humanisation of Medicine' Prize of Georgetown University in Washington, the United States of America, 1986
- The Sasakawa Prize of the World Health Organisation, 1990
- *Honoris causa* degree in medicine from the Jagellonic University of Krakow, 1990, by wish of the Pope John Paul II
- *Honoris causa* degree in medicine from the Medical College of Walhalla, New York, 1991
- Estrella Kennedy of the John F. Kennedy University, Argentina, 1991
- Humanitarian Prize of the Advanced Studies in Immunology and Aging of Washington, the United States of America, 1992
- *Honoris causa* degree in human sciences of the 'Madre y Maestra' Pontifical Catholic University, Santo Domingo, the Dominican Republic, July 1992
- *Honoris causa* degree in medicine from the Catholic University of Santiago, Chile, September 1992
- *Honoris causa* degree in pharmacy at the University of Urbino, October 1992
- Gold medal of health of the World Health Organisation, November 1992
- Commendator of Holy Spirit in Sassia
- Knight of the Grand Cross of the Equestrian Order of the Holy Sepulchre of Jerusalem, 1993
- *Honoris causa* degree in medicine from the Santa Maria Catholic University of Argentina, Buenos Aires, 1996
- Founder and Director of the Review "Dolentium Hominum: Church and Health in the World"
- Organiser and director of twenty annual courses on 'medicine and morality' of an international character in Rome at the State University and the National Research Council
- Organiser and director of various international conferences in the Vatican on various subjects connected with medicine and morality
- Founder and President since 25 March 1997 of the International Institute of Research on the Face of Christ – sixteen international congresses
- President of the Ethical Committee of the Santa Lucia Foundation, Rome
- Founder of the 'Friends of Father Ildebrando Gregori ONLUS' Association, 21 June 2006.

Fiorenzo Angelini

MSGR. JEAN-MARIE MUPENDAWATU
Secretary of the Pontifical Council for Health Care workers

A man of his times and of our times, aware of the responsibilities, strong and determined but humble in dedicating himself to mission *ad gentes* as a work of justice and charity. Such is the image of Fiorenzo Angelini who was born on 1 August 1916 and became during his more than 98 years of life and 75 years as a priest: Don Fiorenzo (1940), Monsignor Angelini (1956) and, lastly, Cardinal Angelini (1991). He was, and will remain, a personality who was decidedly unusual in the multiplicity of his aspects and also in his longevity. He passed away on 22 November of last year, a few hours before the audience granted by the Pope to people with autism spectrum disorders and to those taking part in the twenty-ninth international conference of the Pontifical Council for Health Care Workers, an institution of which he had been the first president.

He now rests at the side of his spiritual father, the venerable Father Ildebrando Gregori, a Sylvestrine Benedictine and the founder of the Benedictine Sisters Repairers of the Holy Face, in the convent of that institute which is located in Bassano Romano. Fiorenzo Angelini, who together with an imposing physique decidedly had an appearance that in Rome is defined as that of 'Mark Anthony', possessed great intelligence and impressive farsightedness, as though from his height, like the giraffe in the African imagination, he could really see further than many other people.

The vice-parish priest of the Roman neighbourhood of S. Lorenzo, he was the guide for Pius XII when the latter went in July 1943 to visit the local population which had been severely bombed by aerial bombing by the Allies. One can from time to time see the film of that visit and the young Don Fiorenzo opening a gap in the crowd for the Supreme Pontiff to pass through.

He became a key figure in the health care of the capital city and subsequently at an international level as well, already engaging in initiatives that were apparently 'revolutionary' as President of the Pontifical Commission for Pastoral Assistance to Health care Workers, which would later become a Pontifical Council in 1988. He spoke French and had a good knowledge of English and was born in Rome, the son of a couple who originally came from Carsòli, a commune located along the boundary that separates Lazio from Abruzzo. They had emigrated to the United States of America and then returned to Italy.

It was perhaps from his family history that he drew his propensity for travelling, to meet people of different languages, cultures and also faiths. How can one forget his journeys, for example, to Russia, where he subsequently managed to have a children's hospital built with the gifts he had received on becoming a Cardinal, and also to Cuba, both of which he engaged in before the political and ideological walls that divided international politics had weakened and then collapsed?

Faithful in his friendships, he never hesitated to show himself in public with Giulio Andreotti, even during the most debated moments of the life of the former Prime Minister.

In the ecclesial world he was an effective implementer of the Second Vatican Council, in which, indeed, he had taken part, and he knew how to make people recognise the importance of the world of suffering and illness, and the needs of those who take care of sick people, of family relatives, of professionals and of volunteers. With Pope John Paul II, who was canonised on 27 April 2014, he found himself in admirable harmony, and from this arose documents, projects and institutional initiatives. It was, in fact, through the reform *Pastor Bonus* that the Pontifical Commission for Pastoral Assistance to Health Care Workers became a Pontifical Council.

Tireless in his ecclesial activity, in the evening he left the Pontifical Council with a briefcase full of work which by the next morning had already been dealt with; he was an able creator of international relationships which were designed to promote *Salus* throughout the world. In many of his initiatives, of his projects, he was able to express the 'catholicity' of the Catholic Church well before the so-called phenomenon of globalisation arrived.

After reaching the 'pensionable' age he could have rested without any difficulty. He was famous, he had honours and awards, together with economic ease. However, at the age of 75 he wanted to give himself to Zaire, to India, to Poland and to Romania. In order to establish care and evangelising works in these countries, he even gave away everything he had that was valuable, even the gold jewellery of his mother. He even risked his own life when crossing or visiting areas that were marked by major insecurity, such as in Congo Kinshasa in August 1998 when he was fortunate to avoid armies that had gone back to fighting each other.

His last work on earth, the Citadel of Charity, bears witness to this great love and it was located in Butembo which is to be found in the east of the Democratic Republic of the Congo. This work has not been completely finished but it certainly will be because it is a great initiative, one wanted and promoted by a Cardinal who was a great personality of the Church and the twentieth century. ■

He Lived Intensely and he Died 'Living'

IN MEMORY OF CARDINAL FIORENZO ANGELINI

H.E. MSGR.
JOSÉ L. REDRADO, OH
Secretary Emeritus
of the Pontifical Council
for Health Care Workers

I have been asked to write a very short account of my memories of Cardinal Fiorenzo Angelini, a short testimony amongst very many others, bringing together what I remember about him.

I was called by Pope John Paul II to be a part – as its Secretary – of the then 'Pontifical Commission for Pastoral Assistance for Health Care Workers'. The day was 19 January 1986. Msgr. Angelini was the Pro-President of that new 'Ministry', and Fr. Felice Ruffini, a Camillian religious, was its Under-Secretary.

We began our work starting from scratch. We had not been allocated our central offices: there was only a founding decree of the Pope and the experience that each one of us brought to this new mission. There was, however, a great deal of enthusiasm and a great desire to work, to invent, to create, and to open up new roadways.

And it was there that I encountered a great personality with whom I immediately felt in harmony. I saw this as a privilege since we began to work not only starting with our offices but also starting with life. We thus began to travel. We went on numerous journeys and engaged in many activities away from our central offices in order, '*in situ*', to learn about the field of health and of illness, about the health-care world, and about an army of technicians and Samaritans. While accompanying Msgr. Angelini on all those journeys for eleven years, I had an opportunity to observe his creative and animating capacities. He was a teacher, an inventor who never spared himself, who taught, who gave and gave of himself. Always present, competent and enthusiastic, he believed in what he was doing and he loved it; I learned from him 'to dream' and to transform dreams into reality.

Was the person I encountered a person with a strong, dominating and powerful character? To many such appeared to be the case, but one had to know him more deeply at a real level, in his interiority. It was there that his authentic riches appeared, his capacity to impress and to illustrate; his piety, his ability to be in many places and to reach very many people, to be a man who was effective; his love for the Church, for the health-care world; his friendships with very many people, who were very different; his capacity to work and to create 'resources', to invent, to receive abundantly and to give with great generosity, with evangelical charity. All of this is not something that is seen from an office – it is seen by taking part in journeys of many miles where one has an opportunity to speak, to propose, to verify, to observe and to know more deeply. Cardinal Angelini was a 'personage', feared by some, loved by others.

At the moment of his retirement, the man who left the Pontifical Council was a sower who had given us a seed to cultivate. He himself, for the next eighteen years until his death, struggled and invented, as a tireless and active traveller, from another platform.

During this final stage I had also seen him engage, at the same time, in an important journey of spiritual maturity, a journey where a person acquires greater riches and depth in what is essential. His death brought back to me unforgettable memories: a life lived with passion, deep thinking about frailty, on the one hand, and the God of love, on the other. Sincerely, although I was deeply saddened, at the same time I was joyful on his death, when he was full in years: it was above all a death that was awaited, prepared for, accompanied and prayed for. He died 'living'. A finale that makes one reflect. In this, as well, he was for me a spiritual teacher. May he rest in peace!

Cardinal Fiorenzo Angelini

FATHER FELICE RUFFINI, M.I.
Under-Secretary Emeritus, the Pontifical Council for Health Care Workers

I do not know whether the journalist who wrote on Cardinal Fiorenzo Angelini in the daily newspaper *L'Avvenire* had or did not have his 'piece', accompanied by a title, ready for some time, or whether this was the work of the editorial board. Whatever the case, amongst the obituaries that I have read hitherto it seems to me that this is the one that most understood to the full the life journey of His Eminence with the Cardinal's hat: 'A Missionary of Life and Health'.

With admirable synthesis this went to the heart of the life journey of this exceptional priest, which, indeed, the diocese of Rome would discover with the passing of time. He wrote pages of history which should be entrusted to the 'Memory' of the clergy of the Roman Church.

The various steps that then led him to be made a bishop and afterwards an Archbishop and a Cardinal, we can see as 'signs' of the esteem and trust that the Popes who followed one another during his life felt towards him, but a 'corner headline' remains there, the fact that he proclaimed that he was just a 'Roman priest of the Bishop of the See of St. Peter', faithful until his death to his involvement in that Primate of the 'Chair of Peter, who presides over the universal communion of charity' (St. Ignatius M, *Ad Romanos*).

This was an approach to life that began in a decided way what was a more visible and authoritative pathway when the Venerable Pius XII in 1956 appointed him to be the Delegate of the Cardinal Vicar for 'pastoral care in health' in the hospitals and places of health care of the diocese of Rome, and which led we Camillians, who in those years were involved in pastoral service as chaplains in what were considerable numbers, to thereby establish a rather intense relationship of cooperation with him, and as regards certain specific activities a relationship of a certain responsibility with a number of other religious.

This is neither the place nor the time to provide a detailed history. Instead, I will offer some brief references and some short paragraphs so as 'not to forget' the revolution that he achieved in 'pastoral service' in the field of Roman health care, prefiguring and 'running in' what years later, with the fraternal and friendship that had been established with St. Pope John Paul II, led to the creation of the 'Pontifical Council for Pastoral Care in Health': this pastoral care was then promoted throughout the Church.

I believe that it is incumbent upon me to emphasise his daily testimony, wherever he went and in whatever circumstances he found himself, to the fact that he felt in his heart the constant inspiration of the wellspring of the 'charism that the crucified Christ gave to St. Camillus' and what under the spiritual guidance of the Venerable Abbot Ildebrando Gregori became a constant of his speech and behaviour. His devotion to the *Holy Face* became an imperative of his action as a pastor who was sent out into the world of suffering and of pain, such as to deserve from St. John Paul II this passage of most excellent definition on the occasion of the 'Second Congress': 'To know and contemplate the face of God has been a human aspiration in every age. The difficulty, wariness or prohibition of portraying the divinity stems from the awareness that every attempt to apply an image to God is inadequate. Nevertheless, the ancient invocation of the Psalm: "O Lord, let the light of your countenance shine upon us" (4:7) prophetically introduced the revelation of Christ, because the God of the Covenant revealed his nature as a personal Being, indeed as the Father, who in the Incarnation would assume, in Christ, a face both human and divine. It is Jesus himself who declares this to the Apostle Philip: "He who has seen me has seen the Father" (Jn 14:9)'.

Yes, indeed: the person who coined the headline of the article in *L'Avvenire* ('A Missionary of Life and Health') should be congratulated because there are many witnesses to the fact that his increasing devotion to the 'Holy Face', which, indeed, was disseminated wherever he went, was not for that little medallion, even though it was precious because of the holy effigy engraved upon it, but because he saw in the face of every sick and suffering person 'the face of man, of the Son of God, of the suffering, of the Resurrected Christ' and I can well say that he was famous for pointing out often in his homilies and speeches that he was pursuing that face. I saw him on a number of occasions with tears in his eyes when he was near to patients in Roman hospitals, and in the hospitals of poor countries that he visited, or when near to the wounded of the agonising war of the Balkans to which St. John Paul II had sent him as his representative.

The news of recent days has told us that he was born in August 1916 in the neighbourhood of Campo Marzio...a few hundred yards from the tomb of St. Camuillus – is this a coincidence? Let me say so – I think I can see in this fact, as well, a certain 'premonitory sign'. He will want to remind us that he was the last 'Commander of the Holy Spirit'…yes, the last…but the one who gave greatest honour to this ancient title of a splendid *living monument to the charity of the Roman Pontiffs* in an area near to the See of St. Peter.

In his study near to him he always kept prominent and in a position of honour two important relics – of St. Camillus and St. John of God – in two valuable reliquaries. These saints were the two inspirers of his 'life consecrated' to the sick, in whom – and this is not banal rhetoric – he saw and beheld the 'suffering Face of Christ', *as his two saints had*.

I saw them at his bedside where he had fallen asleep 'in the sleep of the just' in the early hours of Saturday morning, 22 November 2014. ■

Words that Sound out, Actions that Shine

DR. ANTONINO BAGNATO
Medical Doctor

Reflections brought together by Francesca Cipriani Bianchini

I am a medical doctor. I have studied the human organism all my life, I have learnt to recognise the symptoms of its illness, I have learnt the ways it can be treated, so as to be able to relieve suffering. You put all of this and all of yourself at the service of those who are in need, without any holding back.

It sometimes happens that a patient dies and then a part of your heart suffers unspeakably. You hope, with the dawn of the next day, to have the instruments to ensure that this does not happen again and your prayer to God is that the patient will be welcomed and that you will be helped in your mission.

My meeting His Eminence Cardinal Fiorenzo Angelini almost thirty years ago was a matter of chance. The initial esteem and respect, and then the understanding and affection that followed immediately afterwards, created over the years a very strong tie of sincere friendship.

At times the hardship of the passing of the years and the decline of a person's body touches those who are near. We look after him unceasingly, we reassure him, we try to protect him from suffering, we hope, but perhaps in vain, to protect him from knowing what is happening.

During the days that preceded his departure from this earthly life, I knew the real situation of His Eminence but I did not want to accept it, I repeated to myself that very little was needed for his body to recover, I knew that this had happened a number of times before, perhaps this could be the umpteenth time, but I realised that each time the recovery had been more arduous and that the irreversible crisis was going to arrive.

He died in the night of 21-22 November 2014.

When this took place the air filled with amazement, silence intensified, my eyes darkened with held-back tears which speedily flowed down my cheeks – the comforting caress of someone who was no longer there for a person who was astonished and stunned by life, for one who had seen the abyss of the impossible pass nearby and take away a person dear to his heart.

One was not fully aware that one would no longer hear his voice, that the air would no longer reecho with his happiness and his decisiveness, with his words, with his warnings and his projects.

The days went by, everything was done, those who stayed behind went back to their usual activity, but when one evening my thoughts were turning over quickly, a world of memories opened up, of shared days, and of teachings which at first were lighthouses in the night and then brilliant light by which to govern the rudder of my behaviour as a man, as a medical doctor and as a Catholic.

His choice to be a priest amongst people, a parish priest at the service of the community, was born early in this young Roman seminarian who was willing and generous. Then the war arrived and bombs fell on Rome. He was in the rubble of San Lorenzo to comfort families, to help the wounded, to give the last rites to friends...today if you go to the area around San Lorenzo everything has been rebuilt, there are no ruins, no evident trace of what happened in that far off 1943, only a marble plaque which one even has to look for… I am sure that that was a decisive moment which changed his way of being a priest. Up to that moment his life has been quite calm, certainly marked by the difficulties of the war which had wounded the population, brought the country to its knees, but that day the cruelty of man against man, the brutality of the bombs that ripped apart houses, bodies and hearts, was devastating for him. The air that could not be breathed in of smoke and dust, filled with desperate cries, full of the acrid smell of death, got into his lungs, his cells, under his skin, and from that moment onwards being a parish priest was no longer enough for him.

A single and adamantine thought permeated his work from that day onwards: to help everyone in all possible ways, beyond his strength, unceasingly and without tiredness, and if tiredness arrived to close it up inside himself.

He experienced the devastating feeling of powerlessness that often pervades the work of those who are called to help, to provide aid. The loneliness of those who every day try to combat and defeat suffering, illness and death.

Jesus said 'I was sick and you visited me'. He decided to help those who were called to relieve the suffering of people.

Always in the front line at the side of health-care workers, he was appointed a bishop and the head of pastoral care in health for the diocese of Rome, as well as the national ecclesiastical assistant to the Association of Italian Medical Doctors.

With modesty and generosity but always with tenacity, he took up the missionary vocation of his spiritual father, the Venerable Father Ildebrando Gregori. He became the active promoter of the missionary initiatives of the Benedictine Sisters Repairers of the Holy Face in three continents of the world for the protection of children, the right to education and the defence of the elderly.

This was an extraordinary friendship that led him to face up to journeys that were often tiring, in order to visit, help and comfort populations that were afflicted by war and by poverty but populations that were courageous in their daily struggle for survival.

From his encounter with St. John Paul II was born an incredible project which was shared in the intentions of these two great men who had grown up in very different realities but ones that had both been tormented by the Second World War. This project began the Pontifical Council for Pastoral Assistance to Health Care Workers:

To permeate one's vocation to

help with the most authentic Christian message, even though this is not only a Christian and Catholic question but, rather. possesses a universal meaning of human charity towards those who are in need.

To always and whatever the case put the sick person at the centre of one's care, especially in those increasingly advanced technological realities where often machinery helps in achieving survival but where it can never take the place of a smile, of words of comfort, and of gestures of being near.

To carry out one's ministry as a health-care worker always looking into the eyes of the patient, without allowing oneself to be distracted by modern idols. To see in every sick person Jesus suffering on the cross, always trying to do one's utmost without ever holding back.

Not to be afraid to go to the most inaccessible parts of the world because suffering and death have no geographical borders and have no scruples in striking where poverty and hopelessness have already wounded the lives of people.

To welcome everybody without holding back, being aware of the sacredness of life in all its forms and ages. And when medical science can no longer do anything, to ensure that hurry or distraction do not allow death to find loneliness, as well, at the bedside of the patient.

His message is engraved in our hearts and tomorrow we will perform our duties with renewed vigour. We are certain that we have not lost him and we are sure that we will continue to be guided, in our fleeting earthly pilgrimage, as people, as health-care workers and as Catholics, by his valuable spirit.

He has not left us, he has gone to the house of God and he is in each one of us, in our deeds, which are permeated with mercy and compassion – as he taught us.

…unfortunately he is no longer with us, he is no longer at our side to spur us on, to guide us, to steward us, to give us courage, but his words sound out like thunder, his actions shine like stars.

A Testimony in Memory of His Eminence Cardinal Fiorenzo Angelini

PROF. BONIFACIO HONINGS, OCD
Professor Emeritus of Moral Theology at the Pontifical Lateran University and the Pontifical Urban University of Rome, Consultor of the Pontifical Council for Health Care Workers, the Holy See, Ordinary Member ad vitam of the Pontifical academy for Life, the Holy See

I congratulate the Pontifical Council for Health Care Workers on thinking of dedicating space to the figure of Cardinal Angelini in the review *Dolentium Hominum*. I thank the Secretary Msgr. Jean-Marie Mupendawatu for wanting to involve me in remembering His Eminence, to whom the Church and the health-care world owe a great deal. I had the grace to know His Eminence Cardinal Fiorenzo Angelini for more than forty years. Therefore I have very many memories of, but I will relate only a few which particularly strike me. First of all his belief that he was a priest of the Lord at the service of the Church and humanity. In this priestly service I was above all struck by the fact that for him every hospital was a church and every bed was an altar. Thus with great humility he entered hospitals and comforted and visited the sick. In addition to this humble priestly service of his – which the Lord employed for almost seventy-five years – (indeed on 3 and 7 February we will celebrate this event), I was struck by his deep and acute intelligence and his tenacious will. The Pontifical Council of which he was the President for many years was able to take broad advantage of these attributes for many years. But also those who worked most closely with him. And this allows me a testimony as regards his humanitarian character. Very often, together with His Excellency Msgr. Redrado, the first Secretary, and Father Felice Rufini, the first Under-Secretary, we spent time with him to listen to his very many enlightening experiences as a young priest, a mature bishop and a wise Cardinal. We were at those moments struck above all by his great friendship with the seven-times Prime Minister and life Senator, Giulio Andreotti. During these very spontaneous meetings, and this was an aspect of his humanitarian character, he also willingly listened to some contributions of ours. This brings me to my final memory of him that I want to record: my personal friendship with him. For very many years, until two days before his death, I had the privilege to go and visit him when I wanted and I was always welcomed with great benevolence. Most of the time we spoke about the conferences on the Face of Faces. He was the great creator not only of the truly important topics and subjects but also of the precious iconography which with great regularity was published before Christmas. To end this testimony of mine, I can affirm that with the death of His Eminence I lost – and I was not alone – from many points of view, a great friend. His home had become mine. My heartfelt thanks go to his dear Mother General, Sr. Maria Maurizia Biancucci, because she said to me: Father, this is always your home. Most Reverend Eminence, my heartfelt thanks and let us meet again in heaven.

Spirituality – Humanity – Charity and Action: the Great Virtues of a Painful and Joyous Journey

IN MEMORY OF CARDINAL FIORENZO ANGELINI

PROFESSOR
FILIPPO M. BOSCIA
National President of the AMCI (Association of Italian Catholic Doctors)

The death of a 'person who is very near and loved' can lead one, when remembering him, to an excessive affective involvement, to exaggerate his talents and qualities, or as the Latins suggested to speak well about those who have preceded us '*de mortuis nisi bene*'. In the case of the unforgettable Cardinal Fiorenzo Angelini this is not the case in the least.

Anybody who knew him or simply met him, could only have been struck by his unusual qualities as a great man, a true giant of faith; meek, ready to help, frank, with a steady temperament, at times intransigent, a prelate of notable learning, who was ready to provide advice which was always thoughtful and wise.

I had the joy and the privilege to live at his side for very many years, first as a Councillor, then as the Vice-President and lastly as the National President of the AMCI, the Association of Italian Catholic Doctors.

In truth, during the years before my experience as a national director of the association I had the pleasant opportunity of working with him as president of the diocesan AMCI of Bari for a project of international solidarity for children in Byelorussia, a nation that had been struck by the dramatic explosion of the nuclear reactor of Chernobyl in the then far away April 1986.

Thanks to his humanitarian work in the world, 600 children from the area of Chernobyl, all with pathologies of nuclear contamination, were welcomed and looked after in groups of 60 in Puglia, in the diocese of Bari-Bitonto, at the San Giuseppe di Modugno Institute which was run by the Benedictine Sisters Repairers of the Holy Face of Christ.

The task was to look after them with love and expertise in the Catholic and non-Catholic healthcare institutions in Bari and its Province, offering them for ten consecutive years, from May to September, a period of relaxation and heliotherapy at welcoming seaside centres on the Adriatic and Ionian coasts.

Those were demanding and very intense years when, involving state and private agencies, associations, Church groups and very many friends, I strove with all my strength to meet the wishes of the Cardinal who commended to me 'his sons, his children'.

These 'children of God' did not lack anything, not least because the cooperation, the readiness to help, the generosity, the solidarity, the subsidiarity and the unlimited support of very many of my faithful and dear friends of Bari and Puglia were truly exemplary. This was a happy and fertile period, still present in the hearts and the memories of everyone, which was experienced with pride by the ACMI of Bari.

With an exemplary charge of spirituality, balance, common sense and affability, this demanding project developed in the members of the AMCI of the diocese of Bari feelings of fraternity, sharing and cooperation which characterised the whole of the long period of my diocesan presidency in Bari when various family associations were created to welcome the children of Chernobyl – these, indeed, are still operational.

To say how much the Cardinal influenced my maturation and formation as well as the growth of my personal motivations means to range through innumerable experiences, contacts, works of cooperation and participation in events of a notable ethical and social value.

It was in this way that I came to know and appreciate his resoluteness in the defence of non-negotiable values but also that I took part together with him in humanitarian projects at an international level: in Russia, in India, in Poland, in the Congo (Butembo Beni), in the Lebanon, in the Ivory Coast and in Mexico. I remember many unreported and special episodes which in a precise way envisaged visits to, and support for, care institutions, meetings with the poor and the sick and with the associations which provided assistance, but also visits to Heads of State in the sumptuous residences that were made available for the institutional audiences envisaged for the pontifical delegation to which I belonged.

The Cardinal dialogued with the powerful of the earth, was concerned about social questions, reduced tensions, healed disagreements, sensitised consciences, brought the voice of the Holy Father everywhere, and contributed to all forms of social development with practical activities of faith, hope and economic cooperation.

The missionary activity and fervour of this great Cardinal of the Church of Rome had their roots in the gospel of Charity. With extraordinary humility in various parts of the world he bent down in front of so much frailty, of every 'wounded creature', to care with love for every wound of their bodies, minds and souls, that is to say in order to take care, as

he used to say, of the 'global sickness' of each person.

Cardinal Angelini, a Good Samaritan, made himself a neighbour to very many marginalised and thrown-away people, promoting throughout the world overall pastoral care for suffering, health and salvation. He did this by sensitising men from everywhere – the powerful and those who were not powerful, the frail or the alone – with that love and that Christian spirit that Pope Francis asked us to bear witness to when he received Catholic medical doctors for the seventieth anniversary of the foundation of our association.

Very many of us are grateful to the Cardinal for having proposed to us new forms of work and action which enabled us to achieve important cultural and pastoral results in our lay and religious voluntary work for sick people.

I personally shared with him very beautiful experiences and also cooperated in his role in acknowledging and maintaining steady and strong the role of Italian Catholic doctors in the FEAMC and the FIAMC, emphasising the tasks that were contained in their respective statutes; defending with steady intransigence positions relating to respect for life from conception until its natural end; valuing the interiority of the person; defending families; and promoting respect for the human person, above all if frail, defenceless and sick, even if often incurable but always treatable.

He openly supported the positions of the AMCI without any holding back and stated with conviction that being Catholic is not something to be reduced to a label or a badge but, instead, require deep and clear witness to the faith and values that characterise Christianity, all of which are solidly expressed in the 'C of Catholics' of our emblem.

He reminded us that daily action had to be carried out without too much noise, without personal exaltations, without forms of self-advancement and forms of triumphalism: 'A tree that falls makes more noise than a forest that grows', he used to say!

Very many medical doctors, young ones as well, attracted by his example, joined the AMCI and based themselves on his great wisdom, his solid faith, his illuminated teaching and his profound spirituality.

Cardinal Angelini always commended us to nourish with prayer and a spirit of self-denial every action we engaged in, to work with coherent intellectual honesty, to bear witness without ostentation, so as to be salt or yeast in the multitude.

Humanity, spirituality, charity and action were his great virtues. His life, although it was full of difficulties and sufferings, was a hymn to the dignity and the inviolability of the person which was a part of his great commitment *to doing good well*.

For as many as thirty years in the AMCI, living at the side of Cardinal Fiorenzo Angelini, who was the ecclesiastical assistant to the AMCI from 1959 to 1998, we explored aspects connected with theology, pastoral care in health, spirituality, psychology and sociology.

We lived with him that long period of contemporary history when those great bioethical problems emerged which are still discussed today: abortion, cloning, euthanasia, brain death, transplants, the vegetative state, life testament, biological patents, the use of stem cells, heterologous gametes for assisted fertilisation, with transfers into surrogate wombs as well.

We live in an epoch when an attempt is being made to eliminate conscientious objection; important laws are emerging as regards the ethics of transplants; and assisted human reproduction is opening up endless and polymorphous questions about theories of gender which are generating great uncertainties about what the family is, the truth of paternity and maternity, and the meaning of being parents.

During this long period which was characterised by the innovative methods of a strongly technological medicine, the Cardinal always invited us to rediscover our role and to teach young medical doctors to protect and support life at every one of its stages with practical actions, to live the gospel of care and mercy; and to be a follower of Christ the physician, giving space to the word of God for the wellbeing of man. He inspired the *Charter for Health Care Workers*, inaugurating in pastoral care in health a season of an authentic 'pedagogic art' which leads to a beholding of the face of Christ which is reflected in every man and above all in those who suffer. The *Charter for Health Care Workers* remains today a document which beholds the 'incommensurable dignity of the human being and his transcendent nature, a nature that faith and reason see as absolutely inviolable'.

What a great legacy he left to us Catholic medical doctors!

In order to make our mission even more generative, the Cardinal outlined guidelines to be followed: prayer, self-denial, a lack of interest in careerism, intellectual humility, trusting openness towards other people, compassion and sharing.

Today, in open contrast with the dehumanising negative tendencies, we can argue that illness, pain and suffering do not manifest the absence of God in the history of man but, vice versa, express His full sharing in, and taking upon Himself, our frail condition.

From being a young priest onwards, Cardinal Angelini had the merit of knowing how to understand the signs of the times, responding promptly to the new needs that presented themselves. Still not very much known, he accompanied Pius XII in the streets of wounded Rome. The white clothes of the Pope were stained with blood, and from that moment onwards Fiorenzo Angelini committed himself in a totalising way to transmitting that heritage of faith and life that had been inherited from the apostles and martyrs, Peter and Paul.

Specifically in those years of social confusion, when cooperating with Pope Pius XII his priestly passion was directed towards the sick, the poor, the lay faithful, medical doctors and health-care workers in trying to reorganise care in the city of Rome which had been devastated by war. He established prayer groups but also associations of men and women

from all ethnic groups, of Christians who were strongly involved in society in order to uphold human and civil rights.

As a priest, as a bishop and as a Cardinal, he always taught to everyone the high value of the Christian message which requires the utmost commitment to removing the causes that bring about exclusion and the urgent need to take part to the full in the political and social life of the country.

His pedagogic activity directed towards Catholic medical doctors for more than fifty years of impassioned formation was experienced by him as a precise duty, provoking in many generations of young doctors an ability to discern what is essential from what is not. He filled with a new spirit students, medical doctors, professors and paramedical staff so that they could understand with sensitivity every beat of hope, of faith and of enthusiasm. His total dedication is today the most valuable gift that he could have left us, after calling us to the fullness of Christian life and the perfection of charity.

In thanking the Lord, we are today able to give our society a more human face in conformity with the image of Christ the Saviour and obedient in everything to the will of the Father.

The life of the Cardinal, which was limpidly and solidly intertwined with the life of the Church and the AMCI, was and always will be a model of reference for the whole of our national association.

He obtained honours and credibility for our association in the national and international field, promoting, supporting and encouraging our member who had previously been our national secretary as the head of the international federation.

The volume 'La mia strada' ('My Road') published by Rizzoli is very much worthy of attention. In this work he outlined in a clear way his capacity to take decisions, his patience, but also his constructive impatience, his complete and disinterested generosity, his strength and constancy in every action of his, albeit in difficult epochs and situations.

Endowed with great physical and moral strength, he ventured into the complex and arduous pathways of the missionary apostolate in the world, in Russia, India, Romania, the Congo and the Philippines, making everything that he possessed available, every personal memory, every pectoral cross, every watch, gifts, paintings, sculptures by prestigious painters and artists. I was an eyewitness to his most complete and disinterested generosity.

He served the Church and the Roman Pontiffs, giving them his utmost cooperation and loyalty. Indeed he worked with as many as eight Popes: from Pius XI to Pius XII, from John XXIII to Paul VI, from John Paul I to John Paul II, and from Benedict XVI to Francis, establishing a close relationship between the laity and the hierarchies, at times acting as a mediator where there were cultural and doctrinal divergences.

In him thinking, wanting, acting and feeling worked in unison in permanent harmony, directed towards constructing unthinkable ties which were sources of great riches.

His thought was always directed towards God, as a result of which every action of his, guided by learning and wisdom, was directed towards all frail people, whom he saw as the privileged children of God.

He carried out many contemplative studies on the face of God made up of a myriad of pieces of mosaic depicting the whole of humanity until a '*reductio ad unum*' was achieved.

One of his goals was to strengthen the structure of the AMCI in order to place it within Italian society which at that time was undergoing in a state constant ferment, and this at a time when the world of associations was growing weaker because of the rise of new approaches which had been outlined by the Second Vatican Council. He infused new lymph into Italian society and in particular into the AMCI so that it could understand to the full the spirit of the Second Vatican Council and the ecumenical approach.

Moved by a sincere desire to offer a loyal and disinterested contribution to the unity of Catholic forces, he wove positive relationships with politicians in the strong belief that Catholics could identify their field of action in order to renew the family, professional, social and political life of the country.

He kept high in front of us an essential approach to life which was pure, sensitive and without selfishness. Personally, having had the privilege to be very near to him, I owe a great deal to him when it comes to what I am today.

All of us together, we Catholic medical doctors, in expressing our greatest gratitude to the Cardinal, certain of the Resurrection, believe that the Lord has welcomed him to His merciful arms, granting him the price of eternal life, as is promised to us and we can read in Matthew chapter XXV.

Now the witness is in our hands so that each one of us may know how to live with faithfulness and consistency the gospel message on which he based himself during his life, and also to live the torch of charity, of hope and of fortitude.

VIII Plenary Assembly of the Pontifical Council for Health Care Workers on the Occasion of the XXX Anniversary of the Apostolic Letter *Salvifici Doloris*

'Do good with your suffering and do good to those who suffer' (Salvifici doloris, 30)

24-26 March 2014
Vatican City

Address of Holy Father Francis

CLEMENTINE HALL, MONDAY, 24 MARCH 2014

Dear Brothers and Sisters,

I welcome you on the occasion of your Plenary Session and I thank Archbishop Zimowski for his words. The Bishop of Rome is grateful to each of you for your commitment to the many brothers and sisters who bear the burden of sickness, disability, and difficult old age.

Your work in these days is inspired by what John Paul II said of suffering, 30 years ago, in the Apostolic Letter *Salvifici Doloris*: "to do good by one's suffering and to do good to those who suffer" (n. 30). John Paul II lived and witnessed to these words in an exemplary way. His was a living magisterium, which the People of God reciprocated with so much affection and veneration, recognizing that God was with him.

It is true, in fact, that also in suffering no one is ever alone because God — in his merciful love for man and for the world — embraces even the most inhumane situations, in which the image of the Creator, present in everyone, is blurred or disfigured. Thus it was for Jesus in his Passion. In Him every human pain, every anxiety, every suffering was taken on out of love, out of pure desire to be close to us, to be with us. And here, in Jesus' Passion, is the greatest lesson for anyone who wants to dedicate him-herself to serving our sick and suffering brothers.

The experience of fraternal sharing with those who suffer opens us to the true beauty of human life which includes its frailty. In protecting and promoting life, at any stage or condition, we can recognize the dignity and value of every single human being, from conception until death.

Tomorrow we will celebrate the Solemnity of the Annunciation of the Lord. "The one who accepted 'Life' in the name of all and for the sake of all was Mary, the Virgin Mother; she is thus most closely and personally associated with the Gospel of life" (John Paul II, Encyclical Letter *Evangelium Vitae,* n. 102). Mary offered up her own existence, she made her whole self available to the will of God, becoming a "place" of his presence, a "place" in which the Son of God dwells.

Dear friends, in exercising your daily service, let us keep ever present the flesh of Christ present in the poor, in those suffering, in children, also in the unwanted, in those with physical or mental disabilities and in the elderly.

Thus I invoke upon each of you, upon all those who are sick and suffering together with their families, as well as upon all those who take care of them, the maternal protection of Mary, *Salus infirmorum*, so that she may illumine your reflection and your action in defending and promoting life and in health pastoral care. May the Lord bless you.

Report

'Do good with your suffering and do good to those who suffer': these words of the Holy Father John Paul II, taken from his apostolic letter *Salvifici doloris* (n. 30), became the central theme of the eighth plenary assembly of the Pontifical Council for Health Care Workers which was held on 24-26 March 2014 in the Vatican at the great hall of Palazzo San Pio X.

The plenary assembly was opened with the celebration of a Holy Mass in the grottos of the Vatican basilica at the altar of the tomb of St. Peter, which was presided over by His Eminence Cardinal Pietro Parolin, the Secretary of State, who on behalf of the Holy Father Francis thanked those taking part in the plenary assembly for their presence and their daily activity in favour of sick people, the disabled and the suffering, and pointed out how important it is to have not only the professionalism of health-care workers but also the presence of religious and spiritual assistance at the side of patients

The morning session of Monday 24 March was begun by the President of the Pontifical Council with a broad presentation of the activities engaged in by the dicastery during the years 2009-2014. Citing article 152 of the apostolic constitution *Pastor Bonus* of John Paul II, Archbishop Zimowski emphasised that the Pontifical Council 'shows the solicitude of the Church for the sick by helping those who serve the sick and suffering, so that their apostolate of mercy may ever more effectively respond to people's needs', and then continued by describing the many actions engaged in by the dicastery, associating each one with a specific task indicated in the four sections of article 152 of that constitution.

After this paper, those taking part in the plenary session went to the Apostolic Palace where they were received in private audience by the Pope Francis. After the brief greetings of the President of the Pontifical Council, the Holy Father expressed his gratitude to all those who take care of the sick and the suffering: 'To each one of you', he said, 'goes the gratitude of the Bishop of Rome for your commitment to so many brothers and sisters who bear the burden of illness, of disability, of a difficult old age'. Then referring to the title of the plenary assembly, he emphasised: 'Your work over these days takes its point of departure from what the Blessed John Paul II about thirty years ago stated as regards suffering in his apostolic letter *Salvifici doloris*: 'Do good with your suffering and do good to those who suffer' (n. 30). He experienced these words, he bore witness to them in an exemplary way. His was a living magisterium which the People of God corresponded with very great affection and very great veneration, recognising that God was with him'.

The deliberations in the assembly hall continued in the afternoon with a discussion about report that had been given by the President of the Pontifical Council in the morning. The Members and the Consultors appreciated the breadth of the work of the Pontifical Council over the previous five-year period and provided a positive assessment, in particular, of the two meetings of a pastoral and scientific character which are celebrated respectively every year in the months of November and May. Reference was also made to the need for a greater effort on the part of the Pontifical Council as regards the promotion of Catholic associations of health-care workers which are encountering difficulties in attracting new members, especially young members.

The final contribution of this rich day was a paper on 'The 'Good Samaritan' Foundation – Activities and Projects' which was given by the Secretary of the Pontifical Council, Msgr. Jean-Marie Mupendawatu, who is also the Delegate for the Foundation. Amongst the most important projects of the Foundation, reference was made to the following: the fight against HIV/AIDS – the model project in Tanzania; the network of the Faculties of Medicine of seven Catholic universities in Africa; the fight against malaria; the fight against blindness; the donation of medical products; a centre for medical products; food education for children; and study grants for priests, religious and lay people.

The morning session of the second day of the plenary assembly, 25 March, was preceded by a Holy Mass on the occasion of the feast day of the Annunciation in the Church of the Holy Spirit in Sassia. This was presided over by Archbishop Zimowski and concelebrated with all the those bishops and priests who were taking part in the plenary assembly. The President of the Pontifical Council gave a homily with the title: 'From the Encounter with the Living God to the Journey towards Needy and Suffering Man. The 'Triptych' of Mary, Mother of Life'.

Msgr. Jean-Marie Mupendawatu introduced the deliberations of this day by giving a paper on 'The Institution and Actuation of the World Days of the Sick. The Present Situation and the Prospects for the Solemn World Day of the Sick in the Holy Land, 2016'. In his paper, the Secretary referred to the document by John Paul II which had instituted the World Day of the Sick and he then summarised all the editions of this World Day from 1993 to 2014. The Secretary of the Pontifical Council devoted the last part of his paper to a description of the next World Day of the Sick at a continental level, a World Day that will take place in Nazareth in the Holy Land and will try to involve in a special way all the heads of pastoral care in health of the local Churches in the Middle East.

The Secretary of the Pontifical Council, after receiving a short feedback on his first paper, continued with the second subject of the session: 'The International Committee of Catholic Health-Care Institutions (CIISAC): Genesis and Prospects'. This is a new body which has taken the place of the AISAC (the International Association of Catholic Health-care Institutions) and is one which the Pontifical Council supports and promotes with the aim of carrying out a new evangelisation of hospital institutions.

During the afternoon session Rev. Fr. Augusto Chendi, M.I., the Under-Secretary of the Pontifical Council, illustrated what had been done as regards the revision and updating of the *Charter for Health-Care Workers*, which was originally published in 1994. In particular, the Under-Secretary gave a detailed description of what had been done by the study group since June 2010, pointing out the additions and the changes that had been made to the original text in the light of the advance of the biomedical sciences and their applications, of specific pronouncements of the Magisterium after 1995 during the pontificates, respectively, of St. John Paul II, Benedict XVI and Pope Francis, and of new (political-legislative and political-economic) aspects of the subject that affect the health-care world. During the debate that followed this paper, it was pointed out that the *Charter* does not seek to cover all the problems and questions that arise in the field of health and illness, almost as though it was an 'ethical handbook', but, rather, seeks to offer the clearest possible guidelines on moral judgement for individuals, as well as the most evident ethical problems which have to be addressed in the professional practice of various figures in the world of health in general, where, for that matter, such responses receive the consensus achieved by the doctrine and the Magisterium of the Church.

The last session of the plenary assembly, which was held on Wednesday 26 March, was begun by Archbishop Zygmunt Zimowski with a paper on possible projects of the Pontifical Council for Health Care Workers, and more specifically: the Index of Catholic Health-care Institutions which should outline the current situation of Catholic health care; the international conference on autism (20-22 November 2014); proposals for the subjects of the subsequent international conferences; and the institution of the 'Pius XII International Prize for the Treatment of Pain' for the best contributions made by young researchers.

The deliberations of the eighth plenary assembly were brought to an end by the President of the Pontifical Council for Health Care Workers who made the proposal to draw up the draft of a pontifical document for the thirtieth anniversary of the apostolic letter *Salvifici Doloris*. The general features of this document were described by H.E. Msgr. Sergio Pintor, the Bishop Emeritus of Ozieri (Italy) and a Consultor of the Pontifical Council for Health Care Workers.

Homily of the Secretary of State Cardinal Parolin

24 MARCH 2014

Your Eminences
Dear Bishops and Priests my religious brothers,
Dear Brothers and sisters,

I am happy to celebrate with you this Holy Mass which opens the eighth plenary assembly of the Pontifical Council for Health Care Workers, an institution of the Holy See which is called to manifest the solicitude of the Church towards those who suffer and those who take care of them. You took the theme of your meeting from the apostolic letter *Salvifici doloris* of the Blessed John Paul II, thirty years after its promulgation: 'do good by suffering and… do good to those who suffer' (n. 30). This highlights the power of evangelisation which also advances thanks to those who experience suffering themselves and those who, through their professionalism and concern, assist the sick un charity.

The Church has always seen service to the sick and the suffering as an integral part of the mission entrusted to her by Jesus to proclaim the Kingdom of God (cf. *Lk* 9:2). On this subject the Holy Father, in his apostolic exhortation *Evangelii gaudium*, observed: 'Jesus, the evangelizer par excellence and the Gospel in person, identifies especially with the little ones (cf. *Mt* 25:40). This reminds us Christians that we are called to care for the vulnerable of the earth' (n. 209). Thus the preferred gaze of the disciples of Jesus can only be addressed to the marginalised, to the physical and existential outskirts of the world.

This mission, however, can be obfuscated by shadows, by weak-

ness and by tiredness, which we are called to overcome through clear witness and a personal and communal pathway of conversion, especially during the Lenten time of grace. As we were reminded by the first reading with the example of Naaman the leper, we, being conscious of our limits and our weaknesses, feel the need to be healed, to be purified, and we know that to achieve this we must entrust ourselves to God. But for this to take place we need to come down off our pedestals, lower ourselves and allow ourselves to be reached by the grace of the humility of Christ who made himself poor in order to enrich us with his poverty.

Only starting from this experience of Love that emanates from the Cross and the Redemption of the Lord can we turn our gaze towards others, recognising them in their dignity as persons, in particular when they suffer, as we were reminded by Pope Francis in his *Message* for this Lent: 'we Christians are called to confront the poverty of our brothers and sisters, to touch it, to make it our own and to take practical steps to alleviate it. Destitution is not the same as poverty: destitution is poverty without faith, without support, without hope… In response to this destitution, the Church offers her help, her *diakonia*, in meeting these needs and binding these wounds which disfigure the face of humanity. In the poor, *the sick and suffering*, and in the last we see Christ's face'.

The Gospel that we have listened to with the paradigmatic figure of the Good Samaritan makes us understand the infinite love that God has for every human being, especially when they are afflicted by illness and pain, and points out to us what the attitude of each one of us towards our neighbour must be. 'We are not allowed to "pass by on the other side" indifferently; we must "stop" beside him. *Everyone who stops beside the suffering of another person,* whatever form it may take, is a Good Samaritan. This stopping does not mean curiosity but availability' (John Paul II, apostolic letter *Salvifici doloris*, n. 28).

Health-care workers are called to be neighbours to the sick, always trying to place care and concern at the side of their professionalism. This is what St. Camillus de Lellis asked of his religious when he used the phrase 'more heart in those hands!' The tandem of professionalism and charity applies to all those who draw near to the suffering of other people, recognising in the face of every person the features of a brother and a sister and, in essential terms, of Christ himself.

This gospel parable also points to the pathway by which we can achieve an authentically human civilisation which today is confronted by, and clashes with, cultural models that are based on success, efficiency and the exaggeratedly private dimension of life. What Pope Benedict XVI observed in his encyclical *Spe salvi* is of as much contemporary relevance as it has ever been: 'The true measure of humanity is essentially determined in relationship to suffering and to the sufferer. This holds true both for the individual and for society. A society unable to accept its suffering members and incapable of helping to share their suffering and to bear it inwardly through 'com-passion' is a cruel and inhuman society' (n. 38).

The service of the Pontifical Council for Health Pastoral Care is located in this approach and it should be thanked for the work that it has carried out on behalf and by the mandate of the Holy Father. My thanks also go to all health-care workers, families and volunteers for the valuable service that they offer in relieving the suffering of their neighbours.

Down the centuries very many Catholic – religious and lay – associations have arisen which have been involved in providing pastoral care for the sick, as well as very many organisations of Catholic medical doctors, associations of nurses, of pharmacists, and of volunteers, and national and international diocesan organisations, which have been created to respond to the problems of medicine and health. The task entrusted by the Blessed John Paul II to your Pontifical Council consists of coordinating these complex realities and fostering an ongoing ethical-religious formation, in the face of the new scenarios offered by the biomedical sciences as well.

This plenary assembly constitutes a valuable opportunity for an assessment of the work that has been done and for engaging in dialogue about how the Church can respond in a better way to her task of evangelisation in the world of health and health care.

It is my hope that all of you, dear brothers and sisters, will be animated by the same spirit as Christ, the Good Samaritan. I entrust this intention to the intercession of Mary, *Salus infirmorum*, to all the men and women saints of charity who spangle the history of the Church, and to the Blessed John Paul II. May his witness, especially during his last years when he experienced in his own flesh the burden and the difficulties of infirmity, always be for your Pontifical Council for Health Care Workers and for everyone an admonition and an encouragement to do good to those who suffer and to demonstrate that one can do good through one's own suffering as well. Amen. ■

From the Encounter with the Living God to the Journey Towards Man who is in Need and Suffering, the 'Triptych' of Mary, Mother of Life

HOMILY BY H.E. MSGR. ZYGMUNT ZIMOWSKI,
THE PRESIDENT OF THE PONTIFICAL COUNCIL FOR HEALTH CARE WORKERS,
TUESDAY 25 MARCH 2014, CHURCH OF THE HOLY SPIRIT IN SASSIA

Most Reverend Excellencies, distinguished members and consultors of the Pontifical Council for Health Care Workers (Health Pastoral Care), dear brothers and sisters,

We have just listened to the passage from the Gospel according to St. Luke (Lk 1:26-38) which describes the mystery of the solemnity that we are experiencing today: the Annunciation of the Lord. Behold, the young woman of Nazareth is visited by the Messenger of God – the Archangel Gabriel – who announces to her amazing and unexpected news: '"Hail, *full of grace*, the Lord is with you"', the Archangel said to Mary, who was listening to him, certainly astounded and astonished but also immediately ready to answer his call: '"Do not be afraid, Mary, for you have found favour with God. Behold, you will conceive in your womb and bear a son, and you shall name him Jesus. He will be great and will be called Son of the Most High, and the Lord God will give him the throne of David his father, and he will rule over the house of Jacob forever, and of his kingdom there will be no end"'. Mary, trusting in the will of God, after the dialogue with the Archangel answers: '"Behold, I am the handmaid of the Lord. May it be done to me according to your word"' (Lk 1:36).

Dear brothers and sisters, as we all know, today's solemnity is very important for our faith! God directly entered human history. It was specifically that 'fullness of time' to which St. Paul referred in his Letter to the Galatians (Gal 4:4): God took upon Himself human flesh and became one of us. Even though in a tangible sense He would make Himself seen at the moment of holy Christmas, in reality the decisive act for our salvation by Jesus Christ had already begun at the moment when he was conceived in the womb of Mary, and this took place thanks to the willingness of Mary and her cooperation with divine grace. It is specifically for this reason that the Blessed John Paul II, in his encyclical *Redemptoris Mater,* emphasised the exceptional character of that moment which is unique in the history of salvation and of humanity. Pope John Paul II wrote: 'Mary is definitively introduced into the mystery of Christ through this event: the Annunciation by the angel. This takes place at Nazareth, within the concrete circumstances of the history of Israel, the people which first received God's promises' (*RM*, n. 8).

We are experiencing today the mystery of the incarnation of the Son of God who took on the human conditions. As the Apostle of the Nations writes: 'He has always had the nature of God, but he did not think that by force he should try to remain equal with God. Instead of this, of his own free will he gave up all he had, and took the nature of a servant. He became like a human being and appeared in human likeness. He was humble and walked the path of obedience all the way to death – his death on the cross' (Phil 2:6-8). The Annunciation, indeed, signifies the entrance of God into human history, but also His debasement and His humiliation. Behold the Son of God who – we can say – had enjoyed celestial happiness and then took upon himself the body of a man, of a little baby, who even allowed himself to be 'closed up' in the womb of a creature, even though she was holy and free of original sin. Behold the humility of God which is expressed in obedience to Mary who from that moment became his Mother and whom he, although he was God, had to obey. Let us, therefore, today thank the Father who sent His Son so that he could become our Brother and Redeemer. This mystery also demonstrates the trust that God placed in Our Most Holy Lady!

The solemnity of today makes us understand how great God's love is for humanity: He not only created us, not only does he take care of us 'from afar' in heaven, but He also enters our lives.

As Pope Benedict XVI observed: 'In the present crisis affecting not only the economy but also many sectors of society, the Incarnation of the Son of God speaks to us of how important man is to God, and God to man. Without God, man ultimately chooses selfishness over solidarity and love, material things over values, having over being. We must return to God, so that man may return to being man. With God, even in difficult times or moments of crisis, there is always a horizon of hope: the Incarnation tells us that we are never alone, that God has come to humanity and that he accompanies us' ('Homily in Loreto', 4 October 2012).

We should also emphasise, dearest brothers and sisters, that the mystery of the Incarnation was possible because of this 'Yes' of Mary; because of her full readiness to implement the will of God. '"Behold, I am the handmaid of the Lord. May it be done to me according to your word"' (Lk 1:36), and that today's feast

day must also be an occasion to express our gratitude to the Blessed Virgin Mary who became the Mother of God and our Mother. It was specifically she who made possible the plan of salvation willed by God. The Blessed John Paul II went on to write: 'Mary is "full of grace," because it is precisely in her that the Incarnation of the Word, the hypostatic union of the Son of God with human nature, is accomplished and fulfilled' (*RM*, n. 9).

However, it should also be said that the announcement that the Archangel Gabriel made to Mary was only the beginning of her mission, even though it was fundamental for the further unfolding of the history of salvation. Indeed, the encounter with the Messenger of God called on Mary to go out, to go out to find another person. As we are told by St. Luke, Mary, as soon she learnt from the Archangel (cf. Lk 1:36) that her cousin Elizabeth was expecting a child, although she was already of an advanced age, immediately hurried to see her. She went to a town which according to scholars is today's Ain-Karim, not far from Jerusalem but rather distant from Nazareth. However for Mary the distance was not important. What mattered was her wish to meet the woman that the Archangel had spoken to her about: Elizabeth, her relative. It is interesting to observe that Our Lady, after her encounter with the Archangel, after that is to say accepting the mystery of the incarnation, did not go to the temple or the synagogue to thank the Lord for the gift that had been received, but, rather, she wanted to share the joy of that encounter of divine reality with human reality, almost as though she wanted to take the Annunciation outwards. After her greetings and the mutual enthusiasm of being with her cousin Elizabeth, Mary pronounced the hymn that is known as the *Magnificat* which is an authentic act of praise and exultance for God. Thus can we come to speak about a certain *triptych*: the encounter of Mary with God – *annunciation*; the encounter of Mary with another person – *visitation*; and the exultance of her soul in the Lord – *adoration*.

Dear brothers and sisters, the Most Holy Mary wants, therefore, to teach us today that daily encounter with God must lead us to find our neighbour, to go out of our homes and seek those who are in a state of need, any need, as Mary did by going to Elizabeth to help her, to be near to her during the moment of her pregnancy (all the more so because Elizabeth was not very young!), and to serve unborn life. This action certainly cost Mary a great deal of work. Certainly it would have been much easier and more comfortable for her to have stayed at home. But she was *full of grace* and thus she wanted to share this grace and this joy with other people. She did this both with words and with practical deeds of charity. This is what we should learn from Mary today: first, to encounter God sincerely, to unite ourselves to Jesus through prayer and the sacraments, and in particular the Eucharist, so as then to take him to other people. In doing this we become authentic apostles of Christ and we put into practice his words: 'You have received without paying, so give without being paid' (Mt 10:8). It is said that the Blessed Ozanam after every Holy Mass in which he had taken part used to visit the sick. Faith grows in us and leads to charity when we share it with others. Our love for Christ is multiplied when we bear witness to that love to our neighbour. We cannot keep the gift of the grace of God within ourselves! We are called to give it to other people, even though this means at times hard work and sacrifice! How can we not now refer to the very many appeals of Pope Francis who is untiring in reminding us of this need to go out, to go to the outskirts of existence, to bring the Kingdom of God precisely there where there are marginalised people who are forgotten by the world, people who are sick and suffering?

This going towards other people must, however, be preceded by encounter with God. We cannot go towards others, empty and without divine power! On the other hand, it should also be said that in encountering others, we, too, can find Jesus. As the Holy Father Francis often says, we can even 'touch' Jesus by bending down before the poor and the suffering, the sick, who for him are the real *flesh of Christ*, as he reminded us yesterday as well, during his address. On this point we can also read in the apostolic exhortation *Evangelii gaudium*: 'The Church's closeness to Jesus is part of a common journey; "*communion and mission* are profoundly interconnected". In fidelity to the example of the Master, it is vitally important for the Church today to go forth and preach the Gospel to all: to all places, on all occasions, without hesitation, reluctance or fear. The joy of the Gospel is for all people: no one can be excluded' (*Evangelii gaudium*, 23). And Pope Francis goes on: 'An evangelizing community gets involved by word and deed in people's daily lives; it bridges distances, it is willing to abase itself if necessary, and it embraces human life, touching the suffering flesh of Christ in others. Evangelizers thus take on the "smell of the sheep" and the sheep are willing to hear their voice' (*EG*, n. 24).

To go out, therefore, means to bear witness. But this witness cannot be limited to words alone. We can well see that Mary not only tells Elizabeth about the 'great things' (Lk 1:49) that the Lord has done for her but also makes herself available to help her in practical terms, trying to make easier the difficult period of waiting before the birth of her child. Mary thus teaches us that to evangelise means above all else to serve. She thus shows us that she is a humble handmaid of the Lord who is ready to serve God in the human person! Thus first of all she puts into practice the words that her Son would later say – 'whenever you did this for one of the least important of my family, you did it for me' (Mt 25:40).

In this way we have seen – so to speak – *two wings of the triptych of Mary* and of each one of us: annunciation and visitation; encountering God, uniting oneself to Him so as to then encounter our neighbour: sharing with our neighbour the joy of the Gospel and being filled with this joy that emanates

from others. There thus remains *the third part of this special 'triptych', the central part* that is expressed in adoration and giving praise to the Lord as Our Lady did by exalting God in the hymn called the *Magnificat.* Those who have really found God and then have then found Jesus in their neighbour can but praise God because their hearts are full of that happiness that derives from the fact that the Kingdom of God is growing, that the earth is becoming a 'corner of heaven', and that God has defeated the darkness of the Evil One. Mary thus teaches us how to praise the Lord. First of all she does this in a spontaneous way but at the same time by basing herself on her knowledge of the word of God. Indeed, Mary uses the model of 'praise' which had existed for centuries in the psalms. Thus we can evince that her faith was deep and mature, even though simple and sincere. Mary's faith was built upon listening to the word of God, meditation and prayer. The echo of this 'encounter' of hers with God we find in the text of the *Magnificat.* To praise God, to exalt the Lord, one first needs silence, meditation and at times also the hard work of deepening one's close relationship with God, the one and triune God.

The important thing is that one has the wish to praise God. As Pope Francis often reminds us, we Christians usually confine ourselves to asking God to grant us a grace, to listen to our prayers. We thank him much more rarely and we almost never praise Him. Instead, as the Holy Father reminded us a short time ago in one of his morning sermons at the *Casa Santa Marta*, to praise God is an obligation for us and it is the first act that we must repeat every day. It is precisely God who gave us our lives and conserves them. Everything that we have, we possess thanks to Him! This is something that we should never forget!

We are gathered here together in the Church of the Holy Spirit in Sassia and of Divine Mercy. We should thus remember that the key by which to understand the faith of the Most Holy Mary is the *Person of the Holy Spirit.* St. Luke tells us that Mary was full of the Spirit of God. It was the Holy Spirit who had the Child Jesus conceived in her womb. It was then the Holy Spirit who convinced her to visit Elizabeth. And Elizabeth perceived the presence of God in her home. St. Luke the Evangelist communicates this with the following words: 'When Elizabeth heard Mary's greeting, the infant leaped in her womb, and Elizabeth, filled with the holy Spirit, cried out in a loud voice and said, "Most blessed are you among women, and blessed is the fruit of your womb. And how does this happen to me, that the mother of my Lord should come to me? For at the moment the sound of your greeting reached my ears, the infant in my womb leaped for joy. Blessed are you who believed that what was spoken to you by the Lord would be fulfilled"' (Lk 1:41-45). In a few words, the joyous meeting of Mary and Elizabeth was the *work of the Holy Spirit*. Both were women of faith, full of the Holy Spirit. From the Holy Spirit they obtained the happiness of encounter with God and fear of God, remembering His mercy.

Lastly, I would like to emphasise that today's solemnity must also be seen as the 'Feast Day of Life'. This aspect is very important for us. Mary, indeed, is the *Mother of life*. This meeting of two expectant women makes us reflect upon the gift of life which already begins at conception and which should be supported and protected not only in a physical way but also in a spiritual way. That is to say: every father and mother should pray for their unborn child and invite the Lord to accompany that child for the whole of his or her life. In some countries, such as Poland, the *Day for Life* for the defence of life is specifically organised today. Let us, therefore, pray to Mary, the Mother of life, for all women who are expecting a baby, that they may have the right conditions to bring their pregnancies to a happy conclusion; let us pray for all defenders of life, that their efforts may achieve the construction of the so-named 'culture of life' against the 'civilisation of death', to which the Blessed John Paul II often referred.

At the end of this homily let us turn our eyes to Mary, the Mother of life, with the words of John Paul II:

'O Mary,
bright dawn of the new world,
Mother of the living,
to you do we entrust the *cause of life*
Look down, O Mother,
upon the vast numbers
of babies not allowed to be born,
of the poor whose lives are made difficult,
of men and women
who are victims of brutal violence,
of the elderly and the sick killed by indifference or out of misguided mercy.
Grant that all who believe
in your Son
may proclaim the *Gospel of life*
with honesty and love
to the people of our time.
Obtain for them the grace
to *accept that Gospel*
as a gift ever new,
the joy of *celebrating it*
with gratitude
throughout their lives
and the courage to *bear witness to it*
resolutely, in order to build,
together with all people
of good will,
the civilization of truth and love,
to the praise and glory of God,
the Creator and lover of life'
(*EV*, 105).

Amen!

Report on the Activity of the Pontifical Council for Health Care Workers: 2009-2014

The apostolic Constitution *Pastor Bonus* defines the mission of our Pontifical Council in the following way: 'Art. 152. The Pontifical Council for Pastoral Assistance to Health Care Workers shows the solicitude of the Church for the sick by helping those who serve the sick and suffering, so that their apostolate of mercy may ever more effectively respond to people's needs'.

The tasks of the Pontifical Council according to art. 153 of the same document are described in the following way:

'§ 1. The Council is to spread the Church's teaching on the spiritual and moral aspects of illness as well as the meaning of human suffering'.

1.1 Messages of the Holy Father for the World Day of the Sick
1.2 Messages of the President of the Pontifical Council
1.3 International Conferences of the Pontifical Council for Health Care Workers
1.4 International Study Meetings
1.5 The Review *Dolentium hominum* and other Publications of the Pontifical Council
1.6 Communication: Press Conferences, Presence in the Mass Media, the Web Site of the Pontifical Council.
1.7 Participation in Congresses, Conferences and Meetings
1.8 Cooperation with the Dicasteries of the Roman Curia

'§ 2. It lends its assistance to the particular Churches to ensure that health care workers receive spiritual help in carrying out their work according to Christian teachings, and especially that in turn the pastoral workers in this field may never lack the help they need to carry out their work'.

2.1 Synods of Bishops
2.2 Visits *ad limina* and other Visits to the Pontifical Council
2.3 The Offices for Pastoral Care in Health of Local Churches
2.4 Celebration of the World Day of the Sick
2.5 Journeys and Pastoral Visits
2.6 Contacts with Chaplains and their Pastoral Assistants in Health Care and with Associations of Sick People and Volunteers
2.7 Pilgrimages and Moments of Prayers with Health-Care Workers, Spiritual Assistants and Sick People

'§ 3. The Council fosters studies and actions which international Catholic organizations or other institutions undertake in this field'.

3.1 The 'Good Samaritan' Foundation
3.2 The International Federation of Catholic Medical Associations (FIAMC)
3.3 The Catholic International Committee of Nurses and Medico-Social Assistants (CICIAMS)
3.4 The International Federation of Catholic Pharmacists (FIPC)
3.5 The International Committee of Health-Care Institutions of the Church (CIISAC)
3.6 Institutes of Consecrated Life
3.7 Contacts with Catholic and non-Catholic Associations, Institutes and Organisations Active in the World of Health

'§ 4. With keen interest it follows new health care developments in law and science so that these may be duly taken into account in the pastoral work of the Church'.

4.1 Cooperation with the Pontifical Academy for Life
4.2 Cooperation with Catholic Universities and Other Universities, Research Centres and Institutes
4.3 Study Activities

Introduction

This eighth plenary session of the Pontifical Council for Health Care workers (for Health Pastoral Care) wishes to be first of all a stimulus and encouragement for a renewed and involving pastoral care in health.

Our dicastery was called to constant renewal and updating by its founder the Blessed – and in a short time the saint – John Paul II. In the apostolic Constitution *Pastor Bonus* of 28 June 1988 he stated in article 152 that the Pontifical Council 'shows the solicitude of the Church for the sick by helping those who serve the sick and suffering, so that their apostolate of mercy may ever more effectively respond to people's needs'. In the following article 153 the tasks of the Pontifical Council were then described by the Supreme Pontiff.

This report on the activities that were engaged in from 2009 to 2014 under the presidency of Archbishop Zygmunt Zimowski is organised into four parts based upon the four sections of article 153 of *Pastor Bonus* where the tasks of the dicastery are outlined. The initiatives of the Pontifical Council are described with reference to each of these sections.

Art. 153 § 1: 'The Council is to spread the Church's teaching on the spiritual and moral aspects of illness as well as the meaning of human suffering'

To perform this task the Pontifical Council draws up and disseminates the Messages of the Holy Father for the World Day of the Sick; publishes the Messages of the President of the dicastery; organises international conferences and study meetings; publishes the review *Dolentium hominum* and other publications; organises and takes part in press conferences and is present within the mass media; manages its own web site; takes part in congresses, conferences and meetings; and cooperates with the other dicasteries of the Roman Curia.

1.1 Messages of the Holy Father for the World Day of the Sick

Every year the Pontifical Coun-

cil writes a draft of this Message which is then submitted to the Holy Father. The themes of these Messages correspond to the themes chosen for the World Day of the Sick. The Message is disseminated, translated, and put on the web sites of the Holy See and our own dicastery. The President writes a theological comment which is available to everyone. We like to ensure that the Messages are published as quickly as possible so that they can be used as soon as possible in the pastoral work of local Churches.

Since 2011 these Messages have had a title based on a text from Holy Scripture:

– in 2011: 'By his wounds you have been healed' (1Pt 2:24);

– in 2012: 'Stand up and go, your faith has saved you' (Lk 17:19);

– in 2013 'Go and do likewise' (Lk 10:37).

The first Message of Pope Francis, of this year, had as its theme: 'Faith and charity: "We too must give our lives for our brethren"' (1 Jn 3:16).

1.2 Messages of the President of the Pontifical Council

The Messages of the President of the Pontifical Council are on events such as:

The World Leprosy Day.

The World Day against AIDS.

The World Autism Awareness Day.

The International Day of Older Persons.

The World Diabetes Day.

The World Day of the Disabled.

The World Day for the Collection of Medicines.

There are also Messages for various ecclesiastical associations and institutions in which the Magisterium of the Church on questions relating to the promotion of life and the protection of health is emphasised. Last year alone the following Messages were disseminated:

– To those taking part in the Sixth International Colloquium of the International Association of Catholic Bioethicists.

– To the President of the Catholic Health Association of India on the seventieth anniversary of its foundation.

– To those taking part in the Conference on Conscientious Objection held at the Catholic University of Lublin.

In addition, in 2009, on the occasion of the Year of Priests, the President of the Pontifical Academy published a 'Letter to the Sick and the Suffering in the World'. This was translated into many languages, disseminated through Bishops' Conferences and bishops responsible for pastoral care in health, associations of sick people and also widely through the mass media.

1.3 International Conferences of the Pontifical Council

The international conferences, which are organised each year in the month of November, constitute one of the most important initiatives designed to meet the new needs and issues that emerge in the field of health care and which health-care workers and pastoral workers in health care have to address. Through them the doctrine of the Church on various aspects of illness and human suffering is disseminated. The subjects that have been addressed since 2009 are as follows:

2009 - '*Ephphatha*! The Hearing-impaired Person in the Life of the Church'

2010 - '*Caritas in veritate*. Towards Equitable and Human Health Care'

2011 - 'Pastoral Care in Health at the Service of Life in the Light of the Magisterium of the Blessed John Paul II'

2012 - 'Hospitals as a Setting for Evangelisation: their Human and Spiritual Mission'

2013 – The Church at the Service of Sick Elderly people: Care for People with Neurodegenerative Diseases'.

Before every international conference of the Pontifical Council a *press conference* is held in the Vatican press hall of the Vatican to give greater publicity to the event. The deliberations of the international conferences take place in the Vatican City in the New Hall of the Synod. These meetings bring together hundreds of participants and numerous speakers from all over the world. On average there are 600-650 people from 60-65 countries. The speakers, who are on the whole Catholics, are chosen from amongst the greatest experts in the field and represent variegated geographical, cultural and religious realities. One session is devoted to an inter-religious vision of the subject addressed.

The international conferences are open to everyone and generate great interest, on the part of civil authorities as well, for example Ministers for Health, ambassadors, and representatives of the World Health Organisation and other international institutions.

The culminating moments of the international conferences are the moving meetings with the Holy Father. These are strong moments not only from a doctrinal point of view but also at an emotional level, in particular for those who have an opportunity to greet the Pope individually. Since the year 2012, in order to take part in these meetings at a deeper level, they have been preceded by moments of reflection and prayer in the Paul VI Hall, alternated with moving testimonies of life and songs by choirs. In addition to those taking part in these international conferences, sick people, associations of socio-health-care volunteers, medical students and student nurses also take part.

We would like to point to the special features of the international conference of 2009 which was on hearing-impaired people. The large numbers of these people in the hall meant that major efforts at the level of organisation were required. At the end of the deliberations, and in the light of the address of the Holy Father, a text containing 'Final Recommendations' was drawn up in which it was stated that people with hearing impediments should be integrated into the life of the ecclesial community. These 'Recommendations' were translated into various languages and sent to all the Bishops' Conferences of the world.

1.4 International Study Meetings

These have been a new initiative for the Pontifical Council and were begun in the year 2010 with the idea of organising study meetings of a more contained nature

than the international conferences. These meetings are organised together with the 'Good Samaritan' Foundation which works inside the Pontifical Council. Hitherto four such meetings have taken place in the Vatican.

The first meeting of June 2010 – 'Ephphatha! The Deaf Person: a Herald and Witness to the Evangelical Message' – was a continuation of the international conference of 2009 on hearing-impaired people in the Church. A large number of Italian dioceses under the guidance of the Bishops' Conference of Italy cooperated with this event which was designed to eliminate 'the barriers of physical deafness but above all those of spiritual deafness'. A major contribution was made by the representatives of the American, Spanish, Irish and German Churches.

The second meeting of May 2011 – 'The Centrality of Care for the Person in the Prevention and Treatment of Illnesses Connected with HIV/AIDS' – sought to promote information and discussion about therapies in this area with a view to a 'holistic' approach to illness and its prevention. The objective was to achieve a synthesis of new strategies for action able to conjoin scientific discoveries with the defence of life and the dignity of the human person.

Ecclesial institutions, organisations and movements, as well as bodies not connected with the Church, that are involved in assistance and care for people with HIV/AIDS cooperated with this event.

One outcome of the meeting was the *Test and Treatment Project* for people with HIV/AIDS in the diocese of Shinyanga in Tanzania.

The third meeting of May 2014 – 'The Unsighted Person: Rabbi, Restore my Sight (Mk 10:51)' – sought to explore the subjects of the prevention and treatment of blindness and impaired sight according to the new approaches of study and research in the field, also bearing in mind the experience accumulated in traditional approaches. In addition, this meeting was an opportunity to promote above all else the pastoral dimension to helping people without the faculty of sight, but ut was also to encourage all the national and international, ecclesial and civil, organisations to achieve one of the priority objectives of the fight against blindness: universal and free access to treatment. The *Christian Blind Mission Italy* cooperated with this event.

To facilitate the utilisation of the whole initiative by people with impaired sight, various aids were envisaged, amongst which the publication in Braille of the programme and the showing in the form of a reproduction in bas-relief of two works from the diocesan museum of Mantua, enriched by a guide written in Braille and an audio explanation.

One outcome of this meeting was a project of the diocese of Coroico in Bolivia for the prevention and treatment of visual disability designed to avoid children leaving school because of difficulties with their sight.

The fourth meeting of May 2013 – on the theme *'The Child as a Person and a Patient: Therapeutic Approaches Compared'* – took place as a preparation for the Day of *Evangelium vitae* which was celebrated in the Vatican on 15-16 June last year within the framework of the Year of Faith. More than 200 participants came from over thirty countries of all the continents of the world. The papers were given by 41 speakers, amongst whom were psychologists, psychiatrists, theologians, philosophers, bioethicists, pharmacists, researchers and economists, who were supported by the experiences offered by representatives of the local Churches of Africa, North America, South America, Asia, Oceania and Europe.

The Day of *Evangelium vitae,* which was organised by the Pontifical Council for the New Evangelisation in cooperation with our Pontifical Council, was an important moment to emphasise pastoral action in favour of love and service for life from conception to its natural sunset.

1.5 The Review Dolentium Hominum and Other Publications of the Pontifical Council

During the years 2009-2014, in disseminating the thought of the Church in the field of health and health care, the Pontifical Council for Health Care Workers has continued the publication of its review *Dolentium Hominum – Church and Health in the World*. This is a four-monthly publication and is printed in four languages: Italian, French, English and Spanish. One of its editions contains the proceedings of the international conference that is held every year in November; another contains the proceedings of the study meeting which usually takes place in May or June; and in the third is to be found, starting with the Message of the Holy Father, texts connected with the annual celebration of the World Day of the Sick. This edition is completed by other texts, for example papers given at conferences or texts of a pastoral or scientific character.

In preparation for the World Day of the Sick of 2013 and 2014, *supporting material of a theological-pastoral-liturgical character* was published on subjects indicated by the Holy Father for the World Day of the Sick. These support materials sought to offer patients, healthcare workers, pastoral workers, families, parishes and volunteers points for theological reflection, studies in pastoral care, and formulas for prayers.

In 2012 the Pontifical Council published the volume 'God has Visited His people. On the Way of Suffering Man'. The texts in this collections come from speeches or papers given by the President of the dicastery on public occasions which varied in terms of their context and their importance. This is a publication rich in pastoral experience as regards the field of health and illness.

In 2013 a short book was published entitled 'Pastoral Care in Health and the New Evangelisation for the Transmission of the Faith'. This is a contribution to the debate about the new evangelisation and seeks to respond to the recommendations made at the end of the thirteenth Ordinary general Assembly of Bishops and the Twenty-Seventh International Conference organised by our Pontifical Council on 15-17 November 2012 whose subject was 'Hospitals as Settings for Evangelisation: their Human and Spiritual Mission'.

Two important volumes are be-

ing prepared: the new version of the *Charter for Health Care Workers* and the *Index* of the health-care institutions of the Catholic Church. There will be two separate articles on these two projects.

1.6 Communication: Press Conferences, Presence in the Mass Media, and the Web Site of the Pontifical Council

Starting at the end of September 2009, the presence of the dicastery in the mass media has been decidedly increased in line with a specific strategy and offering the greatest possible cooperation to the Vatican Press Office which has worked prodigiously for our initiatives as well. Carrying out research on Internet, for example using Google, and using as a key the name of our dicastery in Italian, about *60,000* results appear; in English there are about *90,000*. These facts constitute an excellent indication of the quantity of services, news and citations that have appeared in the various parts of the mass media.

This was obtained during a period that was far from being easy for the Church which in recent years has far too often been the subject of criticisms and attacks, notwithstanding the immense amount of positive work that has been engaged in. This result was also obtained thanks to the industriousness of the dicastery and to material produced beforehand *ad hoc*, to targeted interviews, to press releases, and to Messages that were disseminated everywhere, as well as to a careful management of contacts with people who work in the mass media.

The press conferences that have been held over the last five-year period have numbered seven, and all of them were organised by the Vatican Press Office. There were six which launched the same number of international conferences and two connected with the World Days of the Sick which were celebrated in a solemn way, that is to say those of 2010 and 2013.

The photographic archive of the Pontifical Council was digitalised. A DVD was produced containing all the documents of use to pastoral care in health, from documents of the Popes to the entire collections of the review *Dolentium Hominum*.

The web site of the dicastery, holyseeforhealth.net, is rich in material and potentially very productive from the point of view of dissemination. It clearly deserves to be further encouraged and developed.

1.7 Participation in Congresses, Conferences and Meetings

Each year the Pontifical Council receives numerous invitations to take part in various scientific, cultural and religious events which deal with subjects connected with life, health and illness. These are congresses, conferences and meetings organised by various ecclesial and lay institutions. The President, the Secretary and the Under-Secretary, as well as the Officials and the Consultors of the dicastery, travel in Italy and abroad to take part in these events. We may cite here by way of examples:

• *The conferences held in Rome:*

By the 'Don Giuseppe Dossetti' Associations and the Art and Life Association at the Chamber of Deputies.

By the Health Care and Health Observatory at the Senate of Italy.

By the Politics and charity International Association.

By the 'Camillianum' International Institute of the Theology of Pastoral Care at the beginning of its academic year.

By *Matercare International*,

• *The conferences held in Italy:*

By the Gaslini Scientific Institute of Genoa.

By various associations and institutions of Verona.

By the Magna Græcia University in Catanzaro.

• *The conferences held abroad:*

By the National Catholic Bioethics Center in cooperation with the Knights of Columbus in the USA.

By the Catholic University of Lublin in Poland.

By the diocese of Vitebsk in Byelorussia.

The President of the Pontifical Council has spoken on about a *hundred* occasions in the form of keynote lectures, prolusions and shorter papers. Some of the subjects addressed were:

'The Value of Human Life in the Light of the Teaching of the Church'

'The Institution and Activities of the Pontifical Council for Health Care Workers from the Perspective of its Twenty-Fifth Anniversary'

'*Humanae Vitae* and the Challenge to Health-Care Workers'

'Priests and the Mass Media from the Point of View of Human Suffering'

'The Frail Person: the Spiritual Dimension'

'The Theology of the Body and Pastoral Care in Health'

'The Blessed John Paul II: a Marian Pope and an Intrepid Defender of Life'

Over the last five years, the dicastery has given about 160 lectures and talks of this kind.

1.8 Cooperation with the Dicasteries of the Roman Curia

Relations have continued with the various dicasteries of the Roman Curia and these have witnessed the involvement of the superiors and the officials of our Pontifical Council.

First of all reference should be made to cooperation with the Secretariat of State in the drafting of reports on the *conventions* on:

The Rights of Children;

Against Torture or other Cruel, Inhuman or Degrading Punishments or Treatment (CAT);

For the Elimination of all Forms of Racial Discrimination (CERD).

There have also been many other meetings on various subjects of common interest with dicasteries and institutions of the Holy See, and in particular: the Congregation for the Doctrine of the Faith; the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life; the Pontifical Council for Justice and Peace; the Administration of the Patrimony of the Apostolic See (APSA); the Prefecture for the Economic Affairs of the Holy See; the Pontifical Academy for Life; and the Governorate.

Art. 153 § 2: 'It lends its assistance to the particular Churches to ensure that health care workers receive spiritual help in carrying out their work according to Christian teachings, and especially that in turn the pastoral workers in this field may never lack the help they need to carry out their work'.

The Pontifical Council performs this task through: taking part in Synods of Bishops; visits of bishops *ad limina* and other visits; contacts with the offices for pastoral care in health of local Churches; pastoral journeys and visits; contacts with chaplains and their pastoral assistants in health care; cooperation with associations of sick people and volunteers; the celebration of the World Day of the Sick; and pilgrimages and moments of prayer with health-care workers, spiritual assistants and sick people.

2.1 Synods of Bishops

These are fundamental moments of cooperation with the local Churches. Before a specific synod, the Pontifical Council studies the relevant questions and issues and draws up a suitable contribution which is then presented by the president of the dicastery – who is a member by right of the synod – to the synodal assembly.

During the *Thirteenth Ordinary General Assembly of the Synod of Bishops* on 'The New Evangelisation for the Transmission of Christian Faith', Archbishop Zygmunt Zimowski summed up the related observations of the Pontifical Council in his speech entitled 'The *Diakonia* of Charity for the Sick'. He observed amongst other things that during the course of her history the Church has always seen service to the sick as 'an integral part of her evangelising mission'. Thus the tandem of mission and service for the sick is an integral part of overall pastoral care of the sick without which the apostolate becomes mutilated.

At the *Special Assembly for Africa of the Synod of Bishops of 2009*, as well, the observations of the Pontifical Council were summarised in a speech by the President which highlighted the need for the defence and the valuing of life; the importance of inter-religious cooperation in combating the most widespread illnesses; and support for the health-care services of the Church which often are the only points of reference in vast territories, such Africa, Asia and South America.

During the Synod for Africa 275 health-care kits for first aid were donated by the Pontifical Council in cooperation with the embassy of Taiwan to the Holy See, to the Holy Father and the Synodal Fathers.

2.2 Visits ad limina and Other Visits to the Pontifical Council

These are moments of strong fraternal communion and the exchange of experiences in the field of health care and pastoral care in health in order to have greater knowledge of activities, initiatives and projects in the sector of the activity of the local Churches.

To encourage visits to our dicastery, as soon as the annual list of the Bishops' Conferences that will make visits *ad limina* is issued by the Prefecture of the Pontifical Household, the dicastery sends a letter of invitation to their respective Presidents. In preparation for a visit, the Officials of the Pontifical Council study the five-yearly reports that the bishops are obliged to submit to the Holy Father and draw up reports in order to facilitate shared deliberations. Usually we are visited by delegations led by the bishop responsible for pastoral care in health. At times an entire Bishops' Conference comes to visit us; at times, unfortunately, nobody comes. These are lost opportunities for knowing about each other and for growth!

Despite the great amount of work involved, we are happy about the long list of visits *ad limina* of the year now underway. One is dealing here, indeed, with twenty-six bishops' conferences which represent the whole world.

We also receive at the Pontifical Council a large number of visits from prelates, major superiors, academics and professionals, as well as ambassadors and politicians involved in various national and international organisations in the sector of health and pastoral care in health.

2.3 Cooperation with the Offices for Pastoral Care in Health in Local Churches

This cooperation has continued first and foremost through correspondence. The offices for pastoral care in health of all the local Churches have been informed about the more important initiatives of the dicastery. Amongst other things, we sent them the *Recommendations* published after the international conferences and meetings.

The Pontifical Council has organised various initiatives to inform bishops responsible for pastoral care in health about the cooperation between the Church and States in the field of health care and the ideologies of gender and reproductive health. In this field, a notable initiative was the *Meeting of Bishops Responsible for Pastoral Care in Health and their Delegates* which was held in the Vatican in 2011, before the twenty-sixth international conference. 42 prelates from 39 countries, as well as experts and invited guests, came to Rome. The meeting was useful in assessing together the planning and operational forms for a better coordination of action and formation in a field that is as delicate as it is complex, namely the field of health.

Another example of cooperation is the journeys and visits by members of the Pontifical Council in order to take part in various meetings organised by national and diocesan offices for pastoral care in health.

2.4 Celebration of the Word Day of the Sick

By his letter of 23 November 2006, the Holy Father Benedict XVI decided that the World Day of the Sick would be celebrated in solemn form once every three years in order to conform to similar World Days, for example the World Youth Day and the World Family Day.

Because of this decision, the first solemn celebration of the *Eighteenth World Day of the Sick* took place in the year *2010 in Rome* in concomitance with the fifteenth

anniversary of the institution of the Pontifical Council for Health Care Workers. On that occasion, on 9-11 February, the symposium on 'The Church at the Service of Love for the Suffering' was held, with the participation of 600 people from 47 countries.

The Holy Mass of 11 February was presided over by the Holy Father Benedict XVI and concelebrated with a large number of Cardinals, bishops and priests. In the afternoon, along Via della Conciliazione, there was a torchlight procession led by the relic of St. Bernadette and the statue of our Lady of Lourdes which had come for the occasion from France. Sick people accompanied by nurses and volunteers, as well as the superiors of the dicastery, took part. The event ended with a blessing by Benedict XVI from the window of his private study.

Following tradition, on the occasion of the 'World Day', visits were made to a number of places of care, for example, the Hospital of the Holy Spirit in Sassia.

The Twenty-First World Day of the Sick, which was celebrated in a solemn way, took place on 7-11 February 2013 in three dioceses of Bavaria in Germany, the birthplace of the Holy Father Benedict XVI. For the event the Pope appointed as his special envoy Archbishop Zygmunt Zimowski, the President of the Pontifical Council. The programme for the celebrations in Bavaria followed the model of the previous solemn editions of the World Day, namely they were sub-divided into three moments – a theological one, with a conference at the Catholic University of Eichstätt-Ingolstadt; a pastoral one, with visits to various health-care institutions, such as, for example, the Hospital of Grosshadern which has the clinic of the University of Munich; and a liturgical one, with a solemn celebration of the Eucharist on 11 February at the Marian sanctuary of Altötting. The solemn liturgy took place in the large church behind the Chapel of Our Lady of Graces. A large number of German and foreign bishops and priests concelebrated with the special envoy of the Pope. The sacrament of the sick was administered to a large number of sick people.

The next solemn celebration of the World Day of the Sick will take place in Nazareth in the Holy Land in 2016 and its theme will be 'Entrusting Oneself to Jesus like Mary: "Do what I tell you!" (Jn 2:5)', as was decided by the Holy Father Francis.

As regards the celebration of the World Day in ordinary form, that is to say at a local level, one can state that this is by now a usual and consolidated practice in all the local Churches. 2014 witnessed the twenty-second edition of this World Day.

Msgr. Jean-Marie Mupendawatu, the Secretary of the Pontifical Council, will speak in more detail about the meaning of the World Day of the Sick.

2.5 Pastoral Journeys and Visits

These are a tangible sign of cooperation with local Churches in the field of pastoral care in health. Numerous invitations to the dicastery come from Roman institutions: hospitals, private clinics, nursing homes and various health-care institutions.

In addition, over the last five years the President and the Secretary of the Pontifical Council have engaged in many pastoral journeys in Italy in response to invitations from various dioceses and institutions.

Other journeys, always in response to invitations, have been undertaken in Europe: Poland, Switzerland, Germany, France, Spain, Austria, Croatia, Slovakia, Lithuania and Byelorussia. But there have also been longer journeys, such as those in the United States of America, Taipei, Mexico, the Island of Moloki, Reunion Island and Australia.

All these journeys have included moments of prayer, meetings with Church hierarchies and local dignitaries, visits to health-care institutions of the Church but also to public health-care institutions, and meetings with sick people, with health-care workers and with chaplains.

Other journeys were engaged in by Msgr. Jean-Marie Mupendawatu as Secretary of the Pontifical Council and as the delegate of the 'Good Samaritan' Foundation to take part in congresses and meetings and also to promote the Foundation: in Italy, Byelorussia, Slovakia, France, Portugal, Taiwan, Indonesia, the Democratic Republic of the Congo, the United Republic of Tanzania, Zambia, Uganda and South Africa.

The Under-Secretary of the dicastery, Fr. Augusto Chendi MI, engaged in a number of journeys in Italy. In addition he accompanied the ninth national pilgrimage of the Italian National Union for the Transport of Sick People to Lourdes and International Sanctuaries (UNITALSI) to Barcelona, in which 900 people took part, including about 160 disabled children.

2.6 Contacts with Chaplains and their Pastoral Assistants in Health Care and with Associations of Sick People and Volunteers

Chaplaincies in health care are not a homogenous reality inside the Church. In order to learn about the profile of this reality, at the present time we want to organise an *international meeting*. To this end we sent three questions to all the Bishops' Conferences of the world: 1. does an organisation or association of hospital chaplains exist within the Bishops' Conference, in the dioceses and in the parishes? 2. What are the questions, the problems and the challenges that this organisation faces? 3. Does a protocol of understanding between the Church and the State as regards the organisation of chaplaincies in places of health care and the juridical status of the personnel of chaplaincies?

From the answers that we received it emerges that in some countries chaplaincies are well organised whereas in others they still function in an informal way. All those who were questioned assured us that there pastoral care for the sick was provided but that a specific organisation for chaplains did not exist. For this reason, the Pontifical Council is working to help the local Churches to create a network of chaplaincies and the conference for this purpose should be held in the year 2015. But before managing to create this international network it would be

advisable for there to be organisations of some form of this sector at the level of dioceses and Bishops' Conferences. We are in contact with a large number of international and national associations in order to follow how this situations develops.

We can point out that an institute for the formation of those working in chaplaincies in health care has been created in Krakow, Poland, and its name is 'The School for Pastoral Care in Health of St. John of God'. The Pontifical Council has done a great deal as regards this institution.

As regards *associations of sick people*, during this five-year period of 2009-2014 we have cooperated to a greater extent with associations of the hearing impaired and the sight impaired in preparing a conference and two international meetings. The relations with the International Association of the Silent Workers of the Cross intensified before the beatification of their founder, Msgr. Luigi Novarese.

In the year 2009, on the occasion of the Year of Priests, the President of the Pontifical Council sent to all associations of sick people a *Pastoral Letter* in which he asked them to pray and to offer up their sufferings for the sanctification of priests.

As regards *associations of Catholic volunteers in health care*, these have been of great help in the preparation of our initiatives. We are especially grateful to the Italian National Union for the Transport of Sick People to Lourdes and International Sanctuaries (UNITALSI), to the Military Sovereign Order of Malta (SMOM), and to the '*Misericordie*' of Italy.

Last year UNITALSI celebrated the one hundred and tenth anniversary of its foundation. It is very active in the preparations for the World Day of the Sick, in audiences with the Holy Father and during moments of prayers in Rome and Lourdes.

In various ways, through the apostolic nuncios as well, we exhort the pastors of the Church to foster this kind of voluntary work, in particular in hospices and in parishes, providing care to sick people who are on their own, poor and abandoned.

2.7 Pilgrimages and Moments of Prayer with Health-Care Workers, Spiritual Assistants and Sick people

In April 2010, on the occasion of the Year of Priests, the *International Pilgrimage of Hospital Chaplains to Lourdes and Ars* took place. This was organised by the Pontifical Council and led by its President, assisted by the then Secretary, H.E. Msgr. José L. Redrado OH. About fifty chaplains, both religious and diocesan, from thirteen countries and four continents of the world took part in this pilgrimage. During the five days of pilgrimage, the prayers, the meetings with the sick and the liturgical celebrations helped to revive in these priests the meaning of their priestly vocations and their dedication to the sick and the suffering.

In October 2013, before the closing of the *Year of Faith*, the Pontifical Council organised a *Pilgrimage to Israel and the Palestinian Territories*. This group of about eighty people, made up of religious and health-care personnel under the guidance of the Secretary of the dicastery, Msgr. Jean-Marie Mupendawatu, helped by the Under-Secretary, Fr. Augusto Chendi MI, had an opportunity to visit the holy places. This pilgrimage included a visit to a number of important Catholic health-care institutions in the Holy Land. On the final day the pilgrims took part in a solemn Eucharistic liturgy in honour of the Virgin Mary, the Queen of Palestine, during which Archbishop Zygmunt Zimowski officially announced that the next celebration in solemn form of the World Day of the Sick of 2016 would take place in Nazareth. The news was received with great joy and expressions of gratitude to the Lord by the over two thousand faithful.

Another pilgrimage of the Pontifical Council took place during the Year of Faith and thus at the same time as the Camillian jubilee year, which was held on the occasion of the four hundredth anniversary of the death of St. Camillus de Lellis. All the personnel of the Pontifical Council went to *Bucchianico*, which is near to Chieto, the birthplace of St. Camillus, who is one of the greatest promoters of charity and mercy towards the sick.

Art. 153 § 3: 'The Council fosters studies and actions which international Catholic organizations or other institutions undertake in this field'.

To carry out this task the Pontifical Council avails itself of the 'Good Samaritan' Foundation; works with the three most important international associations of Catholic health-care workers: the International Federation of Catholic Medical associations (FIAMC), the Catholic International Committee of Nurses and Medico-Social Assistants (CICIAMS), and the International Federation of Catholic Pharmacists (FIPC); cooperates with institutes of consecrated life; and works with associations, institutes and organisations, both Catholic and otherwise, active in the world of health and health care.

3.1 The 'Good Samaritan' Foundation

This Foundation was instituted by the Blessed John Paul II on 12 September 2004 to give economic support to sick people most in need, and in particular AIDS patients. Over time, the activity of the Foundation has steadily increased and today it is engaged in theoretical-practical initiatives such as the organisation of international study meetings; the fight against HIV/AIDS; the donation of medical products; food education for children; and scholarships.

At a more detailed level, the activity of the 'Good Samaritan' Foundation will be discussed by the Secretary of the Pontifical Council, Msgr. Jean-Marie Mupendawatu, who is the delegate for the Foundation.

3.2 The International Federation of Catholic Medical Associations (FIAMC)

This Federation has always been invited to take part in the activities of the Pontifical Council. The current President, Dr. José Ma-

ría Simón Castellví, has been informed about, and involved in, all of our more important initiatives.

The President of the Pontifical Council was invited: in 2010 to the twenty-third world congress of the FIAMC whose theme was 'Our Faith as Physicians' and which was held in Lourdes; and in 2012 to the twenty-fifth congress on 'Bioethics and Christian Europe' organised by the European Federation of Catholic Medical Associations, together with the Association of Italian Medical Doctors (AMCI), and held at the Catholic University of the Sacred Heart in Rome. In 2012 Msgr. Jean-Marie Mupendawatu went to Bali in Indonesia to take part in the fifteenth conference of the Federation of Associations of Catholic Doctors of Asia, the theme of which was 'The Challenges of Catholic Doctors in the Changing World'. The Secretary of the dicastery gave a prolusion on 'The Mission of the Catholic Doctor Today'. In February 2014, on the occasion of the twenty-second World Day of the Sick, the President of the Pontifical Council met the members of the Federation of Polish Catholic Doctors, who were celebrating the twentieth anniversary of their creation, in Czestochowa in Poland.

It has to be observed, unfortunately, that membership of Catholic medical associations has drastically declined, and this is especially true as regards young medical doctors. The Pontifical Council has constantly called on those responsible for pastoral care in health to greater commitment to producing 'new members' for the associations of Catholic medical doctors in their respective countries.

In 2011, within the context of the nineteenth World Day of the Sick, the dicastery organised a seminar on the subject of 'Catholic Health-Care Associations and the Culture of Life'. One part was on Catholic international federations involved in the field of health and health care, such as those for medical doctors, nurses and pharmacists, all of which were represented by their respective Presidents.

The Pontifical Council has also maintained good relations involving cooperation with other medical associations: *Medicus Mundi International* (MMI), the University College for Aspirant Missionary Doctors – Doctors with Africa (CUAMM), and the Association of Italian Catholic Doctors (AMCI).

3.3 The CICIAMS (Catholic International Committee of Nurses and Medico-Social Assistants)

Cooperation with the CICIAMS is very important because this is the organisation that has the most members as regards international associations of Catholic healthcare workers. In addition, the CICIAMS is the only Catholic body accredited with the World Health Organisation and it is thus strongly encouraged by the Pontifical Council to work for the culture of life. This association has always been involved in the initiatives of the dicastery through its President, Mrs Marylee J. Meehan, and through her successor, the Reverend Sister Anne John RJM,who was elected in 2012. Sister Anne John visited the Pontifical Council on the occasion of the meeting of the executive committee of the CICIAMS which was held in Rome in January 2013.

On 26-29 May 2012, in Lusaka, Zambia, the Secretary of the Pontifical Council took part in the national congress of the CICIAMS of Anglophone countries on the subject 'Catholic Nurses: Instruments of Healing'. 300 Catholic nurses from all over the world took part in this congress.

This year the CICIAMS will organise on 23-26 September in Dublin, Ireland, its nineteenth world congress on the subject 'Protecting Family Life: the Role and Responsibilities of Nurses and Midwives'. This meaning will be a further opportunity to strengthen our contacts. The Secretary of the Pontifical Council will give an introductory lecture to those taking part.

3.4 The International Federation of Catholic Pharmacists (FIPC)

Our contacts have been very frequent with Dr. Piero Uroda, the President of the FIPC. The FIPC has always taken part most willingly in the initiatives of the Pontifical Council. In addition, there have been numerous meetings with the Noble Pharmaceutical Chemical College of Rome.

Furthermore, the President of the Pontifical Council took part in September 2009 in the Federal Days of the FIPC whose subject was 'The Safety of Medical Products: Ethics and the Conscience for Pharmacists', which was held in Poland. He gave a prolusion entitled 'The World Economic Crisis and Access to Medicine for the Poorest, Especially Children'.

In September in Paris, France, the Secretary of the Pontifical Council took part, with an opening paper, in the international congress of the FIPC whose subject was: 'Pharmacists Today: What Work, What Future and What Hope?'

The dicastery strongly supports the right of pharmacists to conscientious objection. In this field the President of the Pontifical Council has spoken on a number of occasions and commented on recent European legislation in this field – for example his 'Letter' to those taking part in the symposium on conscientious objection which was held in November 2013 at the Catholic University of Lublin.

The latest initiative to be directed to all pharmacists was the 'Letter' of the President of 8 February last on the occasion of the fourteenth Day for the Collection of Medical Products which in Italy involves over 3,400 pharmacies to help people in a state of poverty throughout the nation.

3.5 The International Committee of Catholic Health-Care Institutions (CIISAC)

The new International Committee of Catholic Health-Care Institutions (CIISAC) has taken the place of the International Association of Catholic Health-Care Institutions (AISAC) which was created in 1984 to coordinate the Catholic health-care institutions of the Church at an international level. This is a body that promotes a new network which connects the various Catholic health-care associations in the world. The members of the governing council of the CIISAC, who represent the largest associations of Catholic health-

care institutions of the five continents of the world, met in November 2013 in the Vatican to draw up the new statutes of the committee and these will be presented shortly.

The Secretary of the Pontifical Council, Msgr. Jean-Marie Mupendawatu, who is the coordinator of the committee, will speak in greater detail about the CIISAC.

3.6 Institutes of Consecrated Life

First of all one should emphasise the excellent cooperation with institutes of consecrated life (religious institutes and secular institutes), and in particular with: the Hospital Order of St. John of God, the Fatebenefratelli; the Regular Clerics Ministers of the Sick, the Camillians; the Brothers of Charity; the Silvestrine Benedictine Sisters Repairers of the Holy Face; the Sisters of St. Francesca Cabrini; the Sisters of Charity of Mother Teresa of Calcutta; and the Camillian Sisters.

Some Superior Generals are members of the Pontifical Council for Health Care Workers.

Ever since the creation of the dicastery, many institutes of consecrated life have offered some of their members to work as volunteers. At the moment we have two religious working in this capacity for us: *Sister Anna Antida Casolino* of the Sisters of Charity of St. Joan Antida Thouret offers her generous and effective service in the protocol and archives sections; *Frà Jaime Buitrago Gómez* of the Fatebenefratelli, acts as a *trait d'union* with the Church of Latin America.

The Pontifical Council expresses its sincere gratitude to those institutes of consecrated life which freely make available volunteers to the Pontifical Council and the Holy See.

3.7 Contacts with Catholic Associations, Institutes and Associations, and Others, Involved in the World of Health and Health Care

The Pontifical Council carefully follows the work and the initiatives of the World Health Organisation (WHO) in relation to health-care policies. To this end, the dicastery takes part every year in the executive committee of the WHO which is held in January in Geneva, in preparation for the World Health Assembly. This assembly, in which the ministers of health of the member States take part, takes place every year in Geneva in the month of May. On this occasion the President of the Pontifical Council leads the delegation of the Holy See and speaks on the subjects which are debated, expressing the stance of the Church and its concerns regarding the programmes proposed to the member States. Amongst the subjects addressed by Archbishop Zimowski, reference may be made to the reduction of child mortality; access to antiretroviral medical products for HIV/AIDS patients; the counterfeiting and falsification of medical products; access to primary care for all citizens and above all poor and disadvantaged people; education in 'healthy' lifestyles in the fight against non-transmissible diseases; and recognition and support on the part of States for faith organisations and the health-care institutions of the Catholic Church.

The Pontifical Council also works with the various institutions of the organisations of the United Nations involved in the struggle against drug addiction and criminality connected with it: the Office of the United Nations for the Control of Drugs and the Prevention of Crime (UNODC); the International Committee fir the Control of Drugs; and the Commission on Drugs and Narcotics. This is a matter of being near to these agencies in order to dialogue and cooperate for life and the dignity of the person. The World Health Organisation promotes programmes to combat illnesses and drug addiction. The Church is called to work both in the planning and in the implementation of these programmes. In very many countries, the Church through its various institutions, is one of the principal actors for the State in the implementation of these programmes. The Pontifical Council has the precise task of following the initiatives of all international organisations in the field of health care and to denounce everything that is against the doctrine of the Catholic Church.

Within the framework of this cooperation, the Holy See has signed two *Conventions* of the United Nations: the Single Convention on Narcotic Drugs, 1961, amended in 1972, and the Convention on Psychotropic Substances of 1971.

For the United Nations the competent authorities in this field of the Holy See, as well as the guarantors of the Pontifical Council for Health Care Workers and the General Secretariat of the Governorate of the Vatican City.

As regards this task, the Pontifical Council has organised in the past an international conference on drugs which was followed by a handbook on drugs entitled 'The Church, Drugs and Drug Addiction'. The dicastery has continued to disseminate this handbook on various occasions.

On 28 January 2014 Archbishop Zimowski met the President of the International Committee for Drug Control to discuss the imminent revision of these Conventions by the member countries which envisaged for the year 2016, given the risk of a move towards liberalisation.

Art. 153 § 4: 'With keen interest it follows new health care developments in law and science so that these may be duly taken into account in the pastoral work of the Church'

In performing this task the Pontifical Council works with: the Pontifical Academy for Life (PAV), with Catholic and non-Catholic universities, and research centres and institutes. In addition, it engages in various study activities.

4.1 Cooperation with the Pontifical Academy for Life

The Pontifical Academy for life (PAV) was created by the Blessed John Paul II on 11 February 1994 by his Motu Proprio '*Vitae Mysterium*' and bringing together the recommendations expressed by the most important heads of pastoral care in health.

Although independent according to its statutes, the PAV is 'connected and works in a close relationship' with the Pontifical Council for Health Care Workers

in the study of questions and issues connected with life that have a scientific and bioethical relevance, in order to help local Churches to respond in a better way to the new challenges to the sacredness and the defence of life.

The Secretary of the Pontifical Council, Msgr. Jean-Marie Mupendawatu, is a member of the governing council of the Academy and takes part in the meetings and all the important initiatives of the PAV.

On the occasion of the tenth anniversary of the Pontifical Academy for Life which was celebrated last February, a general assembly was held on the subject of 'Ageing and Disability'. The President of the Pontifical Council gave a paper which ended the deliberations of the assembly and this was on 'The Church and the Sick Elderly'

4.2 Cooperation with Catholic and Non-Catholic Universities and Research Centres and Institutes

The Pontifical Council works with universities and in particular with faculties and colleges of medicine, pharmacy and nursing. But not only ones that belong to the Church – secular such institutions are also involved.

The most frequent contacts have been in Rome and more specifically with the Catholic University of the Sacred heart, Tor Vergata University and the Higher Institute of Health Care.

The dicastery also follows the conferences organised in Rome by the pontifical universities: the Gregorian University, the Seraphic University, the Urban University, the University of the Holy Cross and the Regina Apostolorum University.

Abroad there has been cooperation with the Catholic University of Lublin and the Catholic University of Warsaw in Poland; the Catholic University of Eichstätt-Ingolstadt in Germany; and the National Catholic Bioetics Center in the United States of America.

In addition there has been cooperation with seven African Catholic universities within the context of the project called '*Africae Munus*'. This is a network of seven medical schools of the following countries: the Democratic Republic of the Congo, Uganda, Tanzania, Burkina Faso, Chad and Mozambique. It was created to foster mutual and productive cooperation between these universities and Catholic institutions and universities in the world through the 'Good Samaritan' Foundation. The Catholic university of Australia and the Catholic University of Louvain-la-Neuve also take part in this network.

4.3 Study Activities

The activity of this kind which has most involved the Pontifical Council has been the revision and the updating of the *Charter for Health Care Workers*. The work that has been done will be described by the Under-Secretary Fr. Augusto Chendi.

A number of study groups made up of experts in bioethics, medicine, pastoral care in health and related disciplines have been created within the framework of the activities of the Pontifical Council.

In cooperation with the Institute for the Treatment of Infertility of the Agostino Gemelli University Polyclinic, one group has studied natural medicine and fair access to medical products and one has studied perinatal medicine.

A great deal of attention has regularly been paid to dossiers and other documents sent in to the dicastery by papal representatives and Bishops' Conferences.

Many cases are sent to members, consultors and experts of the Pontifical Council to be studied and to obtain their opinions. ■

Presentation of the 'Good Samaritan' Foundation

MSGR. JEAN-MARIE MUPENDAWATU
Secretary of the Pontifical Council for Health Care Workers, Delegate for the 'Good Samaritan' Foundation

Good morning and thank you for being here today,

I am happy to present here the 'Good Samaritan' Foundation and describe its activities and its projects which are now underway.

The Blessed John Paul II on 12 September 2004 established the 'Good Samaritan' Foundation at the Pontifical Council for Health Care Workers (for Health Pastoral Care) in order to provide economic support to those sick people most in need, and in particular AIDS patients, who ask for an act of supportive love from the Church. For the occasion the Holy Father invited 'all men of good will, in particular those of the most economically advanced countries, to contribute to this end', proposing anew what he had already written in his apostolic letter *Novo Millennio Ineunte*: 'Now is the time for a new "creativity" in charity, not only by ensuring that help is effective but also by "getting close" to those who suffer, so that the hand that helps is seen not as a humiliating handout but as a sharing between brothers and sisters'.

With the intention of fully meeting this mandate, ever since its constitution the 'Good Samaritan' foundation has provided assistance to hundreds of thousands of people in need in the various continents of the world, giving economic support to variegated projects which have been principally implemented in the sectors of health care. This has been an undertaking founded on awareness that missionary cooperation starts with Jesus and its recipient is the sick person, who has the very face of Jesus. In this

approach, therefore, the 'Good Samaritan' Foundation intends to serve Christ in the suffering other and to do good as he did.

There are therefore many hospital and care-providing institutions that have been able to carry on their worthy activities thanks to the Foundation in Africa, in Asia, in Latin America and in Europe. This support has been directed in a special way to patients with the HIV/AIDS pathology who, in addition to physical malady, also experience human suffering, humiliation and loneliness – the consequences of the blindness of a society that marginalises them, abandons them, denigrates them and makes them doubly victims. This is a form of social exclusion that obstructs and at times totally impedes access to treatment, delaying taking care of patients and also the possibility of relieving their physical, psychological and spiritual sufferings.

At the present time the action of the 'Good Samaritan' Foundation is expressed in variegated initiatives:

The struggle against HIV/AIDS – the model project in Tanzania. In 2013 there began to the full the project for the struggle against HIV/AIDS promoted by the 'Good Samaritan' Foundation in the diocese of Shinyanga, in Tanzania, in conjunction with the same diocese and the Bishops' Conference of Tanazania, in cooperation with Gilead Sciences – a world leader in the production of antiretroviral medical products – and with the Catholic University of Health and Allied Sciences of Mwanza. This project is called 'Test & Treatment'. Created in response to a request for help from the local Church, this project involves four diocesan health-care centres – the Bugisi Dispensary, the Ngokolo Health Centre, the Buhangija Dispensary and the Mipa Dispensary – which are used by about 300,000 people and which deal, amongst other things, with the prevention and treatment of AIDS. The action plan envisages the free and voluntary administration of tests for the diagnosis of HIV/AIDS to about 120,000 people (from those who go to these four health-care centres) and free antiretroviral treatment for five years to about 20,000 patients, of whom many are children, the intention being to give them antiretroviral treatment fro all of their lives. Amongst the other objectives, reference should also be made to the wish to counter the transmission of the virus from mother to child; to create and/or supplement activities in laboratories and clinics for the prevention and treatment of infection by HIV; to promote the training of health-care workers and managers through suitable study plans and work placements; and to sensitise the local population to the subject of HIV/AIDS, through the support of the local mass media as well.

In November 2013 the 'Good Samaritan' Foundation and Gilead as the sponsoring agencies signed an agreement of intent (the 'Memorandum of Understanding') which allowed the setting in motion of the Project Agreement and the Action Plan 2014-2015 which will both be signed shortly.

In February 2014, in concomitance with the celebrations for the World Day of the Sick, which was instituted by the Blessed Pope John Paul II and which takes place on 11 February of each year, some representatives of the 'Good Samaritan' Foundation and Gilead visited Shinyanga and Dar Es Salaam with the aim of collecting information in order to organise the project at a detailed level, to plan its various stages, and to clarify the roles and tasks of the different parties involved. This visit was, in addition, a valuable opportunity to encounter the local referents of the project, the heads of the Bishops' Conference of Tanzania, medical doctors and university lecturers who work at the Catholic University of Health and Allied Sciences of Mwanza and the Bugando Medical Centre, representatives of the government and of local institutions, and the representative of the World Health Organisation in Tanzania.

The network of Catholic universities of Africa. After the visit of Benedict XVI to Benin in November 2011 – when he took with him the post-synodal apostolic exhortation *Africae Munus* and gave to the pastors of the continent the document containing pastoral recommendations for the Church in Africa over the next decades – the dicasteries of the Roman Curia were asked to do something, each in their own field and according to their own fields of competence, in order to help local pastors to implement the recommendations of the Holy Father. In order to respond to the request of the Holy Father to offer a concrete contribution in this direction, the 'Good Samaritan' Foundation decided to promote the creation of a network of the faculties of medicine of the seven Catholic universities of Africa: the Catholic University of Bukavu (UCB), in the Democratic Republic of the Congo; the University of Ugandan Martyrs (UMU), in Kampala in Uganda; the Catholic University for Health and Associated Sciences, in Mwanza in Tanzania; the St. Thomas Aquinas University (USTA), in Ouagadougou in Burkina Faso; the Catholic University of Graban (UCG), in Butembo in the Democratic Republic of the Congo; the Catholic University of Mozambique (UCM) in Beira; and the '*Le Bon Samaritain*' University Polyclinic of N'Djaména in Chad. The project entitled 'the *Africae Munus* Project' was established in order to foster cooperation between universities and other Church bodies and institutions involved in the world of medical education and research in order to develop more effective programmes of training, assistance, treatment and research in line with the Magisterium of the Church. At the level of detail, the initiative seeks to promote scientific-cultural exchanges between these connected faculties of medicine; the promotion of the training of health-care workers, lecturers and managers, with especial reference to ethics, bioethics and Christian anthropology; improvement in the supply of teaching and research; and the development and the sharing of knowledge that can increase in a notable way the capacity to make reliable diagnoses.

In November 2013, a year after the launching of the project, an international study and planning meeting sought to assess the state of advance of the activities, develop the pathways that had already been followed, and identify new possible synergies. The rectors of the African universities involved in the network and the heads of

their respective faculties of medicine, together with university lecturers and rectors of universities in other continents of the world, took part in this meeting in order to foster dialogue about the possible creation of a system of university twining. During the course of 2013 a pathway of specialisation of medical/health-care disciplines for four Congolese medical doctors was planned and set in motion at the University of Ugandan Martyrs (UCB). Amongst these medical doctors there was a woman religious. Similar pathways will be begun in the year 2014 for other African medical doctors involved in the *Africae Munus* Network.

The fight against malaria. Obeying its mission to provide assistance and care to sick poor people, the 'Good Samaritan' Foundation works to counter the spread of malaria in developing countries, with special attention being paid to Africa, and to disseminate the principle of universal and free access to care and treatment. According to the WHO there were about 207 million ascertained cases of malaria in 2012 and about 627,000 deaths caused by this disease, of which 90% took place in south Saharan Africa and 77% involved children under the age of 5. In the year 2012 malaria killed about 483,000 children from 0-5 years of age, that is to say 1,300 children every year or almost one child every minute. In addition, it is calculated that there are 3.4 billion people who run the risk of contracting the infection. And yet malaria can be prevented and treated. To this end, the 'Good Samaritan' Foundation – in cooperation with medical doctors, institutions and experts in the field – works to foster access to a new medical product of tested effectiveness and a cost that is very much lower than the medical products that are currently available, and is studying a research project designed to reduce the incidence of malaria in children through innovative forms of prevention and treatment. In 2013 this project was launched in Burkina Faso and in Ghana.

The fight against blindness. The Foundation is also involved in the fight against blindness in the poorest countries in the world. In May 2012 an international study conference was held on 'The Unsighted Person: Teacher, that I may see Again' which witnessed in-depth study and discussion on the subjects of the prevention and treatment of blindness and bad sight, with the objective of promoting the engagement of all national and international, ecclesial and governmental, bodies so as to foster the fight against pathologies of sight and to facilitate access to care and treatment. In response to this need, and in cooperation with CBM Italia Onlus, the 'Good Samaritan' Foundation launched a project directed towards the distribution of high-quality glasses of a very low cost to poor patients in Africa. This project also envisages a plan for the prevention and treatment of pathologies of sight through a programme of health-care examinations and check-ups in particular for children, to be carried out in parishes and schools.

To this field also belongs the project that will shortly be launched in Bolivia, in the district of La Paz, where the intention is to provide support for the creation of an eye department at the 'Las Yungas' Hospital of Coroico. The aim of the initiative – implemented in cooperation with CBM Italia Onlus and the University of Padua, with the support of the Rotary Club – is to foster the prevention and treatment of visual disability through a number of activities. A training plan is envisaged for local specialised personnel, Bolivian specialist oculists, workers in Bolivian communities and paramedical personnel. A screening of the population will follow for the identification of refractive defects which will involve in particular a group of 400 pre-school children (4-5 years) and a second group of adults made up of 300 people with long sight(40-50 years). In line with the needs brought out by these examinations, children and adults will at last be able to have access to personalised glasses of a low cost produced locally.

Amongst its other initiatives, the Foundation has also carried out a census of projects for the fight against blindness that have been promoted by the Catholic Church in the world.

The donation of medical products. The 'Good Samaritan' Foundation is also involved in a project for the donation of medical products and equipment to health-care institutions of the Catholic Church in the world. The methodology of action envisages the involvement in every country of apostolic nuncios, national Bishops' Conferences, dioceses and religious Congregations that promote initiatives involving assistance and care in the health-care field. Launched in June 2010, this project is operative in thirteen countries of the continent of Africa. It has been implemented in cooperation with the Catholic Medical Mission Board (CMMB), a no-profit non-governmental organisation with its headquarters in the United States of America involved in providing high-quality health-care services, health-care material and pharmaceutical products, without any form of discrimination based on race, politics or religion, to sick people and people in need throughout the world. The CMMB works in coordination with the Social and Economic Council of the United Nations and with its programmes.

A centre for medical products. The 'Good Samaritan' Foundation in the year 2013 launched the creation of its own centre for medical products for the collection and storage for short periods of time of pharmaceutical products and health-care equipment. This is material – produced by donations – which is sent to Churches in developing countries to be instruments of support for initiatives involving assistance and care for very poor patients who are helped in hospitals and health centres promoted and managed by local Churches. In donating such medical products, the 'Good Samaritan' Foundation responds to explicit requests from bishops and religious Congregations. In 2013 the 'Good Samaritan' Foundation was able to meet the request for support from the bishops of Congo Brazzaville and sent a container with medical products and equipment for Catholic health-care centres managed by the local Church, together with publications, books, support materials and documentation of great relevance to the training of work-

ers in the field of pastoral care in health. The material that was donated was divided between about forty Catholic health-care centres distributed between the seven dioceses into which the country is divided. A second container is ready to be sent very shortly to Madagascar to help patients of the 157 health-care centres supported by the Catholic Church of Madagascar in the twenty-one dioceses into which the country is divided.

Food education for children. The 'Good Samaritan' Foundation is studying a project for the promotion of a healthy food culture in children in the certainty that the prevention of the most widespread pathologies in so-called under-developed countries must begin at an early age in family and school contexts and aim above all else at the promotion of healthy and correct habits and behaviour in relation to food. In this area the Foundation has created at its headquarters a work table that brings together experts in the disciplines of human nutrition, teachers, and associations with recognised experience in this field.

Scholarships. The 'Good Samaritan' Foundation is involved in fostering the educational and training pathways of priests and men and women religious involved in the world of health and health care in order to enable them to acquire knowledge and skills that can be of help in the practice of the medical and nursing professions, something that is of fundamental importance in developing countries where there is widespread shortage of qualified health-care workers.

Thank you for your attention and I wish you successful work. ■

The World Days of the Sick

MSGR. JEAN-MARIE MUPENDAWATU
Secretary of the Pontifical Council for Health Care Workers

O Mary, Immaculate Virgin,
Woman of suffering and hope,
be kind to every suffering person,
obtain fullness of life for each one.

Turn your maternal gaze
especially upon those in Africa
whose need is extreme,
struck down by AIDS
or other mortal illness.

Look upon the mothers who are
mourning their children;
Look upon the grandparents who
lack the resources
to support their orphaned
grandchildren.

Embrace them all, keep them
close to your Mother's heart.

Queen of Africa and of the
whole world,
Virgin Most Holy, pray for us!

From the Vatican,
8 September 2004

This prayer to the Virgin Mary ended the Message of Pope John Paul II to the Thirteenth World Day of the Sick (the last such Message of his) which had the theme 'Jesus, Hope for Africa'. This was an event that the Holy Father had established in 1992 with his 'Letter Addressed to Cardinal Fiorenzo Angelini First President of the Pontifical Council for Pastoral Assistance to Health Care Workers'.

In this letter, dated 13 May – the day when the first Apparition of Our Lady of Fatima in 1917 is remembered – the Pope indicated as a date for the celebrations that of 11 February, the liturgical memorial of the Blessed Virgin of Lourdes, explaining that 'Lourdes, one of the Marian sanctuaries most loved 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 offering up of salvific suffering'.

In his letter the Pope observed that the Church, following the example of Christ, feels that the duty of service to the sick and the suffering – and the loving and generous welcoming of every human life, above all of weak and sick people – is an 'integral part of her mission' and that in this solicitude towards the sick the Church emphasises the 'salvific character of the offering up of suffering which, lived in communion with Christ, belongs to the very essence of redemption'.

Pope John Paul thus explained that the celebration of the World Day of the Sick 'has the purpose of sensitising the People of God and Catholic health-care institutions and civil society to the need to assure the best care for the sick; to help those who are sick and to value suffering at a human level and above all else a supernatural level; to involve in a particular way dioceses, Christian communities and religious families in pastoral care in health; to foster the valuable role of voluntary workers; to stress the importance of the spiritual and moral formation of health-care workers; and, lastly, to make priests and those who live and work at the side of those suffer understand the importance of religious assistance for the sick'.

Starting in the year 1993 the World Days of the Sick have developed according to *a recurrent approach made up of three days*. Firstly, to open the celebrations in a place chosen by the Holy Father because it is especially significant given the nature of the event – in general one is dealing here with some of the most important Marian sanctuaries in the world – a conference is held of a theological-pastoral character on the subjects of pastoral care in health. This is organised in cooperation with the local ecclesiastical institutions and universities. This is followed by visits to sick people and health-care institutions of the local Church. Then to end the days there is a celebration of the Eucharist in the chosen sanctuary during which a reading of the Message of the Pope and the administration of the

sacrament of the anointing of the sick are envisaged. Each year the Message of the Pope is disseminated a few months before the event to help the local Church and churches on the ground in their preparations for the World Day itself.

Whereas at the outset the celebrations of the World Day of the Sick took place every year in a *solemn* way. with the presence of a delegate of the Pope in the chosen place, subsequently the Pope decided that only one celebration every three years should have a solemn character, with the others having 'minor' celebrations in individual countries. From the institution of the World Day of the Sick until today, in carrying the Message of the Holy Father to the local and particular Churches the Pontifical Council for Health Care Workers has reached all the continents of the world.

On the occasion of the last two World Days of the Sick, the Pontifical Council for Health Care Workers (for Health Pastoral Care) published a support document translated into various languages (French, English, German, Portuguese and Polish) and useful for the whole of the liturgical year, arranged around three fundamental times (Advent-Christmas, the World Day of the Sick on the Liturgical Memorial of the Blessed Virgin of Lourdes, Lent-Easter), with at its end a *Via Crucis* to offer to the sick, to health-care workers and to pastoral workers, to families, to parishes and to volunteers points for theological reflection, pastoral analyses and formulas for prayers. The texts were written on the basis of the themes entrusted by the Holy Father for this Day and were made available free by the Pontifical Council for the various Bishops' Conferences that requested it so that they could publish it in their respective languages and through local publishing houses.

Themes of the World Days of the Sick

1993. The First World Day of the Sick

In his Message for the first World Day of the Sick, Pope John Paul II went back to emphasising the meaning of the celebration that he himself had instituted: 'This day…seeks to be "a special time of prayer and sharing, of offering one's suffering for the good of the Church and of reminding everyone to see in his sick brother or sister the face of Christ who, by suffering, dying and rising, achieved the salvation of mankind"…Illness, which in everyday experience is perceived as a frustration of the natural life force, for believers becomes an appeal to "read" the new, difficult situation *in the perspective which is proper to faith*. Outside of faith, moreover, how can we discover in the moment of trial the constructive contribution of pain? How can we give meaning and value to the anguish, unease, and physical and psychic ills accompanying our mortal condition? What justification can we find for the decline of old age and the final goal of death…Yes, only in Christ, the incarnate Word, Redeemer of mankind and victor over death, is it possible to find satisfactory answers to such fundamental questions. In the light of Christ's death and resurrection illness no longer appears as an exclusively negative event; rather, it is seen as a "visit by God", an opportunity "to release love, in order to give birth to works of love towards neighbour"'.

With the celebration of the World Day of the Sick the Pope also called for a renewed commitment in particular to the populations of developing countries 'to wipe out the injustice existing today by devoting greater human, spiritual, and material resources to their needs' and affirmed that 'To make health care more humane and adequate it is, however, essential to draw on a transcendent vision of man which stresses the value and sacredness of life in the sick person as the image and child of God. Illness and pain affect every human being: love for the suffering is the sign and measure of the degree of civilization and progress of a people'.

1994. The Second World Day of the Sick, the Marian Sanctuary of Czestochowa, Poland

On the occasion of the Second World Day of the Sick, the Pope called attention to the subject of 'salvific pain', that is to say to the Christian meaning of suffering, quoting the Apostolic Letter *Salvifici doloris*, which he himself had published. 'In Christ', wrote the Holy Father, 'even pain is taken up into the mystery of infinite charity, which radiates out from God the Trinity and becomes an expression of love and instrument of redemption – that is, it becomes salvific pain. It is in fact the Father who chooses the total gift of the Son as the way to restore the alliance with men rendered ineffective by sin'.

In addition, Pope John Paul II continued, 'A perfect revelation of the salvific value of pain is the passion of the Lord: "In the cross of Christ not only has redemption been fulfilled through suffering, but suffering itself has also been redeemed". Christ "opened his suffering to man", and in him man rediscovers his sufferings "enriched with a new content and a new meaning". All of the tribulations of life can become signs and foundations of future glory… a prolongation of the mystery of the Redemption, which, though complete in Christ, "constantly remains open to all love which is expressed in human suffering"'.

1995. The Third World Day of the Sick, the Sanctuary of Mary Queen of Peace of Yamoussoukro, the Ivory Coast

In his Message for the Third World Day of the Sick, the Pope remembered the institution on 11 February 1985, by his Motu proprio '*Dolentium hominum*', of the Pontifical Commission, which would later become Pontifical Council, *for Pastoral Assistance to Health Care Workers*. For the occasion the Holy Father reaffirmed the aims of this Pontifical Council which 'through multiple initiatives, "manifests the Church's concern for the ill by helping those engaged in serving the sick and the suffering so that the apostolate of mercy to which they are devoted will meet the new demands with increasing effectiveness" (Apostolic Constitution *Pastor Bonus,* art. 152)'.

The official celebrations of the Third World Day of the sick were

held in the Ivory Coast at the Sanctuary of Mary Queen of Peace of Yamoussoukro on the occasion of the centenary of the arrival of the first missionaries. In this circumstance the Pope invited people to reflect on the *relationship between pain and peace*. This is a very profound relationship: when there is no peace suffering spreads and death expands its power among men. In the social, as well as in the familial, community, the decline of peaceful understanding translates into a proliferation of attacks on life, whereas serving, advancing and defending life, even at the cost of personal sacrifice, constitute the indispensable premise for authentically building individual and social peace.

The Pope then exhorted all sick people and believers to offer up to God their own suffering in the name of peace on 'the altar of daily, ardent prayer, together with the sick all over the world, to present the offering of suffering which Christ has accepted as a means to redeem mankind and save it'.

1996. The Fourth World Day of the Sick, the sanctuary of Our Lady of Guadalupe, Mexico City

In his Message for the Fourth World Day of the Sick, Pope John Paul II pointed to the figure of *Mary as* '*Salus Infirmorum*' and her role as *a mediator between God and men*: 'The Mother of Jesus is the model and guide of this effective proclamation, since she "places herself between her Son and mankind in the reality of their wants, needs and sufferings. She puts herself ?in the middle', that is to say, she acts as a mediatrix not as an outsider, but in her position as mother. She knows that as such she can point out to her Son the needs of mankind, and in fact, she 'has the right' to do so. Her mediation is thus in the nature of intercession: Mary 'intercedes' for mankind. And that is not all. As a mother she also wishes the messianic power of her Son to be manifested, that salvific power of his which is meant to help man in his misfortunes, to free him from the evil which in various forms and degrees weighs heavily upon his life" (*Redemptoris Mater,* n. 21)'.

In addition the Pope exhorted the Church, in carrying out her missionary task and in the expression of her solicitude towards the sick and the suffering, to follow the model of the Most Holy Mary, 'who continues today, as she did at the dawn of the Church, to be "the model of that motherly love with which all who join in the Church's apostolic mission for the regeneration of mankind should be animated" (*Lumen gentium,* n. 65)'.

1997. The Fifth World Day of the Sick, the Sanctuary of Our Lady of Fatima, Portugal

For the Fifth World Day of the Sick the Pope chose the Sanctuary of Our Lady of Fatima in Portugal. This was a place, his Message proclaimed, that was 'particularly significant for me. I in fact wished to go there on the anniversary of the assassination attempt I suffered in St. Peter's Square, in order to thank Divine Providence, according to whose inscrutable design the dramatic event had mysteriously coincided with the anniversary of the first appearance of the Mother of Jesus on May 13, 1917, at the Cave of Iria'.

For the occasion the Pope stated that at Fatima Mary became the spokesman of the invitation of Christ: 'Come to me all you who labour and are overburdened, and I will give you rest' (*Mt* 11:28), and that 'And in Fatima this relief is found: sometimes it is physical relief, when, in his providence, God grants healing from illness; more often it is spiritual relief, when the soul, pervaded by the inner light of grace, finds the strength to accept the painful weight of infirmity, transforming it, through communion with Christ, the suffering servant, into an instrument of redemption and salvation for oneself and one's brothers and sisters'.

The Pope observed that 'it is the suffering who feel attracted by the perspective of "relief" which the Divine Physician is able to offer those who turn to Him with trust', and for them he pointed out the path to follow: 'The direction to move in, on this hard road, is pointed out to us by the motherly voice of Mary, who, in the history and life of the Church, has always continued to repeat – and in a special way in our time – the words "*Do whatever He tells you*"'

1998. The Sixth World Day of the Sick, the Sanctuary of Loreto, Italy

In his Message for the Seventh World Day of the Sick, John Paul II dwelt upon the mystery of the *Incarnation of the Word*. The Pope observed that: 'Within the walls of the Holy House, in an especially forceful manner Jesus Christ, "God with us," speaks to us of the Father's love (cf. *Jn* 3:16), which in the redemptive Incarnation was manifested in the loftiest way. God Himself, in search of man, became man, building a bridge between divine transcendence and the human condition'.

'Christ', he went on, 'did not come to remove our afflictions, but to share in them and, in taking them on, to confer upon them a salvific value: by becoming a partaker in the human condition, with its limits and its sorrows, He redeemed it. The salvation accomplished by Him, already prefigured in the healings of the sick, opens up *horizons of hope* for all who find themselves in the difficult time of suffering'.

In addition the Pope emphasised that 'The mystery of the Incarnation is the work of the Spirit' and that 'It is the Spirit who gives the human heart the strength to face difficult situations and overcome them'. 'Poured forth into our hearts, the Holy Spirit brings us to perceive ineffably the "nearby God"…He is the true *guardian of the hope* of all human creatures, and especially of those who "possess the first fruits of the Spirit" and "await the redemption of their bodies" (cf. *Rm* 8:23). In man's heart the Holy Spirit…becomes the…giver of gifts," and "light of hearts"; He becomes the "sweet guest of the soul" who brings "repose" in weariness, "shelter" in the "heat" of the day, and "comfort" in the midst of the preoccupations, struggles, and dangers in every period'.

A spirit to whom one should be meek, as *Mary* was, who 'must be contemplated and imitated above all, as the woman docile to the

voice of the Spirit, the woman of silence and listening, the *woman of hope*, who, like Abraham, was able to accept God's will, 'hoping against all hope''.

1999. The Seventh World Day of the Sick, the Sanctuary of Our Lady of Harissa, Beirut, the Lebanon

The Seventh World Day of the Sick had its solemn celebrations in the Lebanon, a land, wrote the Pope in his Message, which 'more than a country is a message and an example for the East and the West'. 'What place on earth could be better than the Lebanon', asked John Paul II, 'to symbolize unity among Christians and the encounter for all human beings in the communion of love?'

Specifically in that land where different ethnic groups, cultures and religions live together often in peace and in dialogue, the Pope spoke about the need to promote an '*ecumenism of works*' which in care for the sick, the suffering, the poor and those without anything was the most urgent, and at the same time the least arduous, of the pathways of ecumenism. On this way, he explained, it would be possible not only to search for the 'full unity' of those who profess to be Christian 'but also to be open to inter-religious dialogue in a place like the Lebanon where different religious beliefs have in common a certain number of indisputable human and spiritual values' which could spur people 'beyond the important differences between the religions' to discern first and foremost what unites them.

2000. The Eighth World Day of the Sick, the Year of the Great Jubilee

With the drawing near of the Seventh Word Day of the Sick of 11 February 2000, the Holy Father in his Message which had been written for the occasion looked at the *journey hitherto travelled by humanity* and declared: 'at the end of the second millennium we cannot say that humanity has done all that is necessary to alleviate the immense burden of suffering which weighs on individuals, families and entire societies'. The Pope observed the 'suffering inflicted by the mistakes of individuals and of States' and referred to 'the wars that have caused so much bloodshed in this century' and 'the types of disease that are prevalent in society such as drug dependency, AIDS, illnesses caused by the deterioration of the big cities and the environment', organised crime, 'the proposals of euthanasia', but also 'the serious social inequalities in access to health-care resources, which are still present in vast areas of the world, especially in the countries of the South'.

In addition the Pope observed that 'in many cases, the economic, scientific and technological breakthroughs have not brought real progress that is focused on the person and the inviolable dignity of every human being. Even the achievements in the field of genetics… can become an opportunity for inadmissible choices, callous manipulation and interests that contradict real development…On the one hand remarkable efforts are being made to prolong life and even to procreate it artificially; but on the other, birth is not permitted to those who have already been conceived, and the death of those no longer considered to be of use is hastened…we are reduced to considering life as a mere consumer good, setting a new scale of marginalization for the disabled, the elderly and the terminally ill'.

In the face of such a scenario the Holy Father expressed the hope that '"*the purification of memory*" would also be promoted in the world of suffering and health, which would lead to "recognizing the wrongs done by those who have borne or bear the name of Christian"'. In particular the Pope reminded Christians of *two duties: the defence of life and the promotion of health worthy of man*.

The Pope thus outlined the features of the Christian approach to illness: *integral care for the person*. John Paul II wrote: '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. This view, ignoring the person's spiritual and social dimensions, ends by jeopardizing his true good. Precisely because health is not limited to biological perfection, life lived in suffering also offers room for growth and self-fulfillment, and opens the way to discovering new values. This vision of health, based on an anthropology that respects the whole person, far from being identified with the mere absence of illness, strives to achieve a fuller harmony and healthy balance on the physical, psychological, spiritual and social level'.

Lastly, the Pope invited us 'to contemplate the face of *Jesus, the divine Samaritan* of souls and bodies. The example of Christ, the good Samaritan, must inspire the believer's attitude, prompting him to be "close" to his brothers and sisters who are suffering, through respect, understanding, acceptance, tenderness, compassion and gratuitousness'.

2001. The Ninth World Day of the sick, the Cathedral of Sydney, Australia

In his Message for the Ninth World Day of the Sick on the theme 'The New Evangelisation and the Dignity of the Suffering Person', the Pope exhorted us *to evangelise the world of health care in a renewed way*, 'as a place particularly suited to becoming a valuable laboratory for the civilization of love' in order to 'encourage its orientation to the overall well-being of the person and the progress of all people in every part of the world'.

John Paul II declared in his Message that: 'Hospitals, centres for the sick or the elderly and every institution which cares for the suffering are privileged areas for the new evangelization, which must be committed to making the Gospel message of hope heard precisely in these places. Only Jesus the divine Samaritan is the fully satisfying answer to the deepest expectations of every human being in search of peace and salvation. Christ is the Saviour of every person and of the whole person. For this reason the Church never tires of proclaiming him, so that the world of illness and the search for health may be enlivened by his light'.

On this occasion, as well, the

Pope returned to emphasising the need to promote the *integral health of the person*: 'In this perspective, there is increasing discussion of "holistic" care, that is, care that pays attention to the biological, psychological, social and spiritual needs of the sick and of those around them…with regard to medicines, treatments and surgical operations, for clinical experimentation to be conducted with absolute respect for the individual and with a clear awareness of the risks and, consequently, of the limits involved. In this area Christian professionals are called to bear witness to their ethical convictions and to be constantly enlightened by faith'. Lastly the Pope emphasised the urgent need top promote 'the equitable distribution of goods, desired by the Creator' in order to combat 'the persistent injustice that deprives a large part of the population of the treatment indispensable to health'.

2002. The Tenth World Day of the Sick, the Sanctuary of 'Our Lady of Health' in Vailankanny, India

The Tenth World Day of the Sick had its official celebrations in India, in the Sanctuary of 'Our Lady of Health' in Vailankanny which the Pope defined as 'a meeting-point for members of different religions, and an outstanding example of interreligious harmony and exchange'. In this context the Holy Father observed that 'The various religions of humanity have always sought to answer the question of the meaning of suffering', but 'Even though the Church finds much that is valid and noble in non-Christian interpretations of suffering, *her own understanding of this great human mystery is unique*'.

The Pope then declared that the answer to the question of the meaning of suffering has been "given by God to man in the Cross of Jesus Christ"…Through *his suffering on the Cross*, Christ has prevailed over evil and enables us too to overcome it. Our sufferings become meaningful and precious when united with his. As God and man, Christ has taken upon himself the sufferings of humanity, and in him human suffering itself takes on a redemptive meaning'. In other words, 'Faith teaches us to seek the ultimate meaning of suffering in Christ's Passion, Death and Resurrection'. Lastly, the Holy Father observed that 'The Christian response to pain and suffering is never one of passivity. Urged on by Christian charity… the Church goes out to meet the sick and suffering, bringing them comfort and hope'.

2003. The Eleventh World Day of the Sick, the Basilica of the Immaculate Conception, Washington D.C., the United States of America

In his Message for the Eleventh World Day of the Sick, the solemn celebrations for which took place in the United States of America, the Pope addressed with concern *a model of society where the powerful dominate to the detriment of the marginalised*, a model which unfortunately is widespread in parts of the world: 'I am thinking here of unborn children, helpless victims of abortion; the elderly and incurable ill, subjected at times to euthanasia; and the many other people relegated to the margins of society by consumerism and materialism. Nor can I fail to mention the unnecessary recourse to the death penalty . . . This model of society bears the stamp of the culture of death, and is therefore in opposition to the Gospel message'.

In the face of such a reality, the Pope went on, 'Catholics working in the field of health care have the urgent task of doing all they can *to defend life* when it is most seriously threatened and to act with a conscience correctly formed according to the teaching of the Church… Catholic hospitals should be centres of life and hope which promote – together with chaplaincies – ethics committees, training programmes for lay health workers, personal and compassionate care of the sick, attention to the needs of their families and a particular sensitivity to the poor and the marginalized'.

The Pope then quoted his apostolic letter *Novo millennio ineunte*: 'The service of humanity leads us to insist…that those using *the latest advances of science*, especially in the field of biotechnology, must never disregard fundamental ethical requirements by invoking a questionable solidarity which eventually leads to discriminating between one life and another and ignoring the dignity which belongs to every human being'.

'The Church', one reads in the Message, 'which is open to genuine scientific and technological progress, values the effort and sacrifice of those who with dedication and professionalism help to improve the quality of the service rendered to the sick, respecting their inviolable dignity… And while palliative treatment in the final stage of life can be encouraged, avoiding a "treatment at all costs" mentality, it will never be permissible to resort to actions or omissions which by their nature or in the intention of the person acting are designed to bring about death…it remains a fundamental precept *that life is to protected and defended, from its conception to its natural end*'.

2004. The Twelfth World Day of the Sick, the Marian Sanctuary of Lourdes, France

For the Twelfth World Day of the Sick the Pope, the Pope chose the sanctuary of Lourdes in France on the occasion of the one hundred and fiftieth anniversary of the proclamation of the *Immaculate Conception*. At Lourdes Mary said: 'I am the Immaculate Conception' and it is specifically this theme that constitutes the heart of the Message of the Pope.

'At Lourdes' wrote John Paul II, 'it is not difficult to understand Mary's unique participation in the salvific role of Christ'. Precisely 'with the Immaculate Conception of Mary began the great work of Redemption that was brought to fulfilment in the precious blood of Christ…The Immaculate Conception is, therefore, the promising dawn of the radiant day of Christ'.

Furthermore, observed the Pope, 'If Jesus is the source of life that conquers death, Mary is the attentive mother who comes to meet the needs of her children, obtaining for them the health of soul and body… This is also the meaning behind the healings of body and spirit that take

place at the grotto of Massabielle'. 'On that site', continued the Pope, 'since the day of the apparition to Bernadette Soubirous, Mary has "healed" pain and sickness, also restoring many of her sons and daughters to health of body. She has worked much more surprising miracles, however, in the souls of believers, preparing them for the encounter with her Son Jesus, the authentic answer to the deepest expectations of the human heart'. The gift of the conversion of the heart, a source of peace and interior joy 'gift transforms their existence and makes them apostles of the Cross of Christ, standard of hope, even amid the hardest and most difficult trials'.

Lastly, the Holy Father declared that: 'The prodigy of the Immaculate Conception reminds believers of a fundamental truth: it is possible to reach salvation only through docile participation in the project of the Father, who wanted to redeem the world through the death and Resurrection of his only-begotten Son'.

2005. The Thirteenth World Day of the Sick, the Sanctuary of Mary the Queen of the Apostles, in Yaoundé, Cameroon. Theme: Christ, Hope for Africa

As I said at the beginning of this paper, the Pope wanted to dedicate the Thirteenth World Day of the Sick in particular to Africa. Remembering the numerous wounds that scourge the continent, from armed conflicts to inequalities, from poverty to the shortage of food and medical products and on to diseases, the Holy Father dwelt upon the drama of AIDS which he defined as being a 'pathology of the spirit'.

'To fight it responsibly', Pope John Paul II wrote in his Message, 'it is necessary to increase its prevention by teaching respect for the sacred value of life and the correct approach to sexuality. Indeed, if there are many contagious infections passed on through the blood especially during pregnancy - infections that must be combated with every possible means - those contracted through sexual intercourse are by far the most numerous and can only be avoided by responsible conduct and the observance of the virtue of chastity'.

When addressing the bishops of the Bishops' Conferences of other continents of the world, John Paul II exhorted them to a shared commitment to support for the Pastors of Africa in order to face up to these and other emergencies in an effective way. In addition, he referred to the role of the Pontifical Council for Health Care Workers which is called to 'make its own contribution to coordinating and promoting such cooperation, asking every Bishops' Conference for its effective contribution'.

BENEDICT XVI

2006. The Fourteenth World Day of the Sick, the Cathedral of St. Francis Xavier, Adelaide, Australia

In his first Message for a World Day of the Sick, which was the fourteenth edition of the event, Pope Benedict XVI placed emphasis on the subject of mental disturbance, inviting Church communities 'to bear witness to the tender mercy of the Lord'.

'In many countries', observed the Pope, 'legislation in this field does not yet exist and in others, there is no definite mental-health policy. It should then be noted that prolonged armed conflicts in various regions of the world, the succession of terrible natural catastrophes and the spread of terrorism, in addition to causing a shocking number of deaths, has triggered psychological traumas that are sometimes difficult to cure in many survivors. In the economically highly-developed countries, experts then recognize that at the origin of new forms of mental disease we may also find the negative impact of the crisis of moral values. This increases the feeling of loneliness, undermining and even breaking up traditional forms of social cohesion, starting with the family institution, and marginalizing the sick, particularly the mentally ill who are all too often considered as a burden on the family and community'.

Faced with this socio/health-care emergency, the Holy Father encouraged an intensification of efforts 'to ensure that all mentally ill people are given access to necessary forms of care and treatment'. Indeed, he observed with concern, 'in many parts of the world, services for these sick people are lacking, inadequate or in a state of decay. The social context does not always accept the mentally ill with their limitations, and this is another reason difficulties are encountered in securing the human and financial resources that are needed'.

2007. The Fifteenth World Day of the Sick, Seoul, Korea

In his Message for the Fifteenth World Day of the Sick, Pope Benedict XVI called attention to the condition of the *incurably ill,* who are present in every continent of the world and in particular in places where poverty and difficulties cause immense misery and pain.

'Despite the advances of science, a cure cannot be found for every illness, and thus, in hospitals, hospices and homes throughout the world we encounter the sufferings of our many brothers and sisters who are incurably and often terminally ill. In addition, many millions of people in our world still experience insanitary living conditions and lack access to much-needed medical resources, often of the most basic kind, with the result that the number of human beings considered "incurable" is greatly increased'.

The Holy Father then emphasised that: 'The Church wishes to support the incurably and terminally ill by calling for just social policies which can help to eliminate the causes of many diseases and by urging improved care for the dying and those for whom no medical remedy is available. There is a need to promote policies which create conditions where human beings can bear even incurable illnesses and death in a dignified manner'. The Pope then stressed the need to promote 'palliative care centres which provide integral care, offering the sick the human assistance and spiritual accompaniment they need'. Addressing those who suffer from incurable illnesses, the Holy Father said 'your sufferings, united to those of Christ, will prove fruitful for the needs of the Church and the world'.

2008. The Sixteenth World Day of the Sick, theme 'The Eucharist, Lourdes and Pastoral Care for the Sick'

The Sixteenth World Day of the Sick was held in concomitance with two events that are important for the life of the Church: the one hundred and fiftieth anniversary of the apparitions of the Virgin Mary in Lourdes and the celebration of the International Eucharistic Congress in Quebec in Canada. Indeed, the theme of this World Day was 'The Eucharist, Lourdes and Pastoral Care for the Sick'.

In his Message the Pope sought to highlight the close connection that exists between the mystery of the Eucharist, the role of Mary in the project of salvation and the reality of the suffering of man.

In the sacrament of the Eucharist, observed Benedict XVI, one can see the 'indissoluble link between the Mother and the Son generated in her womb by the work of the Holy Spirit': 'The flesh born of Mary, coming from the Holy Spirit, is bread descended from heaven'. Quoting St. Peter Damiani, the Pope explained again that 'That body that the Most Blessed Virgin generated…we now receive from the sacred altar, and we drink its blood as a sacrament of our redemption'.

In addition Benedict XVI declared that 'Mary is a model of total self-abandonment to God's will: she received in her heart the eternal Word and she conceived it in her virginal womb; she trusted in God and, with her soul pierced by a sword (cf. Lk 2: 35), she did not hesitate to share the Passion of her Son, renewing on Calvary at the foot of the Cross her "yes" of the Annunciation'. The Holy Father thus stressed the need 'to allow oneself to be taken and led by her hand to pronounce in one's turn *"fiat"* to the will of God, with all one's existence interwoven with joys and sadness, hopes and disappointments'.

Associated with the sacrifice of Christ, Mary, the sorrowful Mother, who at the foot of the Cross suffered with her divine Son, is felt to be especially near to the Christian community which gathers around its suffering members who bear the signs of the passion of the Lord. Mary suffers with those people who are in tribulation, with them she hopes and she is their comfort, supporting them with her maternal help.

Jesus Christ present in the sacrament of the altar, wrote Benedict XVI, is that 'Hope that does not disappoint…that medicine of immortality which heals the body and the spirit'. His sacrifice is for everyone and thus the Eucharist leads every believer in him to become 'broken bread' for other people. We are thus encouraged to become personally involved in serving our brethren and in particular those who are in difficulty because the vocation of every Christian is truly that of being, together with Jesus, broken bread for the life of the world.

2009. The Seventeenth World Day of the Sick

The Seventeenth World Day of the Sick was dedicated principally to *sick and suffering children*, to all those children – one can read in the Message of Benedict XVI for that occasion – who 'bear in their bodies the consequences of incapacitating diseases, and others who are fighting illnesses'; those who struggle against illnesses 'that are still incurable today'; and those 'injured in body and in mind, subsequent to conflicts and wars, and other innocent victims of the insensate hatred of adults'. And there are also those 'who are deprived of the warmth of a family and left to themselves, and minors defiled by degenerate people who violate their innocence…Then we cannot forget the incalculable number of minors who die of thirst, hunger and the lack of medical help, as well as the small exiles and refugees who flee from their countries together with their parents in search of a better life'. 'A silent cry of pain', declared Benedict XVI, 'rises from all these children which questions our consciences as human beings and believers'.

The Holy Father then emphasised that 'Since the sick child belongs to a family that frequently shares in his or her suffering with serious hardship and difficulties, Christian communities cannot but also feel duty-bound to help families afflicted by the illness of a son or daughter'. In these contexts, 'the acceptance and sharing of suffering is expressed in the practical support of sick children's families, creating in them an atmosphere of serenity and hope and making them feel that they are in the midst of a larger family of brothers and sisters in Christ'.

Lastly, the Pope emphasised that: 'The daily devotion and continuous commitment to serving sick children is an eloquent testimony of love for human life, particularly for the life of those who are weak and dependant on others in all things and for all things'.

2010. The Eighteenth World Day of the Sick

The Eighteenth World Day of the Sick was on the same date as the *twenty-fifth anniversary of the institution of the Pontifical Council for Health Care Workers.*

For the occasion the Pope wanted to raise 'the ecclesial community's awareness to the importance of pastoral service in the vast world of health care' and emphasised that such service is an integral part of the mission of the Church 'since it is engraved in Christ's saving mission itself. He, the divine Doctor, "went about doing good and healing all that were oppressed by the devil"'.

The Pope explained that at the Last Supper, with the gesture of the *washing of feet*, Jesus 'invited his disciples to enter into the same logic of love that is given especially to the lowliest and to the needy. Following his example, every Christian is called to relive, in different and ever new contexts, the Parable of the Good Samaritan who, passing by a man whom robbers had left half-dead by the roadside, "saw him and had compassion, and went to him and bound up his wounds"'. With the words that ended this parable 'Go and do likewise', the Pope wrote, 'he is also addressing us. Jesus exhorts us to bend over the physical and mental wounds of so many of our brothers and sisters'.

When looking at the commitment of the Church to service to the sick, Benedict XVI observed

that 'The ecclesial community's humanitarian and spiritual action for the sick and the suffering has been expressed down the centuries in many forms and health-care structures, also of an institutional character…It is a precious "patrimony" that corresponds with the fact that "love... needs to be organized if it is to be an ordered service to the community". Thus, he went on, 'The creation of the *Pontifical Council for Health-Care Workers* 25 years ago complies with the Church's solicitude for the world of health care'.

At the current historical-cultural time, the Pope ended, one perceives even more 'the need for an attentive and far-reaching ecclesial presence beside the sick, as well as a presence in society that can effectively pass on the Gospel values that safeguard human life in all its phases, from its conception to its natural end'.

2011. The Nineteenth World Day of the Sick, on the Theme 'by his Wounds you Have Been Healed'

In his Message for the Nineteenth World Day of the Sick, Benedict XVI remembered his pastoral visit to Turin and in particular his remaining in prayer in front of the Turin Shroud. To contemplate the suffering face of he who took upon himself the passion of men of all epochs and all places, and also our sufferings, our difficulties, and our sins, wrote Benedict XVI, was an invitation to reflect upon what St. Peter wrote: *'by his wounds you have been healed'*.

'The Son of God suffered, died, but rose again, and precisely because of this those wounds become the sign of our redemption, of forgiveness and reconciliation with the Father; however they also become a test for the faith of the disciples and our faith… For them, as for us, suffering is always charged with mystery, difficult to accept and to bear'. 'It is precisely through the wounds of Christ that we are able to see, with eyes of hope, all the evils that afflict humanity. In rising again, the Lord did not remove suffering and evil from the world, but he defeated them at their root'. Thus it is, therefore, that in front of Christ who displayed his wounds, even the incredulous Thomas expressed a moving profession of faith: 'My Lord and my God'.

With the drawing near of the World Youth Day, which took place in August 2011, Benedict XVI directed special thoughts to sick young people: 'Often the Passion, the Cross of Jesus, generate fear because they seem to be the negation of life. In reality, it is exactly the contrary! The Cross is God's 'yes' to mankind, the highest and most intense expression of his love and the source from which flows eternal life.'

2012. The Twentieth World Day of the Sick, on the Theme 'Stand up and go; your Faith has Saved you'

At the centre of the Twentieth World Day of the Sick Pope Benedict XVI placed emphasis on the 'sacraments of healing', that is to say the *sacrament of penance*, *the sacrament of reconciliation* and the sacrament of the *anointing of the sick*.

The value of *penance*, the Holy Father wrote, 'consists in restoring us to God's grace, and joining with him in an intimate friendship…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'. Merciful God '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'. Thus it is that confession may be defined as a 'medicine' for the soul, thanks to which 'the experience of sin does not degenerate into despair but encounters the Love that forgives and transforms'.

On the other hand *the sacrament of the anointing of the sick* '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"'. But the Garden of Olives, Benedict XVI went on, 'is also the place from which he ascended to the Father, and is therefore the place of redemption'. Thus, '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'.

Together with these two sacraments, the Pope also emphasised the importance of the Eucharist: received at a time of illness, it associates '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'.

2013. The Twenty-First World Day of the Sick, Solemn Celebrations at the Marian Sanctuary of Altötting, Germany

In his Message for the Twenty-First Word Day of the Sick, Benedict XVI directed attention to the *figure of the Good Samaritan*, spoken about by the Gospel of St Luke, and referred to the final words of the parable: 'Go and do likewise'.

In that gospel passage, observed the Pope, 'the Lord also indicates the attitude that each of his disciples should have towards others, especially those in need. We need to draw from the infinite love of God, through an intense relationship with him in prayer, the strength to live day by day with concrete concern, like that of the Good Samaritan, for those suffering in body and spirit who ask for our help, whether or not we know them and however poor they may be'.

'Various Fathers of the Church', the Holy Father explained, 'saw Jesus himself in the Good Samaritan; and in the man who fell among thieves they saw Adam, our very humanity wounded and disoriented on account of its sins…But Jesus is also the one who sheds the garment of his divinity, who leaves his divine condition to assume the likeness of men…in order to bring hope and light. He does not jealously guard his equality with God

but, filled with compassion, he looks into the abyss of human suffering so as to pour out the oil of consolation and the wine of hope'.

POPE FRANCIS

2014. The Twenty-Second World Day of the Sick, on the theme 'Faith and Charity: 'We too must Give our Lives for the Brethren"

The figure of the *Good Samaritan* come to the fore again in the Message for the Twenty-Second World Day of the Sick of Pope Francis. 'By virtue of baptism and confirmation', wrote the Holy Father, 'we are called to be conformed to Christ, the Good Samaritan of all the afflicted'. Thus, he observed, 'When we approach with tenderness those who are in need of care , we bring hope and a smile of God amid the contradictions of the world. When dedication and generosity towards others becomes the style of our actions, we make space for the Heart of Christ and we are warmed by it, thus offering our contribution to the advent of the Kingdom of God'.

In this charitable approach to our suffering neighbour, the model for tenderness and charity to which we should look is Mary, the Mother of Jesus and our mother, attentive to the voice of God and to the needs and difficulties of His children. 'Mary', the Pope wrote, 'moved by the divine mercy which in her has become flesh, forgets about herself and hurries from Galilee to Judea to meet and help her cousin Elizabeth; she intercedes with her Son at the wedding feast of Cana, when she sees that there is a shortage of wine at the party; he carries in her heart, during the pilgrimage of her life, the words of the old Simon who tells her beforehand of a sword that will pierce her soul, and with fortitude she remains at the foot of the Cross of Jesus. She knows how this road is followed and for this reason she is the Mother of all sick people and suffering people'.

2016. The Twenty-Fourth World Day of the Sick, Solemn Celebrations in Nazareth in the Holy Land

In 2016 the Pontifical Council for Health Care Workers will celebrate in a solemn form the Twenty-Fourth World Day of the Sick which will take place in Nazareth in the Holy Land on 11 February with the theme: *'Trust in Jesus like Mary – 'Do whatever he tells you!' (Jn 2:5).*

Following tradition, the local Churches will be involved in the Twenty-Fourth World Day of the Sick not only in the celebration of the Day itself but also in the organisation of the theological-pastoral conference, the subject of which will reflect the specific questions and issues of the Middle East and will thus be connected with peace, reconciliation and health. In addition, a meeting with bishops of the region who are responsible for pastoral care in health will be organised.

During the pilgrimage to the Holy Land organised by the Pontifical Council for Health Care Workers on the occasion of the Year of Faith, a Holy Mass was celebrated in honour of the Virgin Mary, the Queen of Palestine, in Deir Rafat, at the end of which it was officially announced by H.E. Msgr. Zygmunt Zimowski, the President of the Pontifical Council for Health Care Workers, that the Twenty-Fourth World Day of the Sick would be celebrated in the Holy Land.

The Fruits of these World Days

Over the years, the celebration of the World Days of the Sick in the various continents of the world has allowed a dissemination of the contents of the Magisterium of the Church in the field of health amongst sick people and health-care workers; a fostering of the implementation of pastoral care in health; a greater awareness of the need to place the dignity of the human person and the protection of life in all its forms from conception until its natural end at the centre of things; and the promotion of a concept of 'integral care' which unites the medical/health-care aspect with the psychological, social, spiritual and pastoral aspects. ■

The International Committee of Catholic Health-Care Institutions (CIISAC): Genesis and Prospects

• The International Committee of Catholic Health-Care Institutions (CIISAC) is the new organisation which has taken the place of the International Association of Catholic Health-Care Institutions (AISAC).

• The AISAC was founded in 1986 by the Pontifical Commission for Pastoral Assistance to Health Care Workers, following the encouragement given by Pope John Paul II, in order to coordinate the Catholic health-care institutions of the Church at an international level.

• In 1986 the first *draft* of the statutes was drawn up by the Provisional Committee. In July 1990 a second draft was drawn up and this was sent by the then Arch-

bishop Fiorenzo Angelini to the Secretariat of State, which in January 1991 sent back its observations.

• In January 1998 the last *draft* of the statutes was drawn up and in April 1998 the Secretariat of State sent in its observations on it.

• In July 1999 the delegates of the twenty-five nations decided on the creation of a Governing Council made up of various continental delegates who could help the Pontifical Council for Health Care Workers in the process of the growth of the AISAC.

• The President had indicated two principal objectives:

– The economic problems to be solved as regards the management of Catholic hospitals.

– The need to establish guidelines for a new evangelisation of Catholic health-care institutions.

• It was suggested that the AISAC, although continuing to be under the Pontifical Council for Health Care Workers, should become a Federation of Catholic Health-Care Institutions in order to stimulate the creation of new national associations and strengthen the initiatives of those that already existed.

• From 2000 to 2011 the meetings involving planning took place once a year in order to update the Pontifical Council on the situation of Catholic health-care institutions. They witnessed the participation of: the Superiors of the Pontifical Council, bishops responsible for pastoral care in the various continents of the world, Superiors of various religious Institutes, and representatives of Catholic health-care associations.

• At the various meetings the following objectives emerged:

– The strengthening of the identity of Catholic health care.

– The exchange of information about the condition of Catholic health care in the world and the challenges that it has to address.

– The encouragement of the formation of Catholic health-care workers, especially in relation to questions connected with ethics and pastoral care in health.

– The keeping of information/documentation on Catholic health care in order to support the work of the Pontifical Council for Health Care Workers and the international association.

• It was thus necessary to make the activity involving management that had been previously entrusted to the AISAC up-to-date and effective, taking into account:

– The increasing organisational complexities of modern health-care institutions.

– The need to maintain and/or promote the humanisation of care and treatment.

– The need to obtain new human and financial resources.

• The CIISAC wants, therefore, to be an international committee made up of Catholic health-care institutions or bodies represented by their administrators, whose mission is the actuation of a new evangelisation of hospital institutions.

• To match this mission, the CIISAC intends to promote contacts, exchanges and solidarity amongst its members, providing to heads and administrators of Catholic health-care institutions contributions involving theological and spiritual formation, research at the level of pastoral care, and moral and technical-professional assistance, with special reference to those who work in areas of especial difficulty.

• The CIISAC, connected with the Pontifical Council for Health Care Workers, amongst its tasks seeks to promote:

– The theological education and the spiritual formation of those who are involved in the work of the member institutions.

– The implementation of socio/health-care programmes that respect actual socio-political realities, as well as the teaching of the Magisterium and the recommendations at the level of pastoral care of the Pontifical Council for Health Care Workers.

– The birth of new socio/health-care associations and institutions in all those regions where they do not yet exist.

– Cooperation with Bishops' Conferences so that the associations that already exist are strengthened and are encouraged to join the CIISAC.

• Initiatives designed to foster shared awareness of various experiences in the field of health-care administration and management at an international level.

– The creation of a suitable structure in order to provide members with appropriate technical, professional and moral assistance, with especial reference to areas that have specific critical situations.

– Publications or other instruments of communication, with programmes that will be decided upon.

• To this end, this institution intends to organise conferences on subjects involving health-care administration and formation on the basis of Catholic teaching.

• On 23 November 2013, at the end of the twenty-eighth international conference on 'Hospitals as Settings for Evangelisation: their Human and Spiritual Mission', organised by the Pontifical Council for Health Care Workers, a meeting took place of the members of the Governing Council of the Committee.

Invited representatives of the most important associations of Catholic health-care institutions of the world from various countries (amongst which Brazil, Israel, the USA) were present at this meeting.

• The central point of the agenda of this meeting was a discussion of the *draft* of the new statutes of the CIISAC, whose final version will have to be presented to the Secretariat of State for due approval.

• Here, amongst the various projects proposed for insertion into the planning of activity for 2014-2015, we find:

– The up-dating of the *Index* of Catholic health-care institutions.

– The creation of a *web site* and a *news bulletin* of the new Committee of Catholic Health-Care Institutions.

Third International Conference Organised by the Network of Pastoral Care in Health of the Ecumenical Patriarchate of Constantinople

8-12 October 2014
Rhodes, Greece

Report

MSGR. DARIUSZ GIERS
Official of the Pontifical Council for Health Care Workers

On 8-12 October 2014 the third edition of the international conference organised by the *Network of Pastoral Care in Health of the Ecumenical Patriarchate of Constantinople* was held in Rhodes, Greece. Over two-hundred people took part in the event as representatives of the Metropolises – those people who belong in an administrative or spiritual sense to the Ecumenical Patriarchate in the world, of the Orthodox autocephalous Churches, of Orthodox theological schools in Greece and abroad, of health-care workers and of pastoral workers in the field of health.

Amongst those non-Orthodox invited to the conference by Rev. Fr. Stavros Kofinas, the coordinator of this network, reference may be made to: a representative of the World Council of Churches and an Official of the Pontifical Council for Health Care Workers, Rev. Msgr. Dariusz Giers. The presence of the Pontifical Council for Health Care Workers at the conferences that have been held in Rhodes goes back to the year 2008 and has helped to strengthen the relations of the Catholic Church with its sister Orthodox Church in this very important field of the apostolate of mercy.

The aim of the third conference of Rhodes, in addition to that of fostering increasingly deep communion between the Orthodox Churches, was to examine the subject that is expressed by the Greek term 'trauma'. The choice of this subject – explained Rev. Fr. Kofinas when opening the conference – arose from the context in which contemporary humanity finds itself. Modern man is living the illusion of the past and the impasse of today and these cause within him anger, disappointment, discomfort, hopelessness and depression. Faced with increasingly broad bands of society who are afflicted by these woes, the Church of Christ cannot be indifferent. It possesses the grace of God that springs from the love of Christ and it has the strength to heal all human wounds.

Other distinguished speakers, who came exclusively from the Orthodox Greek world, were entrusted with the task of identifying the wounds of the men of today, of classifying them and of pointing to the instruments by which they can be healed. The problem was analysed from the point of view of various disciplines such as medicine, psychology and sociology, but also in theological and spiritual terms.

The introductory paper entitled 'A Great Wound – Man' was given by the Archimandrite Theodoseos Martzouchos, the Metropolitan of Nicopolis and Preveza, who sought to provide the theological and philosophical bases of the subject that was being addressed.

Over the subsequent twelve sessions various subjects were addressed, such as: the psychological meaning of trauma, the wounds derived from eros and complex human relationships, the traumas provoked by an incorrect religious education, the traumas of adolescence, the traumas following surgical operations, and the traumas produced by the ill-treatment of women and children and those connected with road accidents. It emerged that people are exposed to various kinds of traumas during every stage of their lives, and in particular when physical illness, ill-treatment, natural disasters, calamities, violence and terrorist attacks enter their existence. A special trauma is generated by war which involves all imaginable forms of suffering such as the loss of life, of health, of one's family and of one's home. A moving testimony was provided on this subject by Rev. Fr. Bassam Nassif, a lecturer at the Theological university of Ballam in the Lebanon, where the refugee camps for Palestinian refugees are by now on the point of collapse because of the massive inflow of Syrians that has taken place over recent months.

The conference was rich in reflections and ideas which offered a vast survey of the subject that was addressed. The traumas experienced by the categories of most vulnerable people, such as women and children exposed to violence and physical and mental maltreatment, were identified. The traumas to which medical doctors, therapists and even medical students who experience stress and pressure generated by demanding and tiring study were pointed out. The penultimate paper, which was given by His Eminence Paul the Metropolitan of Sisanios and Siatista, was on the wounds of the clergy which quite frequently lead ministers of God to situations of interior crisis, a lack of confidence and burnout.

In the programme of the meeting moments of prayer were envisaged both in the hall and in the Cathedral of the Annunciation of Rhodes as well as in a local sanctuary where the prayers of the 'great vespers' are offered up for the sick and for health-care workers. ■

Intervention of the Pontifical Council for Health Care Workers

MSGR. DARIUSZ GIERS
Official of the Pontifical Council for Health Care Workers

Your Eminence, the Metropolitan of Rhodes Kirill and President of this Conference,

Your Excellences, Representatives of the Metropolises belonging to the Ecumenical Patriarchate,

Dear Father Stavros Kofinas, Coordinator of the Network and Organizing Committee,

All you Distinguished Participants at this Conference, Care Providers in the area of health,

It is a great joy and honour for me, once again, to represent the Pontifical Council for Health Care Workers at this Third International Conference of the Network of the Ecumenical Patriarchate of Constantinople for Pastoral Health Care. I bring to you the greetings and blessings of the President, Archbishop Zygmunt Zimowski, who is very grateful for this invitation and convinced about the necessity of the collaboration of our two Sister Churches in the field of health pastoral care, as we carry on the mission of caring and healing in the name of Christ, all those who suffer and feel pain.

The topic of this Conference "The Wound" and the explicating words of the Ecumenical Patriarch Bartholomew "to minster to the 'great wound' and the 'great miracle' – man", are very central to our mission. It is true that man created in the image and likeness of God is a great miracle of divine creation and occupies a special position in the created reality. He thus demands respect for his dignity and life, and ought to be taken care of with love and compassion.

Speaking about the role of the Church today and the priorities in her pastoral action, Pope Francis, in a broad-ranging interview with the director of the Italian Jesuit Magazine *Civilità Cattolica*, stressed that "what the Church needs today is the ability to heal wounds and the hearts of the faithful, it needs to be by their side. I see - *he explained* - the Church as a field hospital after a battle. It's pointless to ask a seriously injured patient whether his cholesterol or blood sugar levels are high! It is his wounds that need to be healed. The rest we can talk about later. Now we must think about treating those wounds. And we need to start from the bottom." (19,23,29 August 2013)

First of all, according to the Pope, we have to come back to proclamation of the Gospel "in a missionary style focusing on the essentials, on the necessary things: this is also what fascinates and attracts more, what makes the heart burn, as it did for the disciples at Emmaus." He pointed out in the same interview: "the ministers of the Church must be ministers of mercy above all."

A perennial example of this ministry of mercy is offered to us in the Parable of the Good Samaritan (Lk 10:25-37), which shows us in the perfect way what kind of approach we should have towards wounded man. The good Samaritan does not ask for anything, the suffering of the neighbor breaks his heart and he shows compassion. Seeing man in those conditions moves him viscerally with feelings of compassion, he is deeply touched. In the behavior of the good Samaritan the injured and suffering are not addressed by sociological or ideological criteria, but with a personal approach. Injured people are in need of closeness, compassion and support. In suffering that torments what counts is the essential: presence, being there for others. We can speak about the ministry of being there for others, which needs to recuperated. The presence of a priest, a sister, a volunteer, family members, health professionals; all can become good Samaritans and take care of many of our wounded bodies and souls (Cf. Benedict XVI, *Jesus of Nazareth*, chap. VII).

We have to keep before our minds the example of our Lord and Master, Jesus the Good Samaritan per excellence, who shed the garment of his divinity, left his divine condition to assume the likeness of men (*Phil* 2:6-8) and drew near to human suffering, even to the point of descending into the underworld, in order to bring hope and light. He does not jealously guard his equality with God (cf. *Phil* 2:6) but, filled with compassion, he looks into the abyss of human suffering so as to pour out the oil of consolation and the wine of hope on the wounds of human suffering (cf. Benedict XVI, *Message* for the XXI World Day of the Sick, *Go and do likewise*, 11.02.2013).

Finally I wish to reaffirm the commitment of Pontifical Council to the collaboration with the Network of the Ecumenical Patriarchate for Pastoral Health Care. In this spirit I invited the representatives of the Ecumenical Patriarchate to take part in the 29th International Conference of the Pontifical Council for Health Care Workers, which will be held in the Vatican this coming November 20-22, on the topic: "*The Person with Autism Spectrum Disorders: Animating Hope*".

Prompted by the Holy Spirit, let us learn from one another how to cure the wounded bodies and souls of our contempo-

raries and "our path will be even straighter and our cooperation all the more easy in the many areas of daily life which already happily unite us" (Francis, *Address* to the Delegation of the Ecumenical Patriarchate of Constantinople, 28.06.2014).

I wish you all God's blessings, so that you may assiduously carry on the ministry to our sick brothers and sisters during the delicate moments of their lives. Thank you for your attention. ■

TOPICS

Childhood and the Anthropology of Pain

Pain in the Elderly:
Anthropological, Clinical and Theological Aspects.
A New Classification

Childhood and the Anthropology of Pain

PROF. DAVID LE BRETON
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The Tolerance of Pain Depends on the Meaning that it has for the Suffering Person

For anthropology, pain is not only a biological fact. There is another dimension which permanently bears upon how it is tolerated and that is the meaning that pervades it, that is to say, the meaning of it which comes from the individual as a singular being, from the social, from the cultural, from the context, from the unconscious and above all from his or her life history…Pain, indeed, does not concern only the body: it relates to the whole person. When it strikes, it does not bear upon only the organism and it is not limited to a fraction of the body or a nerve pathway: it also marks an individual, the consequences for his or her relationship with the world, and it is not conceived without a moral repercussion. It is, therefore, suffering, even in the case of a child. Although a neuro-physiological phenomenon, it is not only this because there is always an individual who experiences it and modulates its impact through the meaning that it has for him or her and the instruments that he or she employs to control it, whether these are medical doctors or come from his or her own interior resources. Pain, therefore, is not the pure physiological consequence of an alteration of the organism. It is perceived according to a grid of interpretations inherent in the individual. Pain is not only a sensation. It is also emotion and allows, therefore, the emergence of the question of meaning; it is also perception, that is to say activity involving a reading of oneself and not the copy of a somatic alteration (Le Breton, 2004; 2010). In this sense, forms of care and treatment cannot be satisfied with a purely technical action applied to the patient, above all in the case of a child. Accompanying, therefore, imposes itself; a quality in the relationship with him or her in order to allay his or her fears but also to strengthen the therapy that is applied.

The Pain of a Child is Marked by the Relationship with his or her Mother and the Surrounding Environment

A study by *Lancet* on women with pregnancies of between 20 and 34 weeks demonstrated the suffering of foetuses when they were subjected to aggressive forms of treatment. Two-hundred samples of foetal blood had biochemical substances linked to stress. Psychoanalysis has said this from the outset, in particular Otto Rank, G. Groddeck, and more recently Françoise Dolto. In incubators children subjected to aggressive forms of treatment cry, have facial grimaces or become agitated. A neonate suffers, as is borne witness to by his or her cries, crying, refusal of contact, inability to play, agitation or prostration. Words do not exist to give a precise meaning to what he or she experiences. Experience of intense pain, experience as a violation of the self, impregnates personal sensitivity like a wound that never completely closes. All pain imposed by violence, or which is incomprehensible for the child, leaves a scar in his or her memory. For a long time Western medicine engaged in operations on the tonsils or adenoids of children without using any kind of pain-killer and this with the pretext that their neurological system was incomplete. It is certainly the case that babies cried and waves their arms, being for a long time marked by their experience, but in the name of science a medical doctor could not be wrong. Innumerable testimonies attest to the trauma created by pain or unthinkable violence for these children, with the addition of betrayal by their parents. The event was seen as a nameless violence which induced a lasting suffering not expressed by the parents or the medical doctor.

However, in the ordinary circumstances of existence, the reactions of the environment to the pain of a child begin to shape his or her sensitivity. The actions, the words of comfort that are given, the forms of treatment that are applied or indifference towards him or her, the perceived meanings of the discourses that are applied to him or her, and the affective environment in which he or she lives: all these impress an original seal on his or her relationship with pain. The manner in which an individual reacts to pain is rooted, in large measure, in the first years of life and in the quality of the attention that is paid by the parents to the wounds or illnesses of childhood.

The family is an intense place of socialisation where the relationship of the child with his or her body and with the world is constructed. Whether the intentions are or are not educative, during the course of time familial interactions define the field of perceptions and emotions, they educate and ritualise its expression for the child or for other people (Le Breton, 2010). The tone of voice and the quality of presence, first and foremost of the mother, conjoin their respective influences and lead the child gradually to shape his or her experience into a language. The mother gives a name to pain and helps to inscribe it into a fabric of symbols; she allays fears or increases them with a fitting approach, on the one hand, or indifference, on the other. Her ap-

proach encourages or dissuades, calms or nourishes, the pain of the child. The point should be made in clear way: the mother is not alone because the family environment or the medical and nursing team help to give to the child the instruments by which to understand and fight against pain. When growing, the child multiplies his or her experiences of pain and develops his or her awareness of them: the first teeth, falls, illnesses, wounds etc. He or she learns to coordinate movements, to prevent the risks of doing harm to himself or herself, and addresses pain by turning to an interlocutor who understands him or her. The child thus explores his or her environment and defines his or her sovereignty over the world whose peaceful appearances conceal mortal traps and require precautions at the level of use.

Access to language authorises the child to refine his or her subjective experience; to organise his or her knowledge so as to communicate it to other people. For that matter, words of pain are amongst the first to enter into the vocabulary of a child. Being the object of attention on the part of his or her environment when he or she suffers, or a witness to the pain of other people, his or her relationship with pain acquires, with the passing of time, the relatively predictable form of cultural models. Interactions with the other members of the community and the neighbourhood, in particular of his or her generation, strengthens these kinds of forms of behaviour, accompanying them with a sort of natural evidence. But such orientations leave a margin of variation which is connected with the singularity of individual pathways; the child interacts with these influences and they do not affect him or her in a mechanical way.

In our societies, the upbringing of children was for long marked (and this is probably still the case today) by the various images associated with a boy as a future head of a family, and with a girl as a future wife. Family and school upbringing and education privileged, in the case of the first, steadiness in the face of pain and encouraged, and, in the case of the second, in contrary fashion, affectivity. Comfort was the rule in the face of pain of a girl who was invited to abandon herself to her pain. Where sensitivity was attributed to female seduction, a boy was ordered to 'show that he was a man' and not to derogate the values upheld by adults. It was a rule that a man clenched his teeth more in the face of pain in order not to be seen as a 'little girl'. But this schema was never completely univocal, if only because of influences of upbringing and education that combated each other.

The Absence of Preparing a Child for Pain

In the face of experience of adversity, the contemporary individual is often naked. Rarely do adults prepare a child for the affirming of his or her personal defences. He or she learns in an informal way that things are not always pleasant and that is therefore better to address them. However, the more a child is defenceless in this respect, the more pain will have a hold on him or her, if only because of an increasing anxiety. Less than 1% of parents of 994 children in the North of California who underwent surgical operations or a painful episode that required hospitalisation prepared the child for the tribulations that were then experienced. A very low number of them received suggestions or active support so as to be helped in bearing pain where pain-killers or forms of treatment were insufficient to eliminate it. Out of sixty-eight parents who were interviewed, not one wanted to address the question. Removed from their concerns, pain was also removed from their upbringing of their children, even though in an informal way. No special intention was implemented in order to educate the child to mobilise his or her interior resources as well. Only 213 children worked through their fight against pain in a creative way: 93 used diversion (thinking of something else, thinking of the alphabet backwards, etc.); 91 clenched their fists or were tense physically; and 29 used their mental imaginations or relaxation in order to maintain their control over the situation. If the declarations of the children were taken into account, the others had no resource by which to oppose pain (Ross, Ross, 1984).

A study carried out on adolescents afflicted by chronic benign pain stressed the relationship of their approaches with those of their mothers. Those mothers who adopted an approach of fighting without ceasing to encourage their children, tirelessly supporting them, strengthened their will to face up to and to show themselves up to the trial (Dunn Gaier *et al.*, 1986). Engaged in an active struggle against pain, they felt less inclined than their companions to passivity and were less accompanied by a mother with a resigned approach who joined her laments to those of their children. These last rarely ended the exercises prescribed by their doctors to speed up the relief. The ability for restraint on the part of the mother was a decisive fact in understanding the combativeness of the child.

There is another decisive fact which is mixed in part with perception, above all as regards vulnerability to pain, and that is the affective conditions of the child. One study demonstrated that one French person in every three declared that they had addressed constant affective difficulties during childhood. After becoming adults, these adults declared illnesses 43% more than those adults who had not had such problems. Inequality in suffering and illness during adulthood was also rooted in inequalities in the affective climates that governed childhood. By comparison, and in a surprising way, social inequalities in relation to health appeared to be of lesser importance. This study identified various affective problems that in the long term weighed upon individuals. A lack of affection was translated statistically into 49% more supplementary illnesses, 57% of which affected the respiratory and or digestive apparatuses, and 76% more disturbances in mental expression. Conflict between parents corresponded with 45% of

the declarations of further illnesses. Their somewhat prolonged absence produced a figure of 36%. A grave illness, a disability or a mother or father having an accident provided an average of 26% of supplementary declarations in the first case and 23% in the second. An early experience of the death of a parent or their separation reduced this vulnerability. The number of illnesses declared by these individuals was equivalent in approximate terms to that of the population in general. Workers or employees had a marked sensitivity to the problems of childhood and related further health difficulties. In statistical terms, these people who were more marked than others by the affective conditions of childhood were also those people who consulted their medical doctors less and were less attentive to their own health (Menahem, 1994). An American study reached the same conclusion. Of 63 patients with chronic pain, 40% experienced the separation of their parents during childhood, while 23% were abandoned. 82% admitted a grave affective lack during their childhood, 63% a clear rejection, and 19% indifference and the lack of readiness to help of their parents. 33% had been beaten (Violin, 1982). Naturally enough, what matters is not so much the affective conditions but more what people do with them during the course of their natural histories.

Accompanying a Child During Painful Treatment

The accompanying of a child by his or he parents or loved ones during treatment or a stay in hospital, like the quality of the presence of the care team, are of relevance in attenuating suffering. A classic study, which has the value of a paradigm, highlighted the perception of pain and post-operation reactions of children who had been admitted to hospital to have their tonsils removed. The research concentrated on the symbolism of the body and measured the influence of the approach of the mother on the perceptions of pain of the child during his or her stay in hospital.

It is presumed that whether a mother is calm or troubled has the effect of moderating or increasing the stress of her child. Daily experience demonstrates this abundantly. The organisation of the hospital care and treatment fosters anxiety by subjecting the user to a routine where his or her singularity is cancelled and his or he anxiety is rarely taken into consideration. With some exceptions, it does not provide explanations that allow a taming in a propitious way of the person's pain or treatment.

In order to test the influence of the affection of mothers on their children, two groups were isolated. Children who had already had an experience of being admitted to hospital or ran the risk of medical complications were excluded. An optimal conformity between the two groups was looked for. The survey involved a total of eighty children. In the first group a woman nurse welcomed the mothers and tried to create from the outset a climate of truth with them while their children proceeded to have a series of medical examinations. They were provided with the information needed for a good understanding of the conditions of the stay in hospital and had described to them the sequences of the surgical operation and convalescence. They were invited to express their fears and to formulate those questions that concerned them. The woman nurse answered each question with care. During these conversations the children were present without being asked questions directly. In the other group, on the other hand, the mothers and children were subjected to the hospital routine without a particular attempt at communication being attempted.

Over the following days the mothers filled in a questionnaire in which they assessed the level of stress before and after the operation, described the attitudes of their children and, above all, described the convalescence of their children once they had returned to the family home. A second questionnaire on the behaviour of the children during their stay in hospital was distributed to the nurses (who did not know the composition of the two groups). The results were significant. The mothers who had benefited from detailed explanations were markedly less anxious than the mothers of the other group. Relaxed and confident, they controlled their apprehension, and their calm and their words of comfort had a relieving effect on their children. Incontestable physical signs indicated the lower levels of stress experienced by these children: their temperatures and blood pressure did not diverge from the normal; their sleep patterns were better; they did not have nightmares and they quickly regained regular sleep; they cried and complained less during and after the stay in hospital, and they stayed in hospital for less time. On the other hand, in the other group, the anxiety of mothers who did not have information available to them how the hospitalisation of their children was going, doubled the anxiety of their children: high heartbeats, temperatures, bad sleep quality, and more keenly-felt pain. The trauma of a badly assimilated experience was translated into frequent nightmares.

The study was worrying as regards the services that implemented routine care and treatment, leaving patients in a state of uncertainty about their condition or the medical products that they would receive. The ethical and practical applications of this observation command our attention (Skipper, Leonard, 1968). The study also demonstrated how much the children suffered above all because of how their mothers looked at them when these last, unknowingly, modulated the relationships of their children with pain through their own emotions. The first defence against pain (or illness) lay in the meaning that a person, in our case a child, gave it. When there was nothing that made the child involved enter into a framework of meaning or value, it was experienced in a naked way, it lacerated and it often provoked discouragement or depression.

In alleviating pain, a judicious

use of pain-killers goes hand in hand with listening to complaints, with an accompanying and a quality of presence at the bedside of the patient. The relief of anxiety connected with all pain and the development of an illness, the establishment of trust between the child and the medical team, the involvement of the parents and in particular of the mother, all work together to strengthen the efficacy of the pain-killers. Medical and nursing care call attention to the specificity of a patient who alone is able to testify to what he or she is experiencing. The effective relief of pain requires medicine centred around the person and no longer around biological parameters. Recognising that the patient is a subject is a pre-condition for the total efficacy of the treatment and care that is received.

The pain of the child is not always expressed in words but, rather, it is often translated into immobility, into a refusal to play. One should decipher the body language. A child encounters difficulties in translating his or her pain into words. The task of health-care workers is to provide care and treatment without projecting their own values and behaviour in order to judge his or her behaviour. A great deal of research indicates, indeed, a frequent underestimation of pain by health-care workers, in particular in the case of children or elderly people, that is to say the most vulnerable people and those less inclined to complain or make demands (Le Breton, 2010). A health-care worker in good health and who is active is not able to judge the suffering of another person and also runs the risk of projecting his or her own psychology to the detriment of that of the patient. One should care for a man *qua* man, in his singularity. The patient is always right about his or her pain. As René Leriche wrote, the only pain that can be borne is that of other people. In relieving pain it is not enough to provide care and treatment: one should above all take care of pain.

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Pain in the Elderly: Anthropological, Clinical and Theological Aspects. A New Classification

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Dedication

To the Most Reverend Monsignor Angiolo Livi, (Florence, 31 March 1914 - Florence, 28 December 2014) Prelate Prior of the Famous Basilica of St. Laurence of Florence, who is a valuable example of values and hope for all those people who have had the privilege of meeting him, the authors, inspired by him, dedicate this work.

***Fragmenta Paradigmatica Bonae Vitae*.** From the absolutely honest life of Monsignor Angiolo Livi guidance for the well-being of the body (*soma*), of the mind (*psyche*) and of the soul (*pneuma*):

1) Have a capacity to listen.

2) Immerge oneself empathetically in the condition of others.

3) Help the least and the undefended (Msgr. Livi founded the 'Cristina Ogier' Centre for Help in Life).

4) Help the poorest (Msgr. Livi founded the 'Niccolò Stenone' Help Centre).

5) Provide hospitality (Msgr. Livi founded the Casa-Famiglia of via Faenza at Florence);

6) Help elderly people (Msgr. Livi founded the Centre for the Elderly in Taybet-Jerusalem).

7) Have the right quality of life and being in constant dialogue with God, through prayer, in order to receive the light of the journey to be followed.

8) Follow a balanced diet as a principal form of therapy.

9) Follow appropriate treatment at the right moment, that is to say do not follow therapies that have been recently acquired and are heroic.

10) Choose a good doctor, that is say a trained physician with an ethical physiognomy and of great humility and faith.

Preface

I am very happy to introduce the work 'Pain in the Elderly: Anthropological, Clinical and Theological Aspects. A New Classification' by the distinguished scholars Pierluigi Zucchi and Bonifacio Honings. As regards the general part, I was favourably struck by the definition of ageing which these two eminent researchers give of it and which makes a completely new contribution to the literature in the field; ageing, indeed, begins at birth and continues until the *obitus*.

Another interesting fact is the analysis that they provide of pain, the perception of which, according to the studies reported, can be present from the seventh week of pregnancy when in the oral cavity and the soles of the feet the first pain receivers appear.

These two researchers highlight that from the foetal-neonatal period until the sixty-fifth year of life, the perception of pain is the same, even if the studies that they have carried out examine individuals starting with the age of five, referring for the periods prior to this age to the data of the literature in the field.

In the section of the anthropology of pain which examines pain in relation to cultures, it is highlighted how important motivational conditions (the phenomenon of '*couvade*', the initiation rite of tribal chiefs) can create within the organism moments when pain is perceived with a higher threshold.

In the section on the *neurogenesis of the brain in the elderly* it is understood why an elderly person, who, obviously, is not affected by encephalic, neurological or vascular pathologies, can be lucid and serene until the last moment before departure because of a constant, albeit slow, regeneration of the neurons which is facilitated by an ethically directed quality of life.

In the *phenomenon of the memory of pain* reference is made to how a traumatic episode that is distant in time can create – following a repetition of the noxa, and in that part of the body that was previously struck – a very important pain condition comparable to an equivalent trauma that can take place in the same area of the brain on the other side.

The authors of this work also address the question of empathetic pain and empathetic pleasure and offer an original classification of empathy.

In the *phenomenon of mirror neurons and the elderly* it is scientifically highlighted how an improvement in quality of life is obtained when an elderly person is surrounded by friends and pleasant environments.

I would also like to point out that it is emphasised that an ethical-spiritual approach conditions the body and, therefore, illnesses and the perception of pain as well.

As a medical doctor and a moralist theologian, I would like to observe that all the medical-theological explanations given about

pain in the elderly by the distinguished authors of this work emphasise once again how the *Ordo Creationis* always has a continuous relationship with the *Ordo Redemptionis*. These are entities that constitute in a strict way the constituent elements of the human being and in which the advanced chronological age of the body does not in the least condition the soul but, instead, can be elevated by it.

I would also like to highlight the definitions and the physio-pathological interpretations that are given of pain, of the elderly, of the faith-effect, of the prayer-effect, of the placebo effect, of the nocebo-effect, of the caress-effect, of the music-effect (or new Mozart effect) and of ethical therapy, all of which are also described and emphasised with reference to statistical studies to be found in other works published previously.

In the special part the *phenomenon of presbialgia* is described with an original classification involving three levels in which is highlighted the intensity and the frequency of the various types of pain for each age band.

I hope for the authors that this important work, which enriches the medical and theological literature in the field above all in the field of the neurosciences and neuro-theology, will be learnt about in a capillary way at an international level, as for that matter it truly deserves.

His Eminence Cardinal
Willem Jacobus Eijk
Archbishop of Utrecht,
Primate of Holland,
President of the Bishops'
Conference of Holland.

Key Words and Phrases

Elderly, pain, breakthrough pain (or intense episodic pain), empathetic pain, empathetic pleasure, classification of pain in the elderly, classification of empathy, the faith effect, the prayer effect, the placebo effect, the nocebo effect, the stroking effect, the music effect (or new Mozart effect), memory of pain, mirror neurons, neurogenesis (birth of neurons), pharmacological therapy, ethical therapy.

INTRODUCTION

The authors have divided their work into two parts: a general part and a special part.

The general part describes the historical, ethno-anthropological, anatomical, physio-pathological and ethical aspects of pain. A special examination is engaged in of the aspects inherent in neurogenesis and the plasticity of the central and peripheral nervous system: these last two conditions are facilitated above all else by environments and by people that are pleasing to the elderly.

The special part describes:

1. the new classification of the three levels of elderly people, with the most frequent various typologies of pain by level according to different age bands. At the first level is placed the perception of pain (intensity) starting with the foetal-neonatal period until the age of sixty-five. As regards the ontogenesis and phylogenesis of pain starting with the foetus until the age of five, we took advantage of the data that appeared recently in the literature in the field (Bellieni, Anand).

At the first level the pain with greatest frequency and intensity is *vascular pain* (40%) compared to the other three kinds of pain which by frequency and intensity in decreasing order are central pain (25%), oncological pain (20%) and somatic pain (15%).

At the second level (68-85 years) the pain of greatest frequency and intensity is that of the group of patients with *oncological pain* (40%) compared to patients with the other three types of pain which in decreasing order are vascular pain (30%), somatic pain (20%) and neurological pain (10%).

At the third level (86 to over 100 years) the pain with greatest frequency and intensity is that of the group of patients with *somatic pain* (70%) compared to patients with the three other types of pain which in decreasing order are vascular pain (155), neurological pain (8%) and oncological pain (7%).

2. How from the first to the third level the intensity of pain in its various types tends to decrease in a directly proportional way to the increase in the age of the individual involved (cf. VAS).

3. How there did not exist a variability in pain due to sex within the group of patients examined.

4. How the ageing of the organism and the pain receiving system both begin at birth.

5. How the perception of pain and quality of life can be clearly improved by lifestyle, for example following rest and/or listening to music in a systematic way, or when ethical parameters are taken into account which refer to religious practices such as engaging in a thoughtful reading of a passage from the gospels.

GENERAL PART

'I love more than anything else the faces of people who have grown old without doing violence to customs, allowing themselves to go with the laws of time'. This eponym of Paul Cézanne (the impressionist painter, Aix en Provence 1839-1906) emphasises the coherence of a balanced man in accepting time.

A Definition of the Process of Ageing According to the Literature in the Field

In the literature in the field one finds that ageing begins when the individual has ended the period of his or her physical development which is held to take place at the age of twenty-five. This is followed by a period of the full development of youth (25-40 years), after which comes adulthood (40-50 years) and maturity (50-65 years). At the end of maturity old age or senility begins which characterises the class of *young elderly*, individuals who are between the ages of 65 and 75, which is followed by the class of *elderly people* – of 76-85 years, which in turn is followed by the class of *the very old*: 86-100; 120 years with the physiological *obitus*.

However, according to conventional parameters ageing begins at the sixty-fifth year of life (the Committee of Experts of the WHO, 9, 1990).

The Definition of the Process of Ageing of Zucchi and Honings

Ageing is a gradual natural phenomenon (*Ordo Creationis*) which begins with the neonate and proceeds until the *obitus* for organs, including the nervous system, even though, above all in the nervous system itself, there is a reproduction of cells (neurogenesis) which tends to compensate, to a decidedly lesser extent, the physiological loss of neurons.

A Definition of Being Elderly and Old Age from a Clinical Point of View

Being elderly and old age are phrases that are used as synonyms, even though the first is used above all in the human field (for example: an elderly man), whereas the second is used in the animal world (for example: an old dog). When the term 'old' is used in the human field it acquires a negative meaning.

Being elderly (old age) is a universal phenomenon, one that is natural to existence, and where there is a more frequent incidence of pathological situations which are fostered by advanced age because of a decrease in a capacity to adapt to solicitations and modifications of an exogenous character. The appearance of pathological situations can more easily interrupt health and create states of suffering and of illness.

It is also advisable to bear in mind that at times being elderly in a physical (or biological) sense and being elderly in a psychological sense do not coincide. Indeed, one can frequently observe elderly people who are lucid but who at the same time have illnesses, usually of their joints, which are very important.

A Medical Definition (Clinical and Algological) of an Elderly Person

An elderly person is a person where the physical threshold (*algos*) of various kinds of (somatic, vascular, neurological and oncological) pain tends to increase gradually according to the various age bands (this is the phenomenon of presbialgia).

The ISTAT classification of various types of elderly person of and over the age of 65

Young elderly people: individuals for whom age is a mere fact of birth certificates. They make up 30% of the part of the population that is over the age of 65. *Active elderly people*: individuals who say they have some aches and pains but who take part in social life. They constitute 32% of the part of the population over the age of 65. *Withdrawn elderly people*: individuals who see themselves as 'old' and exclude themselves from the social context. They make up 19% of the part of the population over the age of 65. *Marginalised elderly people*: individuals who are isolated from the social and family context, are often disabled, and have limited economic means. They make up 19% of the part of the population over the age of 65.

An Anthropological-Theological Definition of an Elderly Person

An elderly person is a paradigm of semantic and cultural communication. He or she constitutes a resource, a gift, human and social riches, the value of free giving, of history, of the identity of belonging, of experience, and of interdependence (because all people need each other). He or she provides within the context of daily life a fundamental ethical and anthropological direction, emphasising the importance of being as compared to action and activity, pointing to silence as a form of empathetic dialogue with the other.

The development and the quality of life of a society is highlighted by its level of respect for the elderly who become in this way a diagnostic index of health of the society itself.

An Anthropological Definition of Pain

The algological school of Florence defines 'pain as mental-physical entity, with universal values, in the perception of which different individual, cultural and religious causes are at work and in the contextualisation of which take part not only the disciplines of medicine and biology but also those of the human sciences (philosophy and psychology)' (P.L. Zucchi, *Algologia*, 1 (1983), pp. 41-82).

A Medical Definition of Pain

The Committee for the Taxonomy of the International Association for the Study of Pain (IASP) defines pain as an 'unpleasant sensorial and emotional experience associated with a real or potential damage to the tissue or described in terms that refer to such damage' (Sub-committee of IASP for the Taxonomy, 1979, 1982).

This definition is partial because it does not take into consideration the person who cannot express himself or herself or who does not remember (the phenomenon of memory) clinical conditions which are so present above all else in the elderly.

A Theological Definition of Pain

Pain is a value entity in whose physiognomy jointly penetrate, both in the Order of the Creation and in the Order of Redemption, of necessity, the constitutive elements of man: *soma* (the body), *psyche* (the soul), and *pneuma* (the spirit) (Zucchi-Honings, 2013).

This definition seeks to emphasise the meanings of pain from the anthropological point of view in a holistic approach.

A human being, indeed, is not a separated dualistic entity but, rather, a unitary dual entity. His or her constituent elements are the body and the soul; man does not have a body and a soul but a body and a soul together. The French philosopher Merleau Ponty (1908-1961) says on this point, '*le corps c'est moi*', 'my body is me'. In order to distinguish man in essential terms from the other creatures of the earth, plants, and animals, God the Creator willed that man, both male and female, had a human body, a body that is to say animated by a spiritual and immortal soul. This is what is taught explicitly by the Fa-

thers of the Second Vatican Council (cf. *GS*, 14).

For this reason they stated that the three elements – the body (*soma*), the soul (*psyche*) and the spirit (*pneuma*) – are necessarily connected with each other. This connection, however, can make man carnal or spiritual. Indeed, it makes him carnal if the sensual movements of his body – the passions – dominate in his life and determine the style of his behaviour and his way of living. The connection between the *soma*, the *psiche* and the *pneuma* make him, instead, a spiritual man if the movements of the soul – the thoughts of his mind and the effects of his will – are reasonable and virtuous. Now, if we apply this theological anthropology to pain, corporeal, mental and spiritual pain become value entities in the order of the redemption: the order of the pain, of the death and of the resurrection of man.

Historical Aspects

The elderly in Holy Scripture

Elderly people have had different positions in families and society during the course of history. In all of Holy Scripture elderly people are said to deserve great respect: in the book of the Prophet Daniel God Himself is called the 'venerable old man'. In Israelite society the elderly played a pre-eminent role and had to take important decisions in political and social life. In Deuteronomy their juridical function, which was of primary importance, is stressed (Deut 19). Old age is defined as the 'crown of the just' (Pr 10:27). In the Psalms (Ps 92:15) we read: 'The righteous…still bear fruit in old age and are always green and strong'. The righteous die of a 'ripe old age' (Gen 25:8), aware that their lives have been full (Sir 44: 14-15). An example is Tobit who died at the age of 112 and who became blind when he was 62: after he was cured he lived in happiness, gave alms and always continued to bless God and to celebrate His greatness (Tb 14:2). Death is experienced with a grateful blessing, surrounded by children and grandchildren, for whom an example is set even in dying (see Jacob, Gen 49). Death is also experienced as serene martyrdom, with the bequest of a noble example to the young, 'preferring a glorious death to an ignominious life' (see Eleazar, 2 Mac 6:23-28).

In a passage from the Book of Wisdom (Wis 4:7-16) the wise man identifies longevity with spiritual maturity: 'Righteous people, even if they die young, will find rest. We honour old age, but not just because a person has lived a long time. Wisdom and righteousness are signs of the maturity that should come with old age'. The honour that is to be rendered to the elderly is closely connected with the fourth commandment: 'Honour your father and mother'. In Leviticus (Lv 19:92) we read: 'Show respect for old people and honour them. Reverently obey me; I am the Lord'. The Apostle Paul prescribes to Timothy: 'Do not rebuke an elder man, but appeal to him as if he were your father. Treat the younger men as your brothers, the older women as mothers, and the younger women as sisters, with all purity' (1 Tm 5:1-2). In the Book of Sirach we read (8:6): 'Never think less of someone because he is old, some of us are growing old, too'.

In order to emphasise the respect that is due to the elderly, the Eastern peoples, to refer to the family to which they belong, make an immediate reference to their parent – Isaac the son of Abraham – differently to the Western peoples who use the surname of their family.

In the Bible, which is a textbook for prayer to the utmost, it is emphasised that only those who have learnt to establish suitable spaces in solitude and silence will not experience tedium during their old age if they happen to live alone.

In Holy Scripture, unfortunately, there are also some negative examples of the elderly and these become emblems of wickedness, dissoluteness and impiety. These negative features are present in the story of Susanna (Dn 13) and in the episode of the adulterous woman (Jn 8:1-11).

Elderly People in Different Societies and Cultures

In primitive societies there was no distinction between individuals according to age bands. The distinction operated according to the work that was performed with a different evaluation according to the various ethnic groups that were belonged to.

In some groups, indeed, the individual was well seen as long as he could work and be productive, but for those who belonged to the non-working band they were not well seen and they waited for their deaths, having been abandoned by everyone. Before this event, in some populations, above all in Africa and India, propitiatory rites were celebrated and the elderly person was then left to die of hunger or was even buried alive.

In other groups, on the other hand, knowledge about hunting or farming methods, and learning acquired over the years, which, indeed, constituted a fundamental bridge between one generation and another, as held by the elderly was thought to be valuable. In such groups the elderly were loved, esteemed and followed with veneration until their *exitus*. This approach of especial care for the elderly was present above all else in Eastern populations.

Not only in primitive societies but also in ancient Greece, at Athens and Sparta, different attitudes existed in relation to the elderly. The declining condition of the elderly was not accepted in Athens and the preference was that they should not be present in the various contexts of social life. In Sparta, on the other hand, an elderly person had a privileged position and this was so much the case that the *Gerusia* was created, that is to say the assembly of elderly people which had the highest powers in the field of law and education, performing the role of judge in controversies and disputes.

Homer (perhaps the ninth century BC) in his *Iliad* and *The Odyssey*, epic poems that were written in hexameters in twenty-four books between the tenth and eighth centuries BC, believed that an elderly person had to be highly regarded, above all because of his wisdom.

The two great philosophers Aristotle and Plato had different approaches to the elderly. Aristotle (a Greek philosopher, a disciple of Plato, Stagira 384 - Calcide 322 BC) excluded the presence of elderly people from the government of the *polis*, whereas Plato (a Greek

philosopher, a disciple of Socrates, Athens 428-347 BC), in his *The Republic* argued that only elderly men should express the final judgement in difficult situations. The difference between these two thinkers as regards their philosophical idea of man formed the basis of their different approaches.

For Aristotle, man had a soul and a body which were united and indivisible and as a consequence the deterioration of one involved the decline of the other. Plato, on the other hand, did not take into consideration the decline of the body because he believed that the virtues were in the soul and that the body was a mere container.

Mimnermus, the Greek poet, Smirne seventh century BC – first half sixth century BC, defined old age in a negative way and stated that he would have preferred to die rather than grow old.

Sappho (a Greek poetess, Lesbos, end of the seventh century-first half of the sixth century BC) addressed the female side of growing old, which was almost never taken into consideration, and stated that old age was a wound to the physiognomy of the image of a woman who was undergoing deterioration.

Solon (Athenia legislator and poet, c. 630-560 BC) had an ambiguous attitude towards old age. Indeed, he defined it as a period when man still has the wish to act and to learn and thus death was to be welcomed around the age of eighty. To the term 'death', however, he gave contrasting and differing attributes: bent, wrinkly, breathless, pale and sick. These adjectives concerning death with meanings that were clearly negative were opposed by others which had a positive meaning, such as white, candid and venerable.

Phocylides of Miletus (born Miletus 560 BC) in *Maxims, Book XLII*, admonished: 'Respect white hair, render the same tribute to a wise old man as you give to your father'. Also original was his idea of the physiognomy of each kind of woman which he derived from a particular animal: the beauty of a horse, the indifference of a pig and the industrious of a bee. In Greek tragedy emphasis was laid, on the one hand, on the physical and mental decay of old age, and, on the other, on the wisdom and the wealth of the spirit of the same time of life.

In comedy in the Latin world old age was portrayed with all the physical and mental failings that accompanied it.

Marcus Tullius Cicero (Arpino 106 – Formia 43 BC) in his *De Senectute*, in which he examined the art of knowing how to grow old, wrote that an elderly person should not become downcast because of the weight of years because he is the custodian of a heritage of knowledge that is indispensable to future generations; however, he tends to bring out the negative aspects of old age.

Indeed he wrote: 'in reality, when I examine the problems in all its aspects, I find four reasons which make old age appear unhappy. First: it distances a person from activity. Second: it weakens the body. Third: it deprives a person of all the pleasures: Fourth: it is a step from death' (*De Senectute*).

Cicero adopts a critical stance in relation to old age as a chronological period of human existence, but certainly not towards the elderly whom he invites to take part in political life, observing: 'great things are not done with force or speed or with the agility of the body, but with wisdom, with authority, with prestige, of whose virtues old age is not only not without but is indeed enriched' (*De Senectute*).

In *De Senectute* Cicero also suggests the style of life that should be appropriate for an elderly person, that is to say dedicating himself to intellectual and political activities, including rural activities such as looking after an estate. This style of life, in the Latin world, was chosen by many aristocrats and middle-class people in their old age.

Publius Ovidus Nason, Ovid (born in Sulmona on 20 March 43 BC and died in Tomi-Costanza, on the black Sea in what is now Romania, 17 AD, in *Fasti, bk. V, v. 57)* stated that 'At one time there was reverence for the white-haired head'.

Lucius Annaeus Seneca (Latin philosopher, Córdoba c. 4 BC – Rome 65AD) believed that man should commit suicide when as an old man he has to experience a life that is not worthy of being lived, and this because of the physical pain or moral suffering that he has to address. He emphasises the physical decline that man has to undergo as he grows old and he expressed himself in his 'Moral Letters to Lucilius' in the following way: 'But if the body no longer performs its functions, is it not better to free the soul from its sufferings? And perhaps one should act a little before the due moment because, when the moment arrives, one may find it impossible to act: the danger of living badly is greater than the danger of dying early' (*Epistulae Morales ad Lucilium*).

Publius Terentius Afer, Terence (a Roman poet, c. 190 to c. 160 BC) fed prejudices about old age and said that *senectus ipsa morbus.*

In the medieval period (the historical epoch that goes from antiquity to the modern age), whose beginning according to traditional chronology is seen as the fall of the Roman Empire of the West (476 AD) and whose end is seen as the year of the discovery of America in 1492, the elderly person was well regarded.

Dante Alighieri (Florence 1265–Ravenna 1321) in his *Convivio* (1304–1307) described the stages of life and observed that maturity is the period that goes from the age of 25 to the age of 45, and that after that age old age begins.

Roger Bacon (Ilchester 1214 – Oxford 1292), a Franciscan monk, theologian and English scientist, believed that old age was connected with the lifestyle that had been adopted in youth.

In the fifteenth and sixteenth centuries elderly people, especially if they belonged to the upper classes, had an important role at a social and political level.

During the seventeenth century power was wielded by the young and elderly people, especially if they belonged to the upper classes, were seen as the bearers of learning and experience and were seen as useful to those who came after. Treatment marked by abandonment and marginalisation was meted out to elderly people who belonged to the lower classes and were inactive.

During the eighteenth century the Church, which was especially sensitive to the problems of the poor, and especially the elderly poor, created the first poor people's homes. During this century the first industries came into being with an

improvement in health-care conditions and people's diets. However, the advantages derived from economic development benefited only the privileged classes and the poor could use only the poor people's homes and charitable associations.

During the nineteenth century in Europe there was a notable increase in the population which rose from 187 million at the beginning of the century to 300 million in 1870, a period when the figure of the elderly person was re-assessed.

During the twentieth century there was a return to a utilitarian idea of the individual who was valued only according to his productivity and utility both for society and, unfortunately, for families, which tended to rid themselves of their elderly members and put them in old people's homes until their deaths, thereby injuring their dignity and tending to create in actual terms their marginalisation.

The term 'third age' (*troisiemme age*) was coined in France to remove from the definition of the elderly all negative connotations and those elderly people who were autonomous could attend the universities for elderly people that arose in that period.

In 1999 John Paul II, Wadowice 18 May 1920 – Vatican City 2 April 2005, emphasised that the elderly constitute an important presence and an important force for values in the Church and in society and in section 9 of his *Letter to the Elderly* (1 October 1999) he made the following statements: 'In the past, great respect was shown to the elderly… And what of today? If we stop to consider the current situation, we see that among some peoples old age is esteemed and valued, while among others this is much less the case, due to a mentality which gives priority to immediate human usefulness and productivity. Such an attitude frequently leads to contempt for the later years of life, while older people themselves are led to wonder whether their lives are still worthwhile. It has come to the point where euthanasia is increasingly put forward as a solution for difficult situations. Unfortunately, in recent years the idea of euthanasia has lost for many people the sense of horror which it naturally awakens in those who have a sense of respect for life' (*Letter to the Elderly*, n. 9).

It is obvious that in our society and culture 'having' is seen as a foundation for 'existing': power, pleasure, impressing; a person is assessed not for what he is but for what he has, what he does, what he produces. The physiognomy of such a society and culture places the elderly in a position of clear marginalisation, thereby creating the bases for the temptation of euthanasia.

In section 64 of his encyclical *Evangelium Vitae* John Paul II observed: 'Today, as a result of advances in medicine and in a cultural context frequently closed to the transcendent, the experience of dying is marked by new features. When the prevailing tendency is to value life only to the extent that it brings pleasure and well-being, suffering seems like an unbearable setback, something from which one must be freed at all costs. Death is considered "senseless" if it suddenly interrupts a life still open to a future of new and interesting experiences. But it becomes a "rightful liberation" once life is held to be no longer meaningful because it is filled with pain and inexorably doomed to even greater suffering. Furthermore, when he denies or neglects his fundamental relationship to God, man thinks he is his own rule and measure, with the right to demand that society should guarantee him the ways and means of deciding what to do with his life in full and complete autonomy. It is especially people in the developed countries who act in this way… In this context the temptation grows to have recourse to euthanasia, that is, to take control of death and bring it about before its time, "gently" ending one's own life or the life of others. In reality, what might seem logical and humane, when looked at more closely is seen to be senseless and inhumane. Here we are faced with one of the more alarming symptoms of the "culture of death", which is advancing above all in prosperous societies, marked by an attitude of excessive preoccupation with efficiency and which sees the growing number of elderly and disabled people as intolerable and too burdensome. These people are very often isolated by their families and by society, which are organized almost exclusively on the basis of criteria of productive efficiency, according to which a hopelessly impaired life no longer has any value' (*Evangelium Vitae*, n. 64).

John Paul II emphasised that 'Man is understood in a more complete way when he is situated within the sphere of culture through his language, history, and the position he takes towards the fundamental events of life, such as birth, love, work and death. At the heart of every culture lies the attitude man takes to the greatest mystery: the mystery of God' (*Centesimus Annus*, n. 24). In contrary fashion, 'Where God is denied and people live as though he did not exist, or his commandments are not taken into account, the dignity of the human person and the inviolability of human life also end up being rejected or compromised' (*Evangelium Vitae*, n. 96).

From the statistical data that have emerged in various studies, it is advisable to observe that whereas the twentieth century was the century of demographic growth, the twenty-first century is the century of the ageing of populations.

Epidemiological Aspects

Our society is undergoing a sort of 'demographic revolution'. In 2000 there were in the world about 600 million people over the age of sixty. In 2025 there will be 1 billion and 200 million and 2 billion in 2050. In addition, women live more than men in all societies.

As a consequence within the very elderly age band (85-100 years) the ratio of women to men is 2 to 1. In Europe, as in other rich parts of the planet, 1 person in every 5 is over the age of sixty. This ratio falls to 1 in 20 in Africa and, as is the case with other developing areas, the process of the ageing of the population is more rapid than in 'developed' countries.

The ageing of the population is typically accompanied by an increase in the burden of non-transmissible illnesses, such as cardiovascular diseases, diabetes, Alzheimer's disease and other neurodegenerative diseases, tumours, chronic obstructive pulmonary diseases, and pathologies of the skeleton and muscles. As a logical consequence the pressure on the world's health-care system is increasing. Chronic illnesses impose

on the elderly part of the population a heavy burden in terms of health and economics because of the long duration of these illness, of the decrease in quality of life and of the costs of care and treatment.

The Prevention of Illness in Elderly People

Although the risk of illness increases with age, the problems of health are not an inevitable consequence of ageing. Indeed, whereas in the case of many pathologies effective preventive measures are not known about, in the case of others they are already well known about. Amongst these there is the adoption of a healthy lifestyle which involves regular physical activity, a healthy diet and cutting out smoking.

Measures of prevention include clinical examinations to achieve an early diagnosis, as in the case of screening for breast cancer, of uterine cancer and of cancer of the colon and rectum, of diabetes and its connected complications, and of depression.

Ethnic-Anthropological Aspects
Culture and nature. Pain and cultures. The pain threshold. Pain in elderly men and women

The cultural-anthropological factor as a biological-environmental factor has an influence on the perception of pain. Indeed, in our study it was shown that: 1. socially poorer and less educated people feel pain less than compared to socially and culturally more evolved people. 2. The pain threshold is the same in people from different races. 3. The difference between men and women is only located in sexual identity and is not to be found in the pain threshold. However, the way in which problems and communication are addressed in relation to pain and illness exalt the values of different cultural traditions, as is the case in the phenomenon of *couvade* and the initiation rites of tribal chiefs.

The phenomenon of couvade

Amongst the Indian tribes of Latin America and Central Africa and amongst the inhabitants of the Basque Country, women who are about to give birth continue to work in the fields until a short time before the birth of their children, whereas their husbands take to bed and begin to complain during the childbirth of their wives as though they themselves were really feeling pain (empathy pain). After childbirth, the women go back to working in the fields and the men look after the new-born children.

The initiation ceremonies of tribal chiefs

The initiation ceremonies of tribal chiefs are another example that demonstrates how cultural traditions and the acquisition of an important role can influence the perception of pain in individuals. In some populations of India and Latin America, indeed, the man who is chosen from the members of the tribe as a bearer of the power of the gods has iron hooks put in the muscles of both sides of his back. To these are attached ropes with which the individual who has been chosen is raised to the top of a pole on a cart, from which he blesses the populations of various places to which he is then taken.

Man in these conditions not only does not appear to feel pain but, after the hooks are removed from the back the wounds rapidly cicatrise.

These two examples highlight how emotional, motivational and affective factors can stimulate parts of the brain (the hypothalamus, the limbic system, the *nucleus accumbens*, the amygdule) which, through impulses from the cortex to the cerebellum, are able to prevent the transmission of pain-receiving impulses in the dorsal horns and in different levels of the neuraxis, thereby raising the threshold of pain.

These two examples also offer a very important anthropological teaching because, when translated into the medical field, and above all the geriatric sphere, they suggest to us that the sick person should be placed at the centre of things and that his or role should be motivated as a person, to which all attention should be paid.

Aspects of Clinical Neurophysiology
Neurogenesis in the (elderly) adult brain

The brain and in particular the human brain has been traditionally seen as an organ that cannot be renewed. Differently from the other cells of the human body, the neurons that make up the brain are seen as perennial cells that are born and die with the individual to whom they belong. The principle that 'in the adult brain the nerve pathways are finite and immutable, each of which can die and none of which can be regenerated', which was introduced by Ramon y Cajal (Santiago 1852-1934) at the end of the nineteenth century, constituted the central axis of neurobiology and medicine until the experimental data that were obtained at the beginning of the twenty-first century, even though the first studies go back to the 1960s. However, many studies carried out in the 1960s were not listened to even in the face of experimental data which demonstrated that in the brains of small mammals, birds and amphibians new neurons can be generated.

The dominant concept in medical science emphasised that a permanent population of neurons was the indispensable basis for the learning of new information, on whose stability depended the survival of an individual.

In the 1990s it was demonstrated that in phylogenetically ancient and non-cognitive areas of the brain, such as the olfactory bulb, and not in higher cerebral areas, there exists a renewable population of neurons and their circuits.

In 1998 Eriksson (1959-2007), a neurologist from Goteborg, demonstrated that what had been seen in animals also took place in man. This distinguished researcher carried out post-mortem analyses of the brains of five patients with cancer to whom, while they were still alive, he had administered bromodeossiuridina (brdu) for diagnostic purposes. This analogue of thymidine, which is incorporated into the DNA of dividing cells, offered the definitive demonstration that new neurons were generated at the level of the hippocampus and the subventricular area of the lateral ventricles in the human brain as well.

A negligible quantity is involved when compared to the 100 billion neurons that make up the encephalon. However, this phenomenon, which lasts throughout life, implies constant and gradual structural changes.

One must therefore state that the brain, from the foetal period until the pre-death period, is a highly plastic organ which is subject to continuous molecular and cellular modifications, and this neurogenesis constitutes a further instrument of the adoptive response of the individual to the external and internal environment, above all when he or she grows old.

Anatomical Areas Involved in Neurogenesis at the Level of the Encephalon

The generation of a new neurons in the brain of an adult mammal takes place in two areas (fig. 1):

1) The sub-ventricular area of the lateral ventricles.

2) The syb-granular areas of the dentate gyrus of the hippocampus.

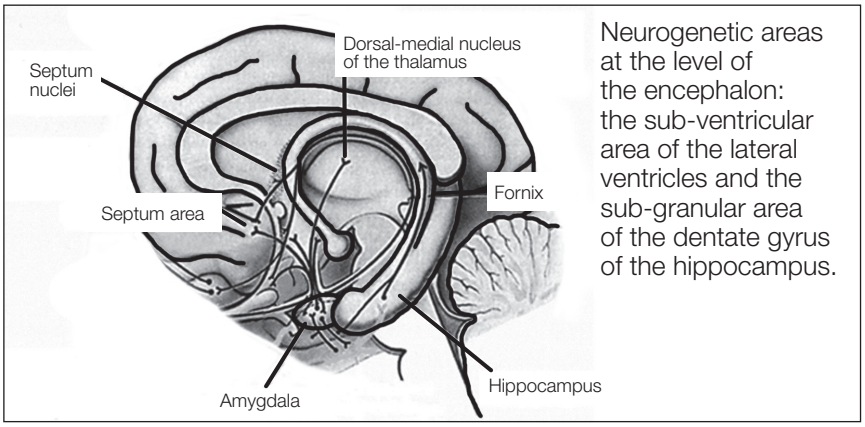

Fig. 1. Anatomical areas involved in neurogenesis at the level of the encephalon

However, it has been demonstrated that areas that are normally not neurogenetic, for example the cortex and the striatum, in response to certain stimuli, such as neurodegeneration and the death of cells, can modify their microenvironment and be induced to become neurogenetic. We also believe that in the (elderly) adult brain, in addition to the two areas of so-termed constitutive neurogenesis, there exist non-neurogenetic areas that respond to stimuli that transform these silent neurogene areas into areas that are neurogenically active.

Neurogenesis and the Plasticity of the Nervous System

The capacity of the adult brain to generate new nerve cells is not only a mechanism to which the brain has resort in order to repair wear and tare in the tissue. It is also the most solid basis for the concept of the plasticity of the nervous system. This means that the final number and the real destination of the newly formed cells is not fixed but connected at any moment to physiological and pathological factors.

Neurogenesis in the brain from birth to senescence: the environment and lifestyle

Interaction with the environment (and with our fellows), as well as a balanced lifestyle (physical exercise, cultural involvement and ethical and spiritual values of reference) are the basis of the physical, mental and spiritual wellbeing of every individual and constitute the physiological stimuli that are most incisive as regards neurogenesis.

In a neonate neurogenesis is quantitatively different according to the quality of life that is experienced. Indeed, in rats, as in man, there are young individuals who are raised by mothers who spend most of their time looking after them and there are those who are only sporadically taken care of.

Neurogenesis is significantly higher in the first category than in the second. The separation of a young individual from the mother for prolonged periods can also create a reduction in neurogenesis, whereas brief periods of such separation do not bear upon neurogenesis.

The separation of a neonate from its mother for prolonged periods of time is used as a model for depression once the individual has become an adult.

With ageing, neurogenesis, above all the level of the hippocampus and the sub-ventricular area, undergoes a drastic reduction which is responsible, it is presumed, for cognitive decline and can be improved through physical exercise and interaction with stimuli from the environment.

Neurogenetic areas at the level of the spinal cord

The greater slowness in the reproduction of neurons that takes place in the age band of 86-100 (level 3) leads to a diminished plasticity which brings about a physiological raising of the pain threshold in line with the impact on areas innervated by those cells of the posterior horn of the spine that correspond to the head (the seat of exteroceptive centres: skin); of the neck (the seat of proprioceptive centres: muscle); and of the base (seat of interoceptive centres: viscera) (fig. 2). This explains why diminished neurogenesis in some areas of the encephalon (lateral ventricles, hippocampus) and the spinal cord can give rise to pain symptoms that are modest or even absent in important pathologies such as: 1. grave injuries (through reduction of the cells of the head of the posterior horn, the sear of the exteroceptive centres: skin); 2, traumas (through reduction of the neurogenesis of cells of the neck of the posterior horn, the seat of proprioceptive centres: muscles, joints); and 3. myocardial heart attack or the perforation of the abdominal viscera (through reduction of the neurogenesis of the base of the posterior corn, the seat of the interoceptive centres).

The neurogenesis of the neurons of the anterior horn is very much

slower and is of an inferior level compared to that of the neurons of the posterior horn. This condition explains in case of the very elderly (86-100 years, and over) the late occurrence of very grave pathologies of the joints (neuro-arthropathies).

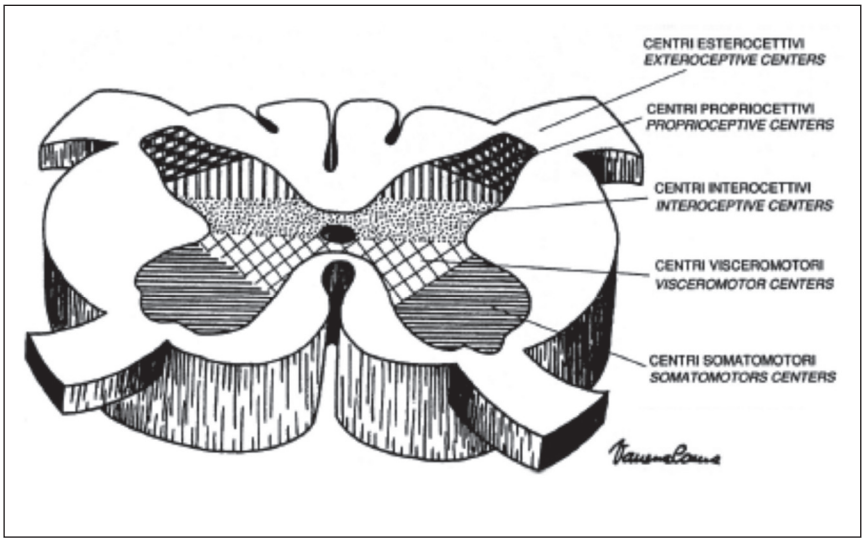

Fig. 2 - Schematic depiction of the sense centers (exteroceptive in the head, proprioceptive in the neck, interoceptive at the base) of the posterior horn and the motor centers (viscermotor centers at the base, somatomotor centers at the top) ot the anterior horn of the grey substance of the spinal cord.

The Phenomenon of Memory of Pain

Traumatic events, which can also occur when a person is young, create an injury which gives rise to a hyperalgesic area which is projected at the level of the corresponding cerebral circuits. This central and peripheral condition, even after many years, can be activated by solicitations of *noxae varie* in a very rapid way through *the phenomenon of memory of pain*. This situation explains the lowering of the pain threshold (hyperalgesia) in specific areas of our organism, compared to normal contra-lateral counterparts, through subliminal stimuli as well (*the phenomenon of allodynia*). In schematic form one can state that memory of pain: 1. is influenced by the intensity of the perceived stimulus and by its consequences; 2. on its own can act as a pain stimulus and cause a painful experience even when there is an absence of painful stimuli (the phenomenon of *mental* alloydynia) and can significantly influence the perception of a new pain stimulus in that area of the brain that was previously damaged (the phenomenon of hyperalgesia); 3. can cause a painful experience in the presence of stimuli that normally do not have this effect (the phenomenon of physical allodynia); and 4. does not exist in biology only at a encephalic level – it is also at a spinal level.

The phenomenon of memory has a positive impact not only in the sphere of painful pathologies, because it creates the conditions of early warning of pain, but also is of great utility in the neurological field. Indeed, a patient can even come out of certain forms of coma through listening to certain kinds of music that he or she liked when he was well.

The Physiopathological Mechanisms behind the Phenomenon of Memory

Unpleasant memories or ones connected to a feeling of pain felt previously can activate specific areas of the brain if there is a new physical or mental traumatic event, and in a way that is not proportional to the size of the *noxa* but much greater. In specific conditions of mental pain, where there is pain or even fear, the *amygdale* (fig. 3) is also activated. This last is called this because of the fact that it has the shape of an almond and it provokes corporeal responses (tachycardia, tachypnea) and behavioural responses (flight, defence, aggression).

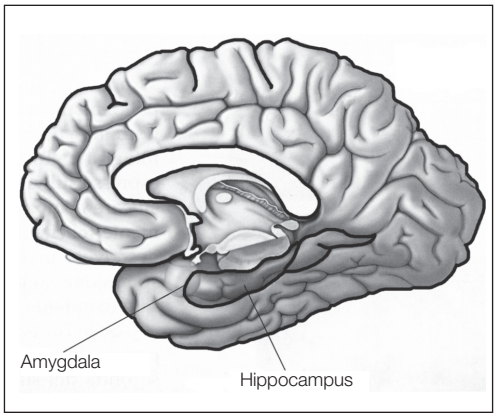

Fig. 3. The amygdale, the seat of the brain that works through fear, aggressiveness and pain.

The ablation of the amygdale reduces fear and aggressiveness, whereas its stimulation can lead to a state of increased vigilance and attention.

Current research is directed towards modulating or blocking the activity of the amygdale, seeking in this way to eliminate the memory of an unpleasant experience and thereby inhibiting the consequence response reactions.

The modulation of the amygdale, according to studies that are underway, could be achieved through pleasurable stimuli (music) that are able to free neurochemical substances that are even able to bring patients out of certain kinds of coma.

It has also been observed experimentally that in acting at the level of the amygdale of mice it is possible to eliminate the fear that they have of anaesthetised cats, leading them to draw near to them in a calm way.

These scientific data inevitably lead to very important observations of an ethical character because although, on the one hand, there can exist an improvement in the quality of life of a patient by acting on unpleasant memories (a previous painful episode) or pleasant ones (listening to pleasant mu-

sic), on the other, research could become an instrument for the authentic manipulation of individuals, especially elderly ones.

Elderly People, Mirror Neurons, Pain, Empathy and Prayer

The sharing of moments in life with people who are truly friends creates the conditions for an activation of parts of the brain involving the perception of the emotions of other people, expressed through movements of the face and with gestures in what is authentic empathetic participation. More specifically, the same neurons located near to the Broca area which are activated by the executor during an action are also activated in the observer of the same action (*mirror neurons*). It is a good thing, therefore, to pass time with people who are ethically correct and well grounded because a large part of our behaviour and learning takes place through the imitation and stimulation of the behaviour of other people.

These data have been highlighted with very sophisticated instrumental examinations: positron emission tomography (PET), functional magnetic resonance (fMRI), transcranial magnetic stimulation (TMS), and magnetoenchephalography (MEG) (Singer, 2004).

With the same examinations it has been shown that during prayer addressed to God as well the same cerebral areas are activated, especially the prefrontal areas, which are activated during a normal conversation with another person, because the mystical dimension is a dialogic dimension, inherent in every human being, including agnostics who, nonetheless, are people made in the image and likeness of God and in whom, obviously enough, different constitutive conditions do not exist when compared to believers.

It is advisable, however, to observe that these radiological explorations which demonstrate the activation of cerebral areas during prayer obviously do not demonstrate that it is the brain that creates faith.

Level of empathy according to age

Different levels of empathy exist according to age (fig. 4).

This graph shows that the highest level of empathy is established in individuals of the first and second levels of the classification (fig. 15). Indeed, it is specifically in childhood-youth (5-15 years) and during maturity (86-100 years) that this phenomenon takes place.

Measurement of the quotient of empathy (Q E): low, average, high

To achieve the measurement of the quotient of empathy (positive: +, or negative: -) certain clinical-semeiological parameters have to be followed:

1. assessment of the emotion of the meeting as pleasurable (positive empathy: +) or unpleasant (negative empathy: -);
2. assessment of the satisfied (+) or suffering (-) expression of the face, which represent the visible form of the indissoluble union with the soul, which is apparently invisibile (*Il dolore e la semiologia del volto*, Zucchi-Honings, in press);
3. assessment of the fluidity, abundant (+) or scarce (-), language of the anamnestic inquiry which evokes painful events (empathetic pain) or painful events (empathetic pleasure);
4. assessment of the high (+; positive empathy; placebo effect) or low (-; negative empathy, antipathy; nocebo effect) of the language;
5. assessment of stroking with the result of the stroking effect (positive: +) or the allodynic effect (negative: -) with the withdrawal of the part of the body that has been stroked.
6. The quotient of empathy (QE) is obtained from the number of plus signs or negative signs. A plus sign creates a low QE; 2 +++ an average QE; and from 3+++ and more a high QE.

Cerebral areas that are interconnected and activated during an empathetic relationship

Brain radiologists, through functional magnetic resonance imaging (fMRI), have been able to demonstrate the activation of cerebral areas during an empathetic relationship. They are: 1. the medial prefrontal cortex, which is sub-divided into a dorso-medial prefrontal cortex and into a ventral part (the ventro-medial prefrontal cortex); 2) the inferior frontal gyrus); 3) the caudal anterior cingolate cor-

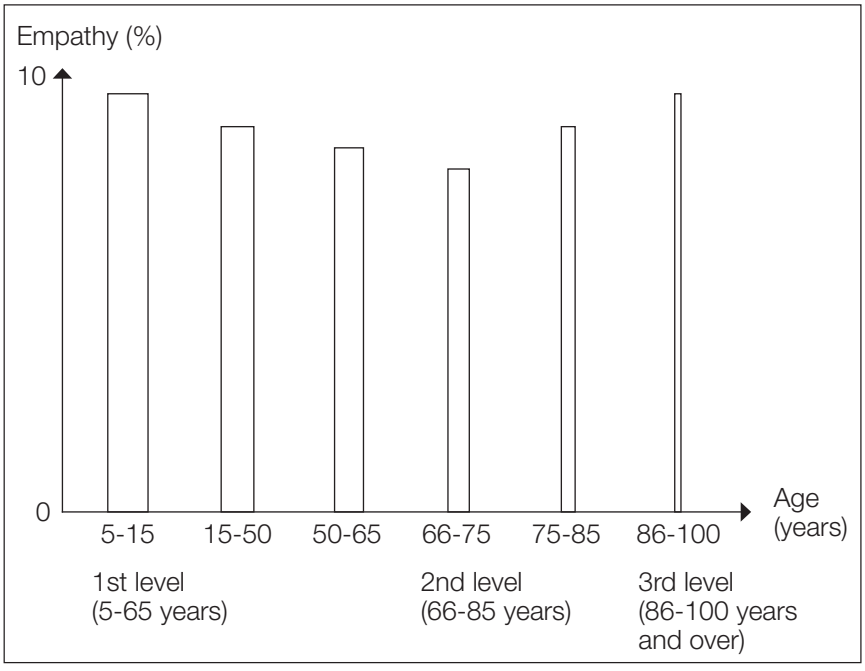

Fig. 4. Distribution of percentage of empathy according to age.

tex); 4) the anterior insula; 5) the right temporo-parietal junction); 6) the posterior superior temporal sulcus); 7) and the somatosensorial cortex); the amygdale (fig. 5).

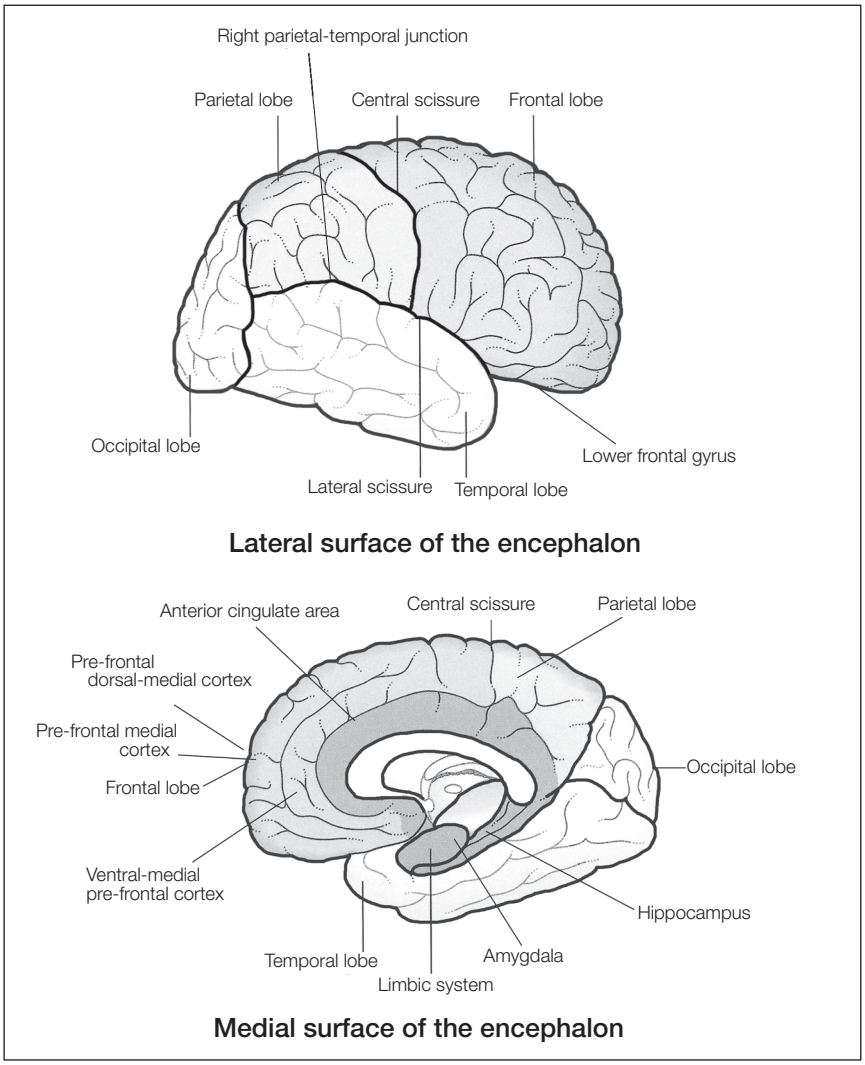

Fig. 5. Cerebral areas that are interconnected and activated during an empathic relationship. Lateral and medial surface of the encephalon.

Tania Singer and her collaborators of Zurich have demonstrated through functional magnetic resonance that when a person has received a painful stimulus on their own hand, or the hand of a loved person has received such a stimulus, the same cerebral areas are activated both when the pain is experienced personally and when it is experienced by the loved person. These cerebral areas are also activated in the observer when he or she sees someone – the whom he or she considers to be correct and agreeable – suffer. These nerve areas are activated to a lesser extent when the observer sees someone whom he or she sees as not correct or unpleasant suffer.

An analogous nerve mechanism has been observed in animals by the research group of Professor Rizzolatti of the Parma School which, when introducing electrodes into the parts of the brain cited above, recorded the activation of neurons (mirror neurons) in the these areas not only when the animal carried out an action but also when it observed another animal carry out the same action.

One can, therefore, assert that the neurons activated in an empathetic relationship are mirror neurons.

Zucchi and Honings in the classification that they have wanted to offer of biological, medical and theological empathy allocate to theological empathy the explanation for empathetic pain and empathetic pleasure, establishing a close connection between the *Ordo Creationis* and the *Ordo Redemptionis* and stressing how in an intimate (empathetic) relationship with the Creator through prayer, or in referring to entities of value, the conditions area created for a raising of the pain threshold ((Zucchi, Honings, 1996, 2001, 2004, 2005, 2008, 2011, 2013).

Empathy and the Elderly. A New Classification of Empathy: Biological (Somatic), Medical (Mental) and Theological (Pneumatic)

In any field, whether somatic, mental or pneumatic, the relationship of a subject – elaborated subject-person, doctor-patient, Creator-creature – becomes important if it develops as an empathetic relationship. This relationship, in all age bands, is important above all else in elderly patients.

On this point we offer a new classification of empathy: biological, medical and theological. *Biological (somatic, aesthetic) empathy* is that condition that arises in a person faced with an event of extraordinary beauty in which the person-subject identifies with the acquired subject (a work of art, music, scenery) without, however, reaching phenomena involving hallucination, as occurs with the Stendhal effect, as described by the physician and psychiatrist of Florence, Magherini (1989), but, rather, experiencing the work of art as an interior neuro-aesthetic identification that leads to a condition of the new subject elaborated through the liberation of endorphins and the raising of the pain threshold.

Within the context of a painful condition (an earthquake, learning about the death of a loved one, an economic collapse), exactly the same phenomenon occurs, experienced, however, in an opposite way, that is to say with negative meanings, which lead within the organism to a situation of pain with the release of pain-inducing substances and the lowering of the pain threshold (fig. 6).

Medical (mental) empathy is that condition of an identification of the pain-pleasure of another person which, if experienced

and shared (sym-pathy) in a negative way (anti-pathy) leads to depression (negative empathy; empathetic pain-pleasure; window pain-pleasure) and if experienced and shared in a positive way (cinestesis) leads to cinestesis (positive empathy; empathetic (sublimated) pain-pleasure (joy, felicitas); (window) pain-pleasure or a state of pneumatic-physical-mental well-being. Sympathy creates the conditions for the entity of empathy to move from a binomial relationship between two people to a choral relationship shared by a number of people. In this hermeneutics was actuated the neurophenomenological synthesis between Max Scheler and Edith Stein (fig. 7).

Theological (pneumatic, ecstatic) empathy has as its goal the interpretation of the empathetic pain of the man-God and the empathetic pain (joy-*felicitas*) of the man-God. From a theological point of view, therefore, we can state that God, who became a man like us, made Himself 'empathiable' in Jesus of Nazareth and in each man. From a clinical point of view, this empathetic relation of God in Christ the man and in suffering-praying man creates the conditions for a raising of the total (physical, mental and spiritual) pain threshold. In Christ in the Garden of Gethsemane, through a (direct) immediate empathetic relationship with God the Father and in highly suffering everyman through prayer (mediated indirect empathy). are created the conditions for the identification of God with the pain of His son Christ the man and the pain of everyman (fig. 8).

Just as in the dying Christ the conditions were created for a more serene passage to the Father, so in everyman the conditions for the more dignified bearing of pain, above all when this takes place at the end of life, are also created.

In the condition of the empathetic pleasure (joy-*felicitas*) of the man God, the joy of the creature becomes empathiable with the Happiness of his Creator. Indeed God, through contemporary Grace, transforms pleasure of the senses into spiritual Joy in man, who becomes a creature empathiable with the Happiness of his Creator, like Jesus in the Father at the day of the Resurrection-Ascension (fig. 9).

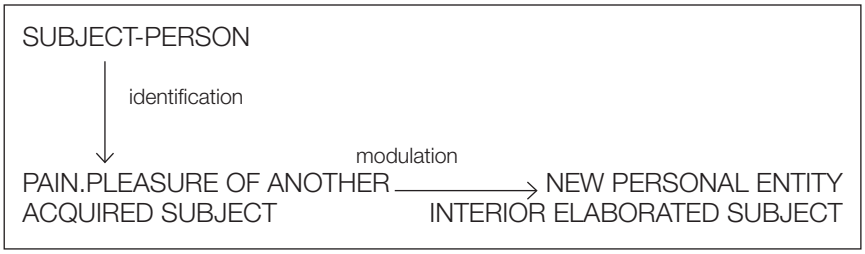

Fig. 6. Biological empathy. A person (the subject) identifies with a condition of pain or pleasure of another person (acquired subject) which modulates into a new personal entity (interior elaborated subject).

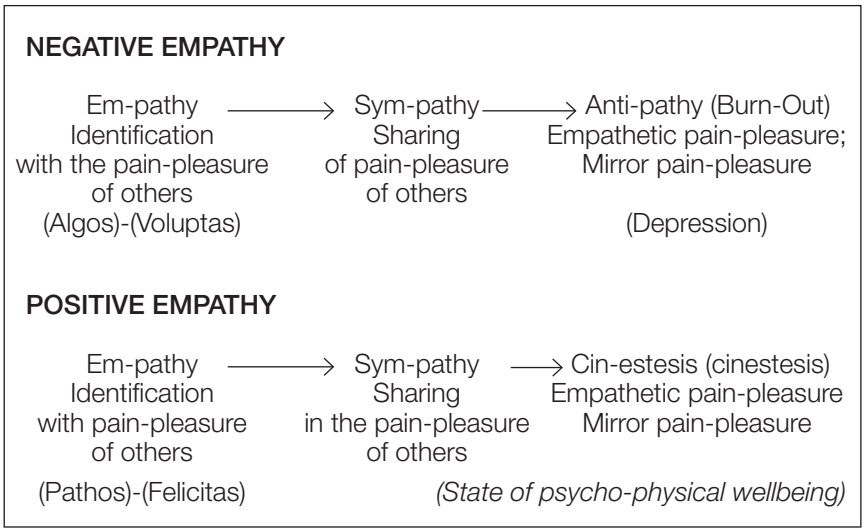

Fig. 7. Medical empathy: positive and negative

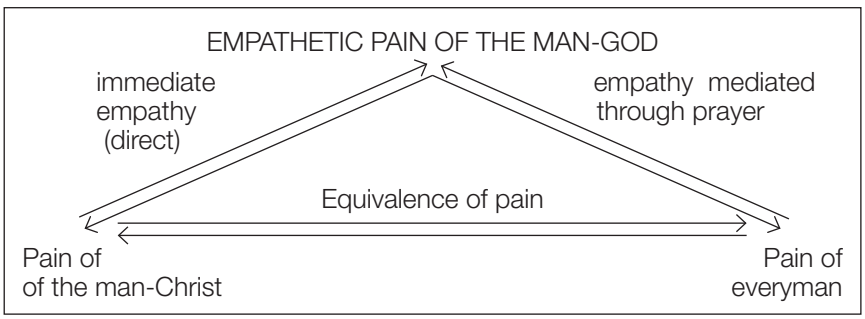

Fig. 8. Theological Empathy. Interpretation of the empathetic pain of the man-God. Empathiability of God in the Pain of the Man-Christ and in the pain of everyman.

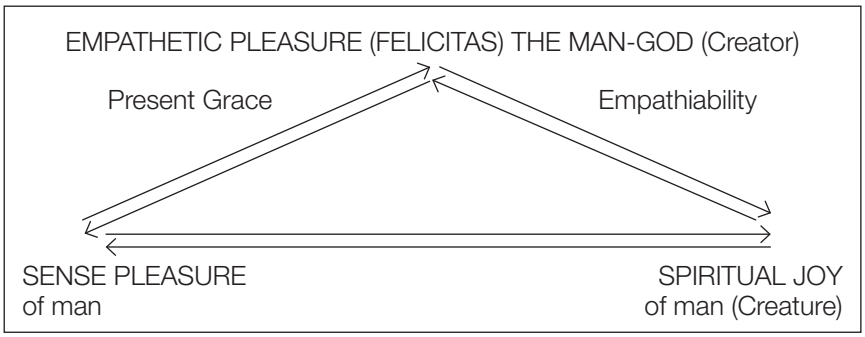

Fig. 9. Theological Empathy. Interpretation of empathetic pleasure. The empathiability of the joy of the creature (ecstatic empathy) with the Happiness of his own Creator.

In man these three forms of empathy – the biological (somatic), the medical (mental) and theological (pneumatic) – are experienced in different ways according to the different age bands, different opportunities and above all different ethical-spiritual formations and we can find in these three empathetic entities a physiological approach that interacts between the soma, the mind and the *pneuma* (fig. 10).

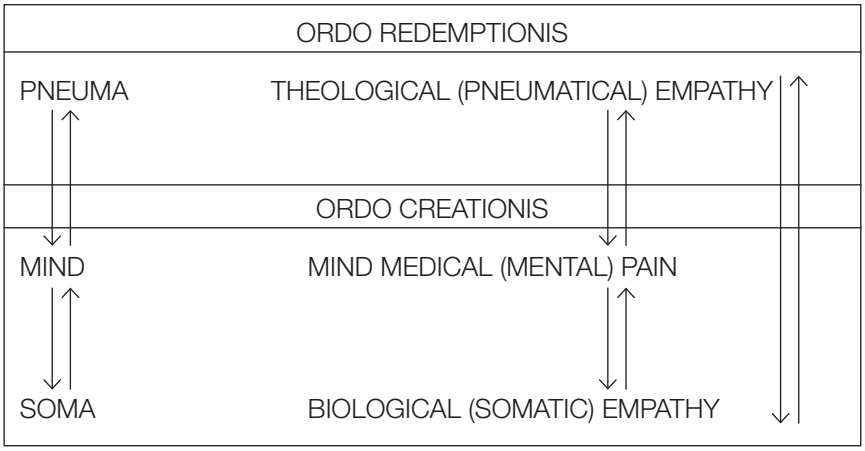

Fig. 10. The physiological interactive process of empathy: from the soma to the mind to the pneuma.

The Perception of Pain in Elderly People

The data presented in the literature in the field on the perception of pain in elderly people do not involve a univocal interpretation. On the basis of clinical studies carried out by our study group we believe that an elderly person has a higher pain threshold in relation to different kinds of pain, above all as regards pain from (radiant) heat.

In an elderly person the decrease in the perception of pain (presbyalgia) is not only an expression of receptor damage as in the case of presbyacusia (*présbus*=old; *akoùein*=to hear), or of an altered accommodation of the stimulus as in the case of presbyopia (*présbus*=old; *òpsis*=sight), but, rather, it is the consequence of a more complex process which involves: 1. the nerve pathways for the transmission and modulation of the nociceptive input; 2. the cortical and sub-cortical integrating centres; and 3. the ethical formation of the subject; the history of pain of that individual; and 4. the socio-cultural context.

Clinical aspects

The faith effect; the prayer effect, the music effect or new Mozart effect, the placebo effect, the nocebo effect, the stroking effect, ethical therapy and pain in the elderly

Ethically correct lifestyles and ones which refer to spiritual moments lived with joy not only create conditions for a longer life but also influence the nociceptive system, improving the perception of pain in each individual, above all if they are elderly.

On this point the authors wish to offer the following definitions of *the faith effect*, *the prayer effect*, *the new Mozart effect*, *the placebo effect*, *the nocebo effect*, *the stroke effect* and *ethical therapy*.

The *faith effect* is the result of that condition in which patients who are believers, compared to patients who are agnostics, have a lower perception of pain and respond better to pharmacological treatment (Zucchi-Honings, 1996; Zucchi, Honings, Voegelin, 2001).

The *prayer effect* is the result of that condition in which both patients who are believers and patients who are agnostics who freely agreed to carry out a meditated reading of a passage from the gospels manifest a better therapeutic response to (pharmacological) treatment as compared to patients (both believers and agnostics) who did not agree to a meditated reading of passage from the gospels (Zucchi, Honings, Voegelin, 2001).

The *new Mozart effect (music effect)* is the result of that clinical condition in which patients with pain syndromes manifest a lower perception of pain and a strengthening of the result obtained from anti-pain therapy, joining prayer to listening to pleasant music, which is usually of a classical or religious character (Zucchi, Honings, Voegelin, 2005).

A placebo is a pharmaceutical product without active principles that contains only inert substances. It is prescribed for psychological reasons or to assess in a comparative way the real action of medical products used with the same form as a placebo with which they are alternated without the patient knowing this (blind trial).

The *placebo effect* is the positive result produced by an inert biomedical substance in relation to the perception of pain which is diminished in a way that is similar to what takes place with the administration of the authentic medical product. The placebo effect is important in the field of the study of pain, above all in elderly people, in long-term therapies and has a reduced effect compared to a meditated reading of a passage from the gospels (Zucchi, Honings, Voegelin, 2008). *Placebo* and the *placebo effect* constitute an authentic oxymoron, that is to say that semantic condition in which two words with opposing meanings are placed together.

A *nocebo* is an inert substance with a negative reaction within the organism. The nocebo effect (which hitherto has not taken place in our case studies) is the negative result that an individual manifests following the administration of a medical product of a completely inert nature but which is perceived by the patient as being harmful. Usually, it takes place because of a bad relationship between the medical doctor and his or her patient (Zucchi, Honings, Voegelin, 2008).

The *stroking effect* is the result of an act that is ethical for the person who engages in it and therapeutic for the person who receives it. It diminishes the perception of pain. It is advisable to stress that skin, which covers the whole of the human body, does not only have an external function involving microbiological defence. It al-

so constitutes a complex interface with the nervous system. Indeed, in embryological terms, the skin derives from the same (embryo) sheet called the *ectoderm* from which the central nervous system and the peripheral nervous system derive. Stroking, on the basis of our studies, specifically because of the very embryological origins of the skin and the brain, which we define as *ectodermic twins*, diminishes the perception of pain (a higher pain threshold), fostering the release of endorphins and neurogenesis. In the paediatric sphere it fosters the growth of the child; in the geriatric sphere it fosters cinestesis in the elderly person.

Ethical therapy is the result of that condition characterised by the strengthening of therapeutic treatment, usually of a pharmacological character, both in believers and in agnostics who freely agreed to engage in a meditated reading of a passage from the gospels (Zucchi, Honings, 1996, 2001, 2005, 2008, 2011).

Different Frequency of Acute and Chronic Pain with Age

'Growing old is a privilege and a goal of society, it is also a challenge which has an impact on all aspects of twenty-first century society' (WHO).

A different frequency of acute and chronic pain exists with the advance of age. Acute pain of recent irruption diminishes with the advance of age whereas chronic pain increases. The use of health-care measures for acute pain reach a peak between the first and second halves of the fifth decade of life whereas resort to a medical doctor for chronic pain increases in a linear way until the age of 65, to then decrease from the age of 66 onwards, even though the real decrease takes place after the age of 86 (cf. fig. 15. Classification of pain in the elderly at three levels).

It is interesting to observe how the clinical conditions that most frequently cause pain in young adults (migraine, chronic headaches, peptic ulcers, abdominal pain, heart pain) diminish at an advanced age, whereas painful clinical conditions increase as regards the joint apparatus, the respiratory apparatus, and the syndromes of immunodeficiency (zoster herpes) which usually accompany neoplasms.

Quality of Life in the Elderly with Pain. The Ethical-Religious Iter

Tab. I. Positive conditions that are obtained through a meditated reading of a passage from the gospels in painful and cardiovascular pathologies, including ones treated pharmacologically.

From this study one can state that a meditated reading of a passage from the gospels offers in elderly people with painful pathologies (5-65 years: level 1; 66-85 years: level 2; 86-100 years, level 3), the following positive conditions:

1) Strengthening of the action of pain-killing medical products that are taken (Zucchi, Honings, Voegelin, 2001.
2) Reduction of the quantity of medical products which have to be taken (Zucchi, Honings, Voegelin, 2001).
3) Reduction of the perception of physical and medical pain (raising of the physical and mental pain threshold, Zucchi, Honings, Voegelin, 2001).
4) Improvement of the quality of life and therefore of the state of health (Zucchi, Honings, Voegelin, 2001).
5) Improvement of the interior conditions of assessments of others and one's own ways of behaving (Zucchi, Honings, Voegelin, 2001).
6) Greater satisfaction as regards one's life. Greater self-esteem, greater optimism, better prospects (Zucchi, Honings, Voegelin, 2001).
7) A 20% increase in life expectation compared to those who do not engage in religious practices (Zucchi, Honings, Voegelin, 2001).
8) Reduction in the cystic and diastolic blood pressure levels in individuals with hypertension (Lagi et al. 2001).
9) Reduced risk of death caused by cardiovascular or pulmonary diseases (Lagi et al. 2001).
10) More incisive health-inducing effects as compared to the music effect (Zucchi-Honings, 2005).
11) More effective health-inducing effects compared to the placebo effect (Zucchi-Honings, 2008).

NON-TREATED PAIN

Pain, however, even if perceived by an elderly person as being lower compared to individuals who are younger, must, whatever the case, be treated. Instead, often it is underestimated and thus under-treated.

As a consequence untreated pain, in individuals who entrust themselves to prayer as well, causes a worsening of quality of life in patients ands brings about the following conditions: (tab. II).

Tab. II. Conditions of a deterioration of quality of life in elderly people with untreated pain.

1) Reduction in social relationships.
2) Depression.
3) Anxiety.
4) Low/malnutrition.
5) Sleep disturbance
6) Increase in disability
7) Greater resort to health-care and social services.

Myths and facts about pain in elderly people

Myths: 'if they do not complain it means that they do not have pain'

Facts: there are a large number of reasons why elderly people are reluctant to admit that they are in pain, even though pain significantly reduces good mood and their functional state.

Reasons why Elderly People do not Speak about their Pain

1) Fear of being subjected to diagnostic examinations.
2) Fear of medical products.

3) Fear of the cause of pain.
4) Perception of the fact that the medical doctor is too busy.
5) Believing that nothing can be done or will be done.

However, the most reliable indicator of pain and its seriousness is the description provided of it by the patient himself or herself.

Objectives of a medical doctor when faced with an elderly patient who is in pain:

1) A careful anamnesis to identify the causes (when this is possible, inquiries into previous illnesses and the use of medical products).
2) An ethno-anthropological and social assessment.
3) A psychological assessment with psychometric tests.
4) A clinical-physical assessment with the focus of somatic pain (the skeletal-muscular system, with special attention paid to the palpation of trigger points).
5) An instrumental assessment: algometric tests (VAS; hyperalgesia; telethermography; acceptance; algogenic substances: free radicals: d-roms-test; bap-test; lactic acid; ascorbic acid; PCT; homocysteine; hydroxyproline; PTH).
6) Identification of the qualitative and quantitative aspects of pain control.

Assessment of Geriatric Pain

'Geriatric pain is underestimated and undertreated' (Bernabei, R., *et al*., *Jama*, 279 (1998) 237-249).

The control of pain in a foetus, in neonates and in adults (men, women) has received great attention over the last thirty years. In contrary fashion, pain in elderly patients has been very little studied.

The points to be borne in mind as regards geriatric pain: morbidity (the set of illnesses that afflict an individual) and co-morbidity or co-morbosity (associated pathologies).

1) An increase in life expectancy means the possibility of an increase in morbidity.
2) Pain constitutes a parameter that can influence morbidity.
3) Pain is the most feared complication of illness.
4) Pain is the first symptom that is referred to a medical doctor.
5) Often pain is under-diagnosed and undertreated.
6) Pain modifies mood, the functional state and quality of life.
7) Pain increases the use of health-care services.

Breakthrough Pain (BP) or Intense Episodic Pain (IEP) in Elderly People

By the phrases 'intense episodic pain' (IEP) or 'breakthrough pain' (BP) we mean a sudden increase, and as a rule not predictable, increase in the pain of a patient who is having well controlled basic pain treatment.

In the cases that we have examined BP is most frequent in patients of the first-level age band with a maximum incidence around the age of fifty. However, it is also present in patients who belong to the other two levels, but with a much lower incidence. Amongst the four types of first-level pain examined in the classification we have proposed (somatic pain, neurological pain, vascular-visceral pain, oncologic pain), BO is more frequent in patients with neurological cancer (40%; migraine), oncological cancer (30%), gastric tumour, tumour of the genital-urinary apparatus, tumour of the ear, nose and throat area; vascular cancer (20%); and, to a lesser extent, somatic cancer (10%).

The Aetiology of BP

BP can be caused: by movements, coughs and changes in position (predictable intense episodic pain) or by: distension of the urinary or intestinal tracts (unpredictable intense episodic pain). In some cases a real cause is not recognised (idiopathic BP)

The Characteristics of BP

BP is characterised by sudden pain of notable intensity which is piercing and burning. The seat is often that of basic pain, is prevalently nocturnal and of short duration (from 10 to 30 minutes). The treatment of BP must be seen as a clinical and ethical priority because it is a type of pain that undermines quality of life. The management of BP can be achieved in an optimal way with the adjustment of the therapy underway, but overcoming cultural attitudes that are not correct and rather widespread amongst patients who say they have to bear crises of acute pain after the basic therapy has been established. In the oncological field BP creates a prognosis that is even worse.

SPECIAL PART
Clinical Experimentation

Ethical-Religious Aspects

In this part of the paper we examine how the transcendent element of faith together with a meditated reading of a passage from the gospels can influence the threshold of the perception of pain and the strengthening of pharmacological therapeutic responses in elderly patients, whether believers or agnostics, who have chronic painful pathologies.

The Clinical-Statistical Approach to the Therapeutic Effectiveness of a 'New' Medical Product

In order to assess the efficacy of medical product 'X' (prayer) in relation to a given pathology, a 'G' group of patients is selected who suffer from that pathology; this group is divided into two subgroups G1 and G2; G1 is treated with medical product 'F' and G2 is treated with medical product 'F' and with medical product 'X' which is being studied.

The gravity of the pathology is assessed with an objective index 'P' which is measured at the beginning (P1) and at the end of the therapy (P2) . Two P1 independent variables are obtained as an index of the gravity of the initial pathology and DP = P1-P2, as an index of its improvement.

The statistical inquiry involves assessing whether there exists a meaningful difference of the value of DP in the two sub-groups G1 and G2, that is to say whether the new medical product 'X' strengthens improvement.

A further exploration of the characteristics of the medical product 'X' used involves assessing whether the improvement produced by this is greater when the gravity of the pathology is greater, that is to say if there is a positive correlation between DP and P1. All the patients have to sign a declaration of informed consent.

The Fundamental Parameters of the Study

The study examines the existing relationships of five fundamental parameters:

1) The faith effect (assessment of the initial intensity of the pain perceived V1 and the therapeutic result V2 in relation to the faith parameter).

2) The prayer effect (assessment of therapeutic improvement VD in relation to the parameter of a meditated reading of a passage from the gospels).

3) V1 (initial intensity of pain before treatment).

4) VD (intensity of pain at the end of treatment).

5) Correlation of VD/V1: the relationship between improvement tin the intensity of pain VD and the initial pain V1 in relation to the parameters of faith and prayer.

Declaration of Informed Consent

I the undersigned

……

Declare that I have received from Dr.

……

exhaustive explanations about the request for my participation in the Experimental Study described above. A copy of the present information sheet has been given to me.

I declare that I have been able to discuss these explanations, that I have posed questions and that I have received answers to them that are satisfactory.

I also declare that I have had an opportunity to inform myself about the features of the study with other person in whom I trust as well.

I therefore freely agree to take part in the research, having perfectly understood all the information given above.

I am aware that my participation in the research is voluntary and that I have the option to withdraw at any moment without this prejudicing the medical treatment that I might need.

I have been informed about my right to have free access to the documentation relating to this research.

In addition I am aware that according to respect for laws in force my personal data will be used exclusively for the purposes of scientific research.

Date

……

Signature of the Patient

……

Date
……

Signature of the
medical doctor researcher

……

Clinical Experimentation

As regards prenatal, neonatal and paediatric pain, we based ourselves on the data to be found in the literature in the field (Bellieni, Anand, Phil, Hickey, Fisk) which demonstrate that a foetus perceives pain starting in the seventh week of pregnancy, with the appearance of sense receptors in the perioral area, in the palms of the hand and in the souls of the feet (Gleiss, 1970). However, despite the evidence of the scientific data, some researchers (Enghelhardt, Derbyshire) argue that a foetus only feels pain when it adopts the position of a neonate.

On this point we would like to stress what the *Catechism of the Catholic Church* says in section 2274: 'Since it must be treated from conception as a person, the embryo must be defended in its integrity, cared for, and healed, as far as possible, like any other human being'. Indeed, to recognise that a foetus can feel pain is a step forward in recognising that it is a person. Given that we believe that a foetus and a neonate have the same perception of pain as adults (5-65 years) because of a completion of the pain-receiving system, we also placed patients of a paediatric age in the experimentation.

The data on pain relating to people of a paediatric age start with

observations of people of the age of five and above, a period when it is possible assess the strengthening of the efficacy of medical products through being accompanied by prayer.

The sample of individuals belonging to the first level (5-65 years) was made up of 120 people, of whom a small part (1/6) belonged to the age band of 5 to 10 years. In those who belonged to the first level the most frequent pathologies involved vascular pain, differently from what happened in level 2 individuals where oncological pain was prevalent, and level 3 where somatic (bone, joint and muscular) pain was prevalent.

The individuals who belonged to the three levels (young-old, 5-65 years, level 1; old-old, 66-85 years, level 2; oldest-old, 86 to 100 and over, level 3) and had chronic painful pathologies, in part admitted to the departments of internal medicine and in part examined in clinics of the specialist clinics of Florence and the Biomedical university Campus of Rome, were enrolled in a blind study, that is to say without knowing beforehand the religious beliefs of the people taking part in the project.

When the patients entered a department or clinic an assessment was made of the pathology that was responsible for their algic state. The various painful pathologies were divided into four groups: a central kind (neurological); a somatic kind (joints–myofascial); of a vascular kind; and of an oncological kind.

The patient were then sub-divided according to a random criterion (chance allocation of patients) into two groups: an S group (study: treatment with medical products and prayer) and a C group (control: treatment only with medical products).

All the patients were amply informed about the clinical experimentation and consented to it.

PREVALENCE OF PAIN TYPE IN 120 PATIENTS BELONGING TO EACH LEVEL

AT LEVEL 1 (INDIVIDUALS BETWEEN THE AGES OF 5 AND 65); AT LEVEL 2 (INDIVIDUALS BETWEEN THE AGES OF 66 AND 85); AND LEVEL 3 (INDIVIDUALS BETWEEN THE AGES OF 86 AND 100 AND OVER).

Tab. III. Sub-division by frequency of prevalent pain in decreasing order (vascular pain, neurological pain, oncological pain, somatic pain) in the 120 individuals belonging to level 1: young-old (5-65 years). Within the four types of pain the VAS level (10/9 –> 5/4) was the same.

Vascular pain: (40%): 48 individuals (32 S and 16 C) Neurological pain (25%): 30 individuals (20 S and 10 C) Oncological pain (20%): 24 individuals (20 S and 4 C) Somatic pain (15%): 18 individuals (10 S and 8 C)

Tab. IV. Sub-division by frequency of prevalent pain in a decreasing order (oncological pain, vascular pain, somatic pain, neurological pain) of the 120 patients belonging to level 2: old-old (individuals between the ages of 66 and 85. Within the 4 types of pain the VAS assessment (8/7 –> 4/3) was the same in each level.

Oncological pain (40%): 48 individuals (20 S and 28 C) Vascular pain (30%): 36 individuals (10 S and 26 C) Somatic pain (20%): 24 individuals (14 S and 10 C) Neurological pain (10%): 12 individuals (7 S and 5 C)

Tab. V. Sub-division by frequency of prevalent pain in a decreasing order (somatic pain, vascular pain, neurological pain, oncological pain) of the 120 patients belonging to level 3: oldest-old (individuals between the ages of 86 and 100. Within the 4 types of pain the VAS assessment (7/6 –> 3/2) was the same.

Somatic pain (70%): 84 individuals (45 S and 39 C) Vascular pain (15%): 18 individuals (10 S and 8 C) Neurological pain (8%): 9,6 individuals (4 S and 5 C) Oncological pain (7%): 8,4 individuals (6 S and 2 C)

To both groups – the S (study) group and the C (control) group – belonging to the three levels 1 (5-65 years), 2 (66-85 years) and 3 (86-100 years), an 'F' pharmacological therapy was administered based on FANS.

The S group was also invited to engage in a meditated reading of a passage from the gospels (prayer) before the beginning of the treatment, and this lasted ten days.

On the first, fifth and tenth days the individuals of the two groups (S and C) of the three levels 1, 2 and 3, underwent a psycho-physical assessment of their pain two hours before and after, the administration of the treatment which involved the administration of the medical product F to the control group and of the medical product F, together with a meditated reading of a passage from the gospels, to the study group.

In the case of the younger individuals prayers were often said in the presence of an older adult, usually one of the parents of these individuals.

The assessment of pain was carried out using the analogical visual scale (VAS) (Zucchi, Honings, Voegelin, 2008).

The initial VAS was the variable VI, an index of the painful pathology and the difference between the indicator of initial VAS and that of the final VAS made up the variable VD, an index of improvement.

At the end of the treatment, that is to say at the end of the tenth day of admission, the patients were asked if they were believers or otherwise, and in this way was obtained, in each of the three levels, two groups of individuals with different responses to the therapy, according to their own spiritual approaches as well.

Tab. VI. Sub-group of patients with neurological (or central) pain. Level 1: 5-65 years.

EXAMINATION OF THE SUB-GROUPS AT THE END OF THE THERAPY C1= 5 believers treated with prayer and pharmacological therapy C3= 4 believers treated only with pharmacological therapy A2= 15 agnostics treated with prayer and pharmacological therapy A4= 6 agnostics treated only with pharmacological therapy

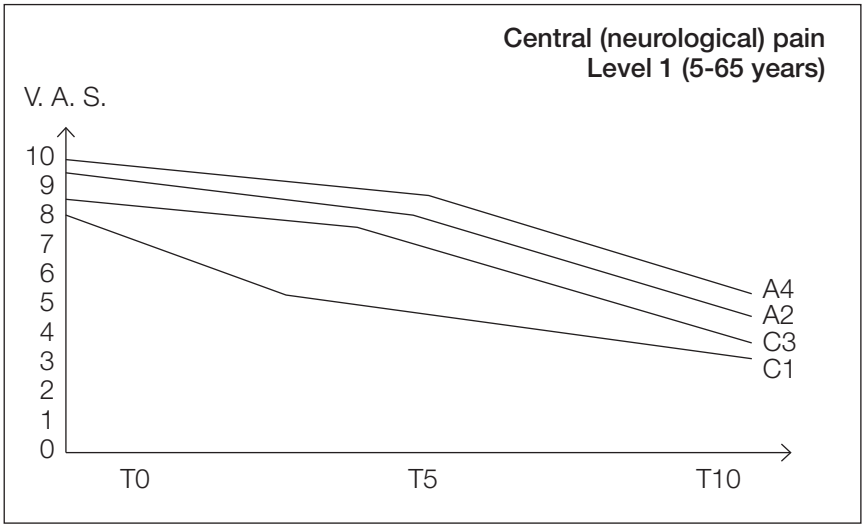

Fig. 11 A. Central pain (acute headaches, migraine, trigeminal neuralgia, outcomes of ischemic or haemorrhage stroke, Alzheimer's disease, multi-heart attack dementia, Parkinson's disease) in patients of the first level (5-65 years).

Tab. VI A. Sub-group of patients with neurological (or central) pain. Level 2: 66-85 years.

C1= 4 believers treated with prayer and pharmacological therapy C3= 3 believers treated only with pharmacological therapy A2= 3 agnostics treated with prayer and pharmacological therapy A4= 2 agnostics treated only with pharmacological therapy

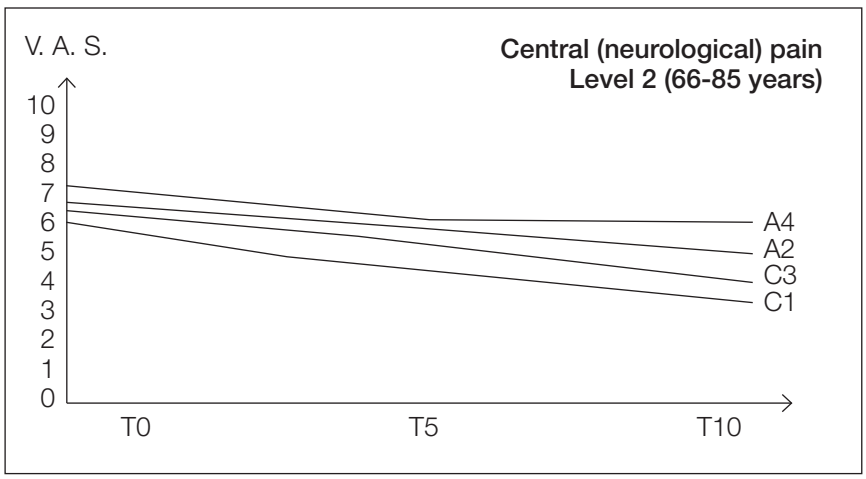

Fig. 11 B. Central pain (acute headaches, migraine, trigeminal neuralgia, outcomes of ischemic or haemorrhage stroke, Alzheimer's disease, multi-heart attack dementia, Parkinson's disease) in patient of the second level (66-85 years).

Tab. VI B. Sub-group of patients with neurological 8or central9 pain. Level 3: 86-100 years.

C1= 2 believers treated with prayer and pharmacological therapy C3= 3 believers treated only with pharmacological therapy A2= 2 agnostics treated with prayer and pharmacological therapy A4= 2 agnostics treated only with pharmacological therapy

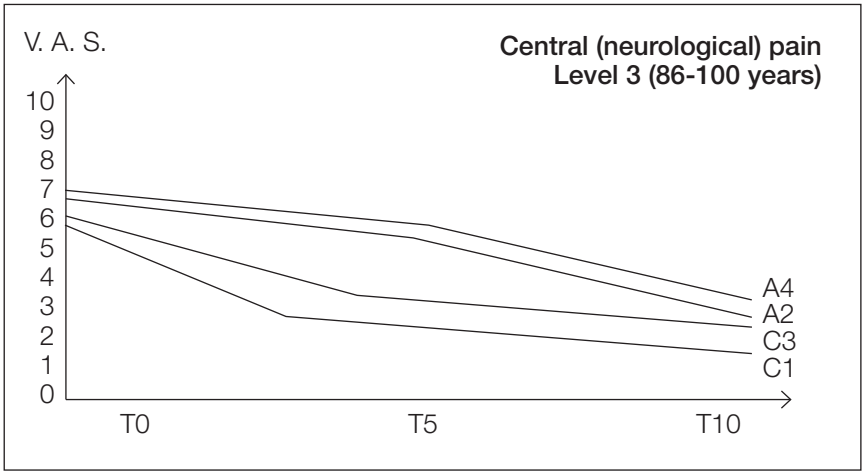

Fig. 11 C. Central pain (acute headaches, migraine, trigeminal neuralgia, outcomes of ischemic or haemorrhage stroke, Alzheimer's disease, multi-heart attack dementia, Parkinson's disease) in third-level patients (86-100 years).

Tab. VII. Sub-group of patients with oncological pain. Level 1 (5-65 years).

C1= 6 believers treated with prayer and pharmacological therapy C3= 3 believers treated only with pharmacological therapy A2= 4 agnostics treated with prayer and pharmacological therapy A4= 11 agnostics treated only with pharmacological therapy

Tab. VII A. Sub-group of patients with oncological pain. Level 2 (66-85 years).

C1= 9 believers treated with prayer and pharmacological therapy C3= 12 believers treated only with pharmacological therapy A2= 11 agnostics treated with prayer and pharmacological therapy A4= 8 agnostics treated only with pharmacological therapy

Tab. VII B. sub-group of patients with oncological pain. Level 3 (86-100 years).

C1= 3 believers treated with prayer and pharmacological therapy C3= 1 believer treated only with pharmacological therapy A2= 3 agnostics treated with prayer and pharmacological therapy A4= 1 agnostic treated only with pharmacological therapy

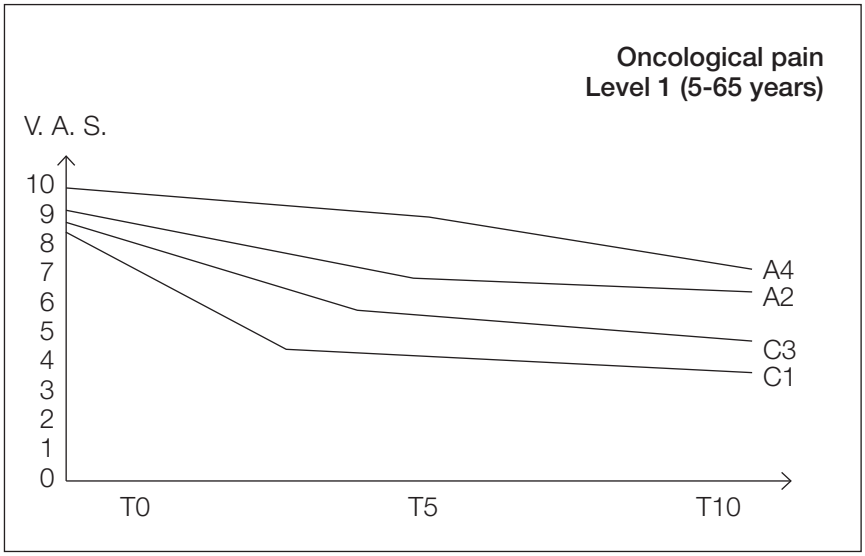

Fig. 12 A. Oncological pain of patients of the first level (5-65 years).

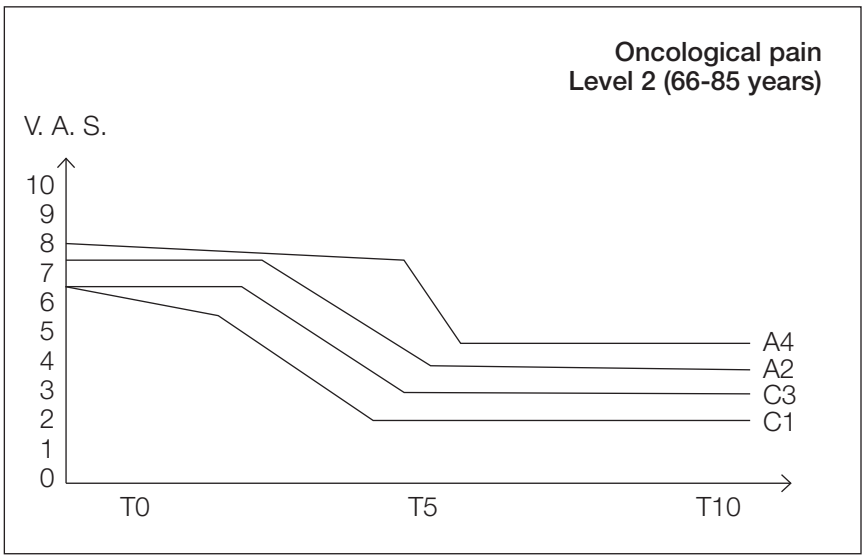

Fig. 12 B. Oncological pain in patients of the second level (66-85 years).

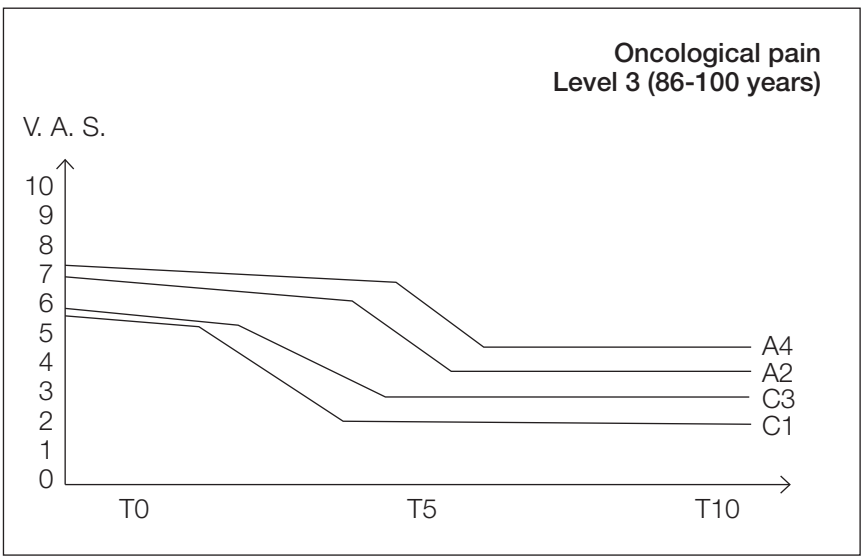

Fig. 12 C. Oncological pain in patients of the third level (86-100 years).

Tab. VIII. Sub-group of patients with vascular pain. Level 1 (5-65 years).

C1= 20 believers treated with prayer and pharmacological therapy
C3= 6 believers treated only with pharmacological therapy
A2= 12 agnostics treated with prayer and pharmacological therapy
A4= 10 agnostics treated only with pharmacological therapy

Tab. VIIIA. Sub-group of patients with vascular pain. Level 2 (66-85 years).

C1= 4 believers treated with prayer and pharmacological therapy
C3= 10 believers treated only with pharmacological therapy
A2= 6 agnostics treated with prayer and pharmacological therapy
A4= 16 agnostics treated only with pharmacological therapy

Tab. VIII B. Sub-group of patients with vascular pain. Level 3 (86-100 years).

C1= 4 believers treated with prayer and pharmacological therapy
C3= 3 believers treated only with pharmacological therapy
A2= 6 agnostics treated with prayer and pharmacological therapy
A4= 5 agnostics treated only with pharmacological therapy

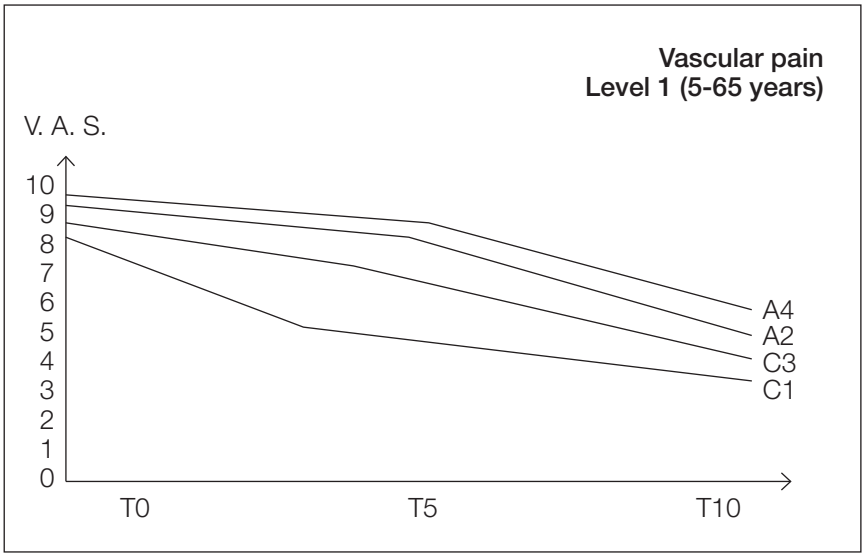

Fig. 13 A. Vascular pain in patients of level 1 (5-65 years).

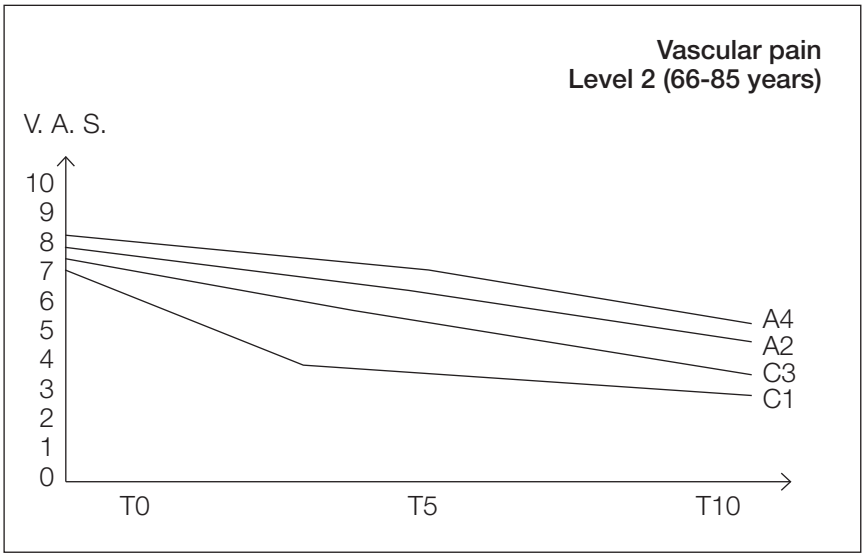

Fig. 13 B. Vascular pain of level 2 (66-85 years).

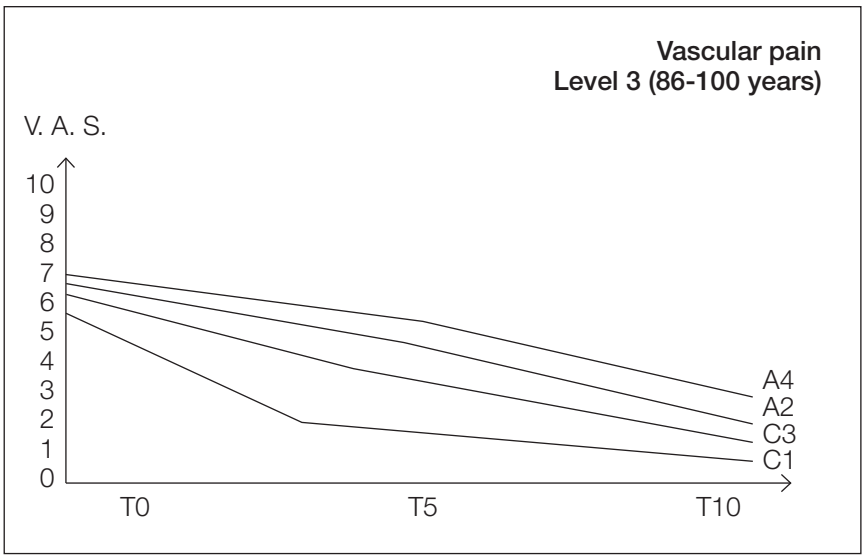

Fig. 13 C. Vascular pain in patients of level 3 (86-100 years).

Tab. IX. Sub-group of patients with somatic pain (joints/myo-fascial). Level 1 (5-65 years).

C1= 6 believers treated with prayer and pharmacological therapy
C3= believers treated only with pharmacological therapy
A2= 4 agnostics treated with prayer and pharmacological therapy
A4= 3 agnostics treated only with pharmacological therapy

Tab. IX A. sub-group of patients with somatic pain (joints/myo-fascial). Level 2 (66-85 years).

C1= 9 believers treated with prayer and pharmacological therapy
C3= 6 believers treated only with pharmacological therapy
A2= 5 agnostics treated with prayer and pharmacological therapy
A4= 4 agnostics treated only with pharmacological therapy

Tab IX B. Sub-group of patients with somatic pain (joints/myo-fascial). Level 3 (86-100 years).

C1= 30 believers treated with prayer and pharmacological therapy
C3= 19 believers treated only with pharmacological therapy
A2= 15 agnostics treated with prayer and pharmacological therapy
A4= 20 agnostics treated only with pharmacological therapy

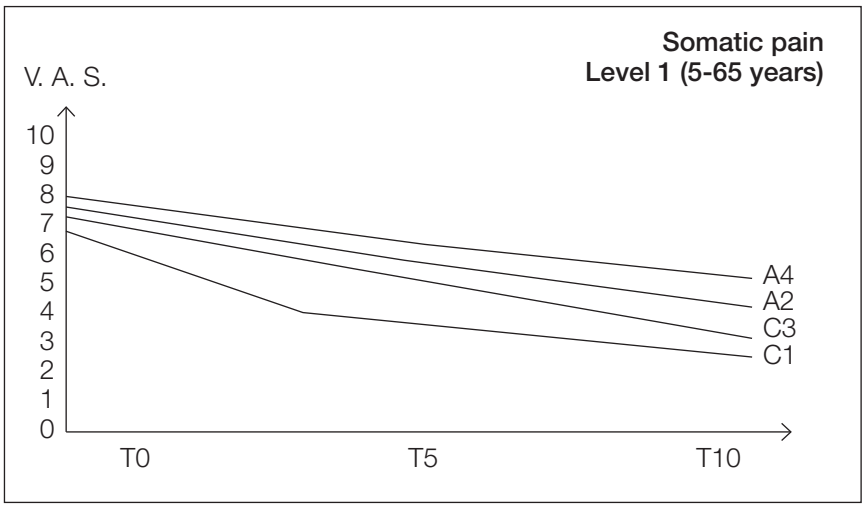

Fig. 14 A. Somatic pain (articular and joints/myo-fascial; arthritis, arthrosis; cervical pain; dorsal pain; lower back pain) in patients of level 1 (5-65 years).

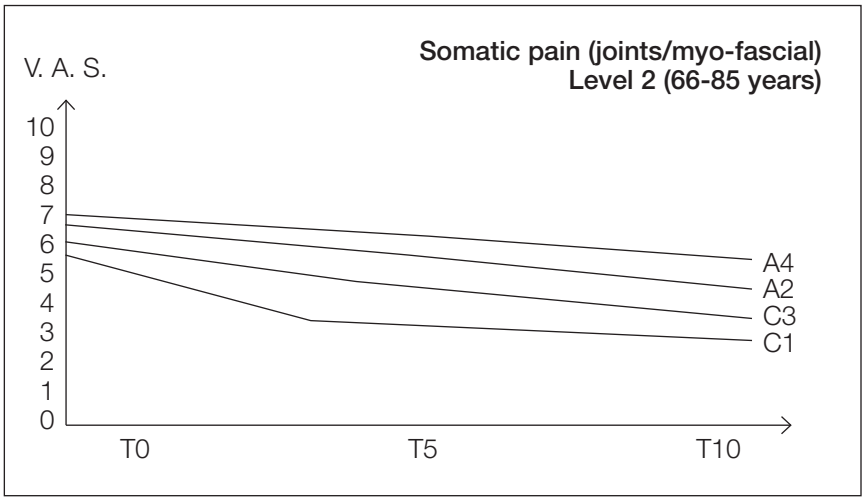

Fig. 14 B. Somatic pain (articular and joints/myo-fascial: arthritis, arthrosis, cervical pain; dorsal pain; lower back pain) in patients of level 2 (66-85 years).

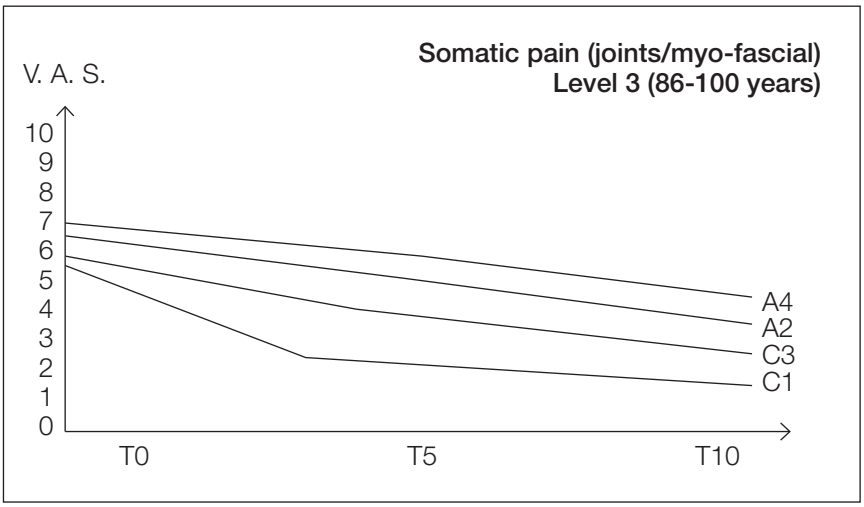

Fig. 14 C. Somatic pain (articular and joints/myo-fascial: arthritis, arthrosis, cervical pain, dorsal pain, lower back pain) in patients of level 3 (86-100 years).

Results and Conclusions

From the data examined in this study it has been shown that the variability of the intensity of pain correlates with:

1) Age: the elderly people of the third level (86-100 years) perceived less pain than those of the second level (65-85 years) and of the first level (5-65 years).

2) The environmental phenotype factor: less comforted environments engendered a greater perception of pain.

3) Culture: classes with a lower culture and people with a more humble physiognomy tolerated pain better and responded better to therapies than more cultured and arrogant people.

4) As regards sex, there were no significant variations in the perception of pain in men and women, when elderly as well, as had already been indicated in previous studies (Zucchi-Honings, 2005).

The Characteristics of Different Types of Pain in the Three Levels

From this study it also emerged that:

1. Some clinical forms of vascular-visceral (silent myocardial infarction and complicated ulcer illnesses) constitute pathologies with painful symptoms in minimal intensity in patients of the geriatric age of the third level (86-100 years) as compared to the groups of patients of the first and second levels.

In these pathologies vascular-visceral pain emerges when sufficient levels of afferent impulses are reached and when there is an appropriate activation of the central ascendant pathways. In asymptomatic elderly people there takes place an insufficient stimulus of the tissues with a related decreased spinal transmission and consequential lesser cortical integration.

2. At level 3 the clinical conditions of vascular-visceral pain, together with those of central pain and oncological pain, have lesser frequency, as an epidemiological fact, compared to clinical forms of somatic pain (arthrosis, arthritis, zoster herpes, injuries) which are very well represented in the cases of medical services and admissions carried out in the emergency departments of hospitals in various cities.

3. The patients in the study group (S) and those of the control group (C) of level 3 require lower quantities of pain-killing medical products and opioids in the four types of pain (somatic, vascular, neurological, oncological) compared to the patients (S and C) of the first and second levels.

4. The instrument of a meditated reading of a passage from the gospels (prayer) strengthens the effect of pain-killing medical products in all the levels of the patients subjected to examination, even though to a greater extent in those of the third level because of a physiological condition of lesser perception of pain due, as well, to the application of more aware lifestyles.

It is advisable to emphasise, therefore, that the intensity of the different types of pain within the different age bands of the individuals belonging to each of the three levels tends to decrease from level 1 to level 2.

Classification (at Three levels) of Pain in the Elderly

On the basis of the results obtained from this study we formu-

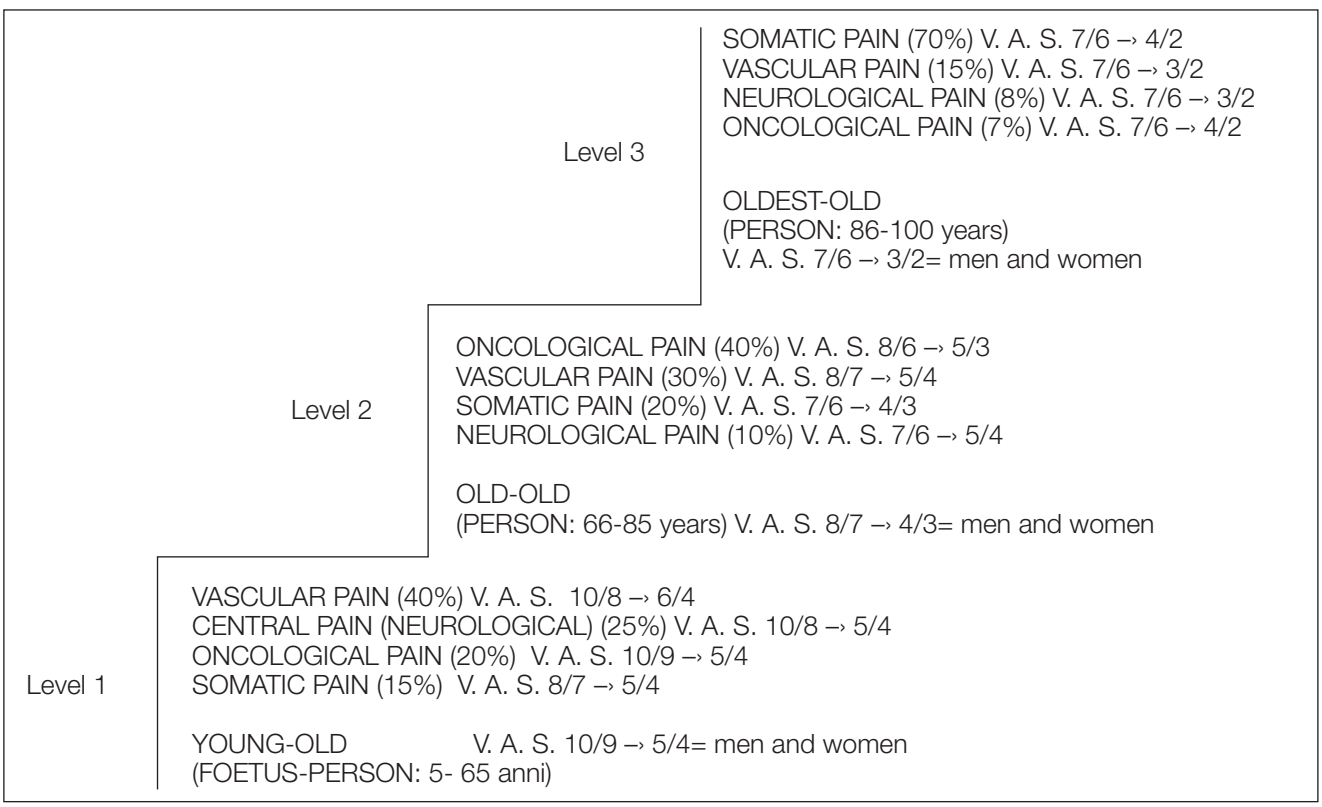

Fig.15. Classification at the three levels of the threshold of various types of pain according to age.

lated a scale with three levels of pain in the elderly in order to offer a new classification that examines the intensity and the frequency of the various types of pain on the basis of the age of the patient. This condition places the foetus (of the seventh week of pregnancy) and the neonate at the same level as the adult person (65 years) because with the same condition they posses the same nociceptive apparatus and thus the same perception of pain (minimal variability of the VAS within the level).

Frequency of the various types of pain (vascular, neurological, oncological, somatic) and average intensity (VAS) in the basis of the age of the individual within each level.

The age examined in the first level on the basis of the perception of pain starts with the foetus and goes on until the age of 65. As regards the perception of pain during the foetal and neonatal period we took advantage of the data to be found in the literature in the field, examining in our cases patients starting with the age of 5. The age of the second level goes from 66 to 85 years of age, and the age of the third level goes from the age of 85 to over the age of 100. The level of pain highlights a decrease in its parameters (intensity, duration, frequency) as the levels gradually go up with age.

Within each level is identified not only the performance with small variation of the VAS for the four different types of pain on the basis of age but also the frequency of the type of the prevalent pain: in the first level the first place is occupied by *vascular pain* where the VAS goes from a level of 10/9 to a level of 5/4; in the second level *oncological pain* comes first where the VAS goes from a level of 8/7 to a level of 4/3; and in the third level *somatic pain* comes first where the VAS goes from a level of 7/6 to a level of 3/2. In each of these three levels the level of VAS (intensity of pain) is the same in men and women, with small differences within the four types of pain.

The patients of all these three levels, in addition to the pharmacological therapy, were also invited to engage in a meditated reading of a passage from the gospels with a strengthening of the therapeutic effects in the various types of pain.

We wanted in this classification of pain in the elderly to provide an overall view of man starting from the foetus in order to give this entity the dignity of a person who perceives all the signs of pain equivalent to those in adults, emphasising that the perception of human pain begins with man's *foetal being* and that man's ageing begins with his *neonatal being*.

In this work we would like to emphasise that the perception of pain begins to decrease with the increase in age and that this parameter emerges with a clearer physiognomy in believers as compared to agnostics in the various types of pain examined in each level. This observation is important not only from a clinical point of view. It is also important in ethical terms because it demonstrates that a life based upon the values of sobriety and prayer-faith helps in corroborating our organism from an algic point of view as well.

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