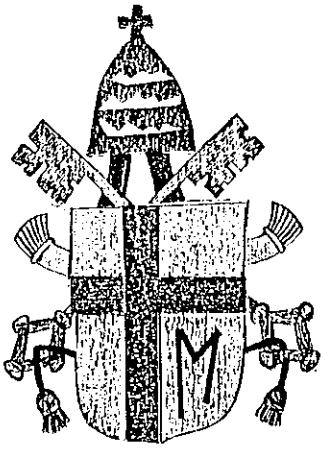

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Summary

The illustrations for this issue have been taken from The Golden Ages of Medicine. 700 Years of Science in Padua *(Panini, 1986), a Catalogue of the Exhibit devoted to this subject at the Palace of Reason in Padua, Italy.*


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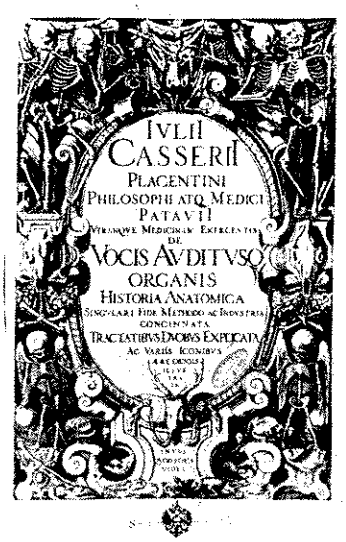


Giulio Casseri, Tabulae Anatomicae *(Padua, 1627)*

A High Price on Loyalty

When Yankee-great Roger Maris died, I told a story about my father, Babe Ruth and the Yankees.

A great baseball fan who could talk fondly of Rogers Hornsby and Ty Cobb and Christy Matthewson and the Big Train, Walter Johnson, he became really euphoric only when he got on to the subject of Ruth, which was every time he talked baseball, which was very often. As I reminded Mrs. Maris and her youngsters, with no disrespect to her wonderful husband, my father would never accept the notion that Roger could conceivably have broken the Babe's home run record. His was not merely the standard argument about a longer season. My father was too shrewd for that. It was the ball — the "lively" ball. For my father, it was absolutely, categorically unfair to compare *anybody* with Ruth, and that included Di Maggio and Mantle, along with Maris, because they didn't have to get up there and hit the old "dead" ball over the fence as he did (and clearly a much shorter fence, incidentally, he would argue).

At any rate, the Babe died. My father could accept that as what life is all about. What he couldn't accept, then and until the day he himself died, was that the Yankees played ball the day Ruth was buried! The Yankees played ball! The Yankees, whose stadium was "the house that Ruth built." He had been mad at the Yankees before, like when he realized they sold hot dogs at ball games on Friday, but this was too much. There was no arguing with him, such as: "Dad, did you ever think maybe they played out of respect for the Babe — as a kind of tribute?" My father could give withering looks even when he was happy. None ever compared to the one I got when I pulled that one.

At any rate, and here's the point of the story, he swore off baseball totally and definitely. Wouldn't go to a game, wouldn't read the sports page or listen to the radio (no television set at the time). He stuck to it for — how long? Maybe five years? Then I insisted on getting him a television set and he couldn't resist. He even turned my mother into a fan, although she would occasionally talk about the center fielder being on the 10-yard line, or the shortstop going off tackle. Indeed, before *she* died, in turn, she could argue with anybody who talked about Roger Maris that he never broke the Babe's record. That's loyalty!

And it's loyalty I'm reflecting about, not seriously enough, perhaps, but quite sincerely. I suppose what started me thinking was a hole or two of golf I caught on television in between the multitudinous events that spell Sunday in the archdiocese. (I believe it was right after the touching little service we had in the cathedral celebrating the loyalty of the 354 couples married 50 years each. It was great to shake hands with them all and give them their certificates, which should really have been solid gold).

A number of fine young players were in the field, with perhaps a dozen of the leaders well under par. No question at all about their skill, but in watching and admiring and liking them all, I came once again to recognize what I note so frequently — how much I'm like my father. Why? Because Jack Nicklaus wasn't there, nor was Julius Boros or Arnold Palmer, nor, of course, Ken Venturi or Ben Hogan, and so I found my attention wandering. It wasn't the same. They're today's greats and future greats, the ones I was watching, and I know I'll watch them with pleasure whenever I can, but it's not the same, and it won't be the same. And whatever else makes that the case, I'm certain that in large measure it's that I was reared to put a high price on loyalty, a very high price indeed.

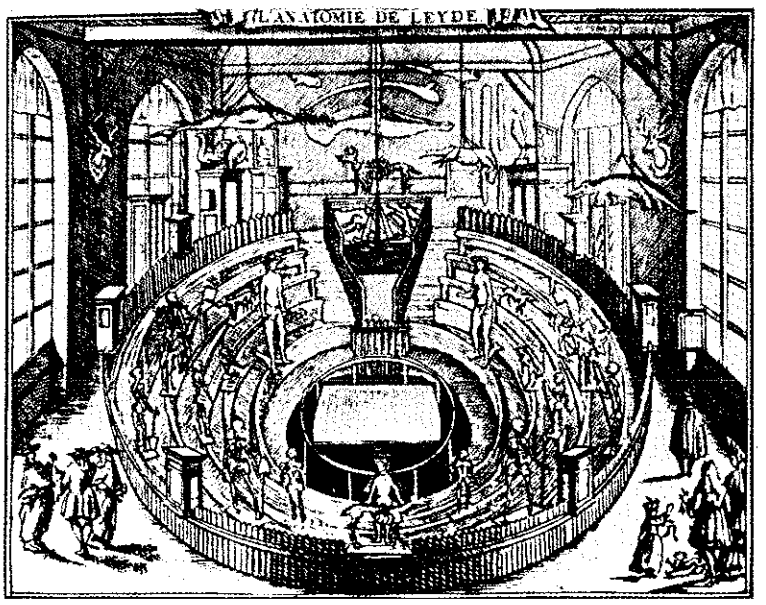
It may seem to be a radically different subject to talk about, but I suspect that what we learned about loyalty in our house says a lot about why I feel the way I do about the Church and the pope. I

know that honest criticism can be a high form of loyalty, and must always be welcome. I have to wonder, however, if some of the criticisms I read about these days concerning the Church and the pope are really honest, and are motivated by loyalty. Indeed, some of the criticism seems so extraordinary to me that I find myself wondering if such critics are talking about the same Church and the same pope I know, the Church described so beautifully by Karl Adam in "The Spirit of Catholicism."

"God permits so much weakness and wretchedness in the earthly Church just because He is good. One may even venture the paradox that the mystical Christ has taken so much weakness for Himself for our sakes and for our welfare. For how might we, who are 'prone to evil from our youth', who are constantly stumbling, constantly struggling, and never spotless, not even in our fairest virtue — how might we gladly adhere to a Church which displayed holiness not as a chaste hope, but as a radiant achievement? Her very beauty would be a stumbling block to us. Her glory would accuse and condemn us. How would we dare to call her, the rich and glorious, our mother, the mother of poor and wretched mortals? No, we need a redemptress mother, one who, however celestial she be in the deepest recesses of her being, never turns coldly away from her children, when their soiled fingers touch her, and when folly and wickedness rend her marriage robe. We need a poor mother, for we ourselves are poor.

"Therefore we love our Church in spite of, nay just because of, her poor outward appearance. The Catholic affirms the Church just as it is. For in its actual form the Church is to him the revelation of the divine Holiness, Justice and Goodness. The Catholic does not desire some ideal Church, a Church of the philosopher or the poet. Though his mother be travel-stained with long journeying, though her countenance be furrowed with care and trouble — yet, she is his mother. In her heart burns the ancient love. Out of her eyes shines the ancient faith. From her hands flow ever the ancient blessings. What would heaven be without God? What would the earth be without this Church? I believe in One Holy Catholic and Apostolic Church."

CARDINAL
JOHN J O'CONNOR
Archbishop of New York



Anatomical Theater of Leida, Padua
Picture Library of the Institute for the History of Medicine

Andrea Vesalio, De humani corporis fabrica, *title page, Padua Picture Library of the Institute for the History of Medicine*

Spanning the Barriers

Catholic Health Care in a World of Need

Health care has ever been and will always be an essential component of the Church's mission. Caring for the sick, both personally and collectively through Catholic health care facilities, is an integral element of the Church's ministry. I come before you today, as a pastor, to speak about this ministry. I come as one who subscribes wholeheartedly to the commitment made by the U.S bishops in their pastoral letter, *Health and Health Care*:

"We pledge ourselves to the preservation and further development of the rich heritage that is embodied in the Church's formal health apostolate..... We commit ourselves to do our part in maintaining and developing a Catholic institutional presence within the health care field in our country."

What I wish to do this morning is reflect with you on the implications of that statement. If health care is an integral component of the Church's mission, how should the whole Church be involved in health care ministry? What roles should the various members of the Church — laity, religious, clergy, and bishops — play in such a ministry? How does a reading of the "signs of the times" tend to shape that ministry today?

I would like to set the broader context for these reflections by briefly recalling the historical development of Catholic health care services in this country and the changes which are occurring today.

Historically, the Church has supported a health care ministry primarily through various health care facilities. The impetus for Catholic hospitals in this country often came from religious congregations. In many instances, they saw the need for health care in a specific geographical area or among a particular group of immigrants. To respond to this need, the religious sought the approval of the diocesan bishop to initiate a health care ministry within his diocese. Sometimes the bishop himself invited the religious to establish such a facility. Whatever their origin, most bishops thought — and still think — of Catholic hospitals as indispensable to the Church's mission of service.

Nonetheless, in the past, each health care facility operated more or less on its own. Its relationship with the local diocese, for example, usually consisted in adherence to Catholic moral principles, provision of chaplains, and an occasional visit from the bishop to celebrate a special occasion. This relationship seemed suitable at the time. Catholic hospital flourished, and the entire Church is both proud of and grateful for the outstanding service which they have given to their patients — regardless of race, religion, or socio-economic status.

However, the health care scene in this nation has changed dramatically in recent years. Undoubtedly, you have looked long and hard this week — as you do every working day — at the difficulties Catholic hospitals face today because of limited resources, lower patient census, DRG's, the expense of advanced technology, and myriad other problematic circumstances. Because of media exposure and marketing programs, the general public is very much aware that hospitals are vigorously competing for health care business.

Perhaps the core of the present crisis facing Catholic hospitals is the fact that health care is being identified more and more as a "growth industry" or an "investment opportunity." How will we be able to remain faithful to our concept of mission and service in such an environment? How will we be able to balance a commitment to providing health care for the poor with the need for cost containment? The impact of these significant changes in contemporary health care is articulated clearly and forcefully in the report of the CHA Task Force on Health Care for the Poor. I understand that you are reflecting on that document during this annual meeting.

Recently a prominent phy-

sician wrote to me in anticipation of this address. He pointed out that, even as we speak about the Church's mission and healing ministry, "the hard financial issues faced by our institutions are forcing us to choose between ministry and economic pressure. The choice of money over ministry will ultimately lead to either the loss of a sense of mission and ministry, or a significant perversion of the meaning of these terms." He then reflected on the concomitant crisis in Catholic health care, its service to the poor: "When mission and ministry are subverted to technologic competitiveness and financial survival, it is this population [the poor] that falls through the cracks."

In short, Catholic health care is in crisis. The battle for its very soul is being waged. We are at a fork in the road, and we must make critical decisions.

I wish to make it very clear, however, that I look upon the current situation as an opportunity for new growth, as a challenge to realize more fully than ever the Church's healing mission. While I share your anxieties, I do not despair. In fact, I am quite optimistic. First, God has entrusted this mission to the Church, and he always gives us what we need to carry out our responsibility. I believe this with all my heart and soul! Second, we have incredibly valuable human resources within the Church. All we need is to tap our creative potential to solve problems. We must pool our creative resources and energies. We need to span the barriers. We must work together to do what we cannot accomplish alone!

Collaboration

Today, with a greater awareness of health care as a ministry of the entire Church and with the severe crisis threatening individual hospitals, my basic thesis is that *collaboration* rather than competition will make the difference between survival and demise. It will provide the catalyst that brings about new growth.

Collaboration is intimately related to Gospel values; it is, indeed, implicit in those values. When Jesus prayed at the Last Supper for those who would be his future followers, he did not pray that they would be successful or even that they would be happy! Instead, he prayed that they might be *one* — united — so that the world might believe the Gospel. Through collaborative efforts we can witness to the fact that we are a living community based on a common faith, common values, and a common mission.

Many hospitals have already begun to collaborate with others. There are new hospital systems, systems of hospital systems, joint ventures. These relationships tend to strengthen each partner's position, thus enabling it to fulfill its mission better and serve its people more effectively. Nevertheless, it is important that, when such choices and decisions are made, adequate consideration be given to the potential harm that may be caused to other facilities in the area which share the same ecclesial mission.

Collaboration, however, does not imply getting rid of all competition. Competition is healthy when it provides an incentive to be unsatisfied with oneself, to improve, to excel, to be the best one can be. Such competition can lead health care providers to excellence, and this benefits the people they serve. However, competition is morally unacceptable when it is dishonest or when its primary purpose is to eliminate or destroy others. The basic motivation, if we are to preserve our values and very purpose of existence, must be the health and well-being of those we serve.

Within the Catholic health care apostolate, diverse talents — as well as the differing vocations of the laity, the religious, and the ordained — provide an excellent opportunity to witness to the kind of Church Jesus prayed for. In other words, even if there were no particular crisis facing Catholic health care today, the time would still be ripe for collaboration because of the renewal of Church life and ministry inaugurated by the Second Vatican Council.

Let us now reflect upon some of the changes and challenges facing three actors in the Church's health ministry: the religious, the laity, and the pastors of the Church.

The role of the religious

As I noted earlier, the extensive system of Catholic hospitals owes its existence primarily to the religious institutes of women and men that founded them. Today most of the Catholic acute care hospitals remain under the sponsorship of religious congregations. These congregations have enriched the Church with their diversity, their number, and their dedicated service. It is impossible to imagine the Church in the United States without them!

Although the decline in numbers of religious is unde-

niable, it would be a tragic loss to the Church and to its health apostolate if the unique witness provided by religious completely disappeared. For the sake of the kingdom, religious have left everything to follow Christ, reminding the rest of us that there is something more than the "here and now." They show us how to glorify God through selfless service to the deepest needs of the human family.

The primary responsibility to provide long-term direction to Catholic health care facilities and to ensure their mission effectiveness belongs to the sponsoring body, which, in most cases, is a religious congregation. This sponsorship is the element that perdures over the years despite changes in personnel and administration. The continuing and deeper involvement of many sponsors in directing their health care facilities is an encouraging sign for the future of Catholic health care.

Nonetheless, the leaders of religious communities necessarily have multiple concerns. Their responsibilities often extend beyond the individual health care institution to include other ministries to which the congregation is committed. They cannot neglect the well-being of the entire religious institute and its individual members. On the other hand, hospitals' chief executive officers, whether religious or lay, necessarily focus their attention on the good of their particular institution, and rightly so.

While, at times, there may be differences or tensions because of the differing priorities of the sponsors and the administrators, open communication about the mission needs and the business exigencies of an institution can lead to a healthy balance between Christian ministry and financial viability.

Another hopeful sign for the future of Catholic health care is the increasing effort to promote inter-congregational cooperation and collaboration. Religious congregations often have more in common than they may, at first, think. Even though each congregation is shaped by the special charism of its founder or foundress, all are firmly rooted in the one Christ. A Chinese proverb says: "One moon shows in every pool; in every pool the one moon." Although every pool, pond, and puddle is different, a single source of light is reflected many times over. Likewise, the one Christ is reflected in each of us, different though we are. No one of us, either individually or gathered in community, can fully or perfectly mirror the Lord. His gifts and charisms are not meant solely for us; they are to be shared with others. They are not in competition but are eminently complementary.

If we were to examine the mission statements of your hospitals, we would undoubtedly discover in most of them an expression of or allusion to the unique charism which motivates the sponsoring congregation. But we would also find much common ground in the stated purposes: for example, in such concepts as the healing mission of Jesus, the sacredness of life, care for the total person, adherence to Catholic ethical standards, a concern for social justice, a special love for the poor. What each Catholic hospital shares in common with all the others — its Catholic vision of mission and service — provides the basis and the motivation


TABULÆ
ANATOMICÆ
CLARISSIMI VIRI
BARTHOLOMÆI EUSTACHII
Quas è tenebris tandem vindicatas
ET
Sanctissimi Domini
CLEMENTIS XI.
PONT. MAX.
Munificentiâ dono acceptas
Præfatione, Notisque illustratis, ac ipsi suæ Bibliothecæ
dedicatissimis ac publici juris fecit
JO. MARIA LANCISIUS
Intimus Cubicularius, & Archiater Pontificius.
ROMÆ MDCCXIV.
Ex Officina Typographica Francisci Gonzaga in Via lata.
PERMISSU.


L'HORTO
DE I SEMPLICI
di Padoua,
Oue si vede primieramente la forma di tutta
la Pianta con le sue misure: & indi i
suoi Partimenti distinti per Nu-
meri in ciascuna
Aretta,
Intagliato in Rame.
Opera, che serue mirabilmente alla memoria
de gli Studiosi.
CON PRIVILEGIO.
IN VENETIA,
Appresso Girolamo Porro. 1591.

Bartolomeo Eustachio, Tabulae Anatomicae, *1714*

Girolamo Porro
The Garden of the Simple in Padua
1591

for taking steps toward working together more closely. With these elements as building blocks we can begin to erect bridges between and among religious communities.

The role of the laity

Along with the religious who play such a significant role in Catholic health care, we need also to affirm the legitimate and, indeed, necessary role of the laity.

Although a lay apostolate has existed in the Church since its beginning, it has been given new emphasis and importance by the Second Vatican Council. There are two arenas of apostolic activity for the layperson: the secular world and the Church. The world, the marketplace, if not the exclusive area of the laity, is certainly their primary responsibility. Nonetheless, they also have an indispensable role to play within Church institutions as well.

Although it is important that the laity participate in health care endeavors sponsored by other than Catholic institutions, bringing Gospel values and the principles of ethics and social justice to these settings, I will concentrate my reflections on the lay role in Catholic health care facilities.

While the laity have always been associated with religious in Catholic hospitals, it is only more recently that they have assumed positions of leadership in administration and governance. Whatever the reasons for this development, Catholic health care ministry must clearly continue to be a collaborative endeavor with both lay and religious participation.

To put it briefly, the expertise and insight which the layperson alone can offer is indispensable for effective ministry and for a more perfect reflection of the whole Church. Sometimes people mistakenly think that the mission aspects of health care are the responsibility of the religious and clergy, and the business aspects, the responsibility of the laity. The integration of both aspects is essential for both religious and laity.

Continuing education and formation in spirituality, theology, and faith development, however, are required to make this an actuality. While religious have been afforded intensive Christian formation within their congregations, lay persons often have not had similar opportunities. Retreats, value-oriented seminars, and educational programs in the Catholic philosophy of health care can build bridges toward mutual understanding.

Organizations, such as the Academy of Catholic Health Care Leadership, can strengthen Catholic health care ministry through education and formation of their members. The CHA Task Force on Health Care of the Poor recommends that the CHA develop "a seminar on the spirituality, mission, and ethical concerns involved in service of the poor" for adaptation by sponsoring groups, systems, and local facilities. This would undoubtedly be a welcome help in the education and formation of board members and employees.

Catholic hospitals and other health care facilities will survive and even grow in number for service to future generations only if their leadership has a thorough understanding of the philosophy of Catholic health care and a personal commitment to it as a vital Church ministry. The formation of lay leadership becomes even more essential as we explore models of lay sponsorship as an alternative to more traditional means of sponsoring Catholic health facilities.

The role of the Church's pastors

What role do the pastors of the Church play in regard to health care? Although I will primarily speak in terms of bishops, I wish to include all the clergy under the rubric of "pastors."

Because most Catholic hospitals are sponsored by religious communities, bishops are quite sensitive to their autonomy and particular responsibilities. At the same time, because they provide health care within the local churches, bishops, as shepherds of those communities, also have an important role to play in helping health care institutions carry out their individual missions.

The bishop is the leader, the spokesperson, the representative of the Church in his region. His responsibility, however, is not to control but "to foster the various aspects of the apostolate within his diocese and see to it that within the entire diocese or within its individual district all the works of the apostolate are coordinated under his direction, with due regard for their distinctive character" (Revised Code of Canon Law, c. 396).

While he may not interfere in the internal affairs of a religious institute or its institutions, he must be solicitous in those matters which pertain

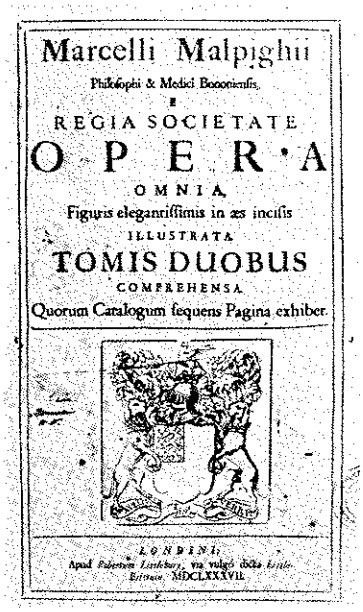
to works of the apostolate. In hospital planning and the expansion or curtailment of services, communication and consultation with the bishop can offer another perspective to meeting the needs of the community.

Because health care is so vital to the Church's overall mission, the bishop exercises a moral leadership when he facilitates a continued Catholic presence in the provision of quality health care for those who need it — including the poor. Especially where several Catholic hospitals are located in a city or metropolitan region, we must find ways to translate dreams and concerns about cooperation and collaboration into reality.

The report of your Task Force on Health Care for the Poor strikes me as a document of uncommon vision and realism. Detailing the increasingly difficult problems surrounding the accessibility to adequate health care for the indigent, the report recommends a plan of action which includes greater cooperation between health care providers, Church agencies, and government to assure all citizens the right to health care. Through efforts such as these, we are building bridges, consistent with and faithful to our mission.

To underline the fact that we can come up with creative solutions to the problems facing health care, I would like to share with you some of the initiatives being taken in the Archdiocese of Chicago. I do so not to suggest that we have all the answers but rather that many of the recommendations in your Task Force report are feasible.

This past Sunday I attended the dedication ceremonies


Marcelli Malpighii
Philosophi & Medici Bononiensis,
E
REGIA SOCIETATE
OPERA
OMNIA,
Figuris elegantissimis in æs incisis
ILLUSTRATA.
TOMIS DUOBUS
COMPREHENSA.
Quorum Catalogum sequens Pagina exhibet.
LONDINI,
MDCLXXXVII.

Marcello Malpighi, Opera Omnia *(London. 1687), title page*

of the Howard Area Center of St. Francis Hospital. This represents a collaborative venture of St. Francis Hospital, which is in Evanston, Illinois, and the Howard Area Community Center in Chicago. Its purpose is to provide health care and education for the many poor in the area, especially newly arrived Spanish-speaking immigrants.

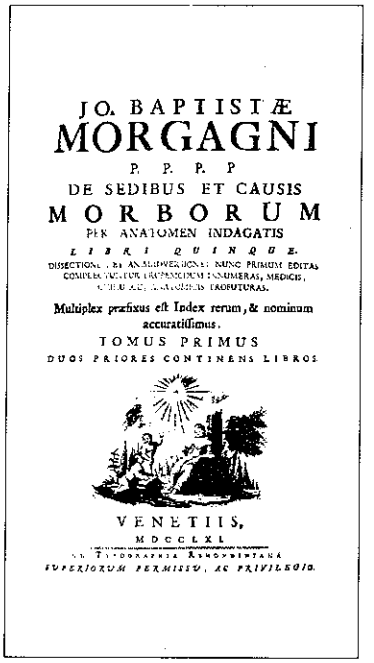
Loyola University of Chicago recently sponsored a symposium on Limited Resources and Commitment to the Poor. It was a response to an address on "The Consistent Ethic of Life and Health Care Systems" which I delivered there at the Foster McGaw Triennial Conference last May. During the symposium the Executive Dean of the Stritch School of Medicine raised the possibility, among others, of Loyola's establishing a community-based primary care satellite clinic in Maywood, one of the poorer suburbs of the Chicago area.

In the past two years we have been developing an area ministry in Englewood, an inner-city neighborhood. Because poverty is widespread in the area, the ten Catholic parishes devote considerable resources to social services. In addition to a Catholic hospital within its boundaries, Englewood also has a clinic staffed by volunteers at St. Basil's parish and a primary health care center run by the Alexian Brothers at Our Lady of Solace parish. The St. Basil operation is two years old and has served between five and six thousand persons. The Our Lady of Solace center is less than a year old, but has served about five hundred people in the past three months.

Motivated by my own concern for the future viability of Catholic health care, over a year ago I called together the chief executive officers of the twenty-three Catholic hospitals in the Archdiocese, along with representatives of the sixteen religious congregations that sponsor them. Our purpose was to discuss how joint effort and collaboration would strengthen our position, and hence our mission, in a highly competitive environment.

The participants agreed to undertake a professional study to ascertain the level of interest in joint action and to chart possible directions for the future. Based upon interviews with the CEO's, the provincials, Archdiocesan officials, and several respected health care experts, the study advocated a change. It indicated that to continue a "business as usual" approach would bring far greater risks than the new model it was proposing. No change would weaken the competitive business position of surviving Catholic hospitals in the Archdiocese and diminish their capacity overall to fulfill their mission. A number of them would be picked off — one by one, usually in the poorer sections of the city. To minimize these risks, the report recommended the development of several formalized structures for joint action which would support both the charitable and the business outreach of Catholic hospitals.

In effect, these structures will establish a new network involving the hospitals, the sponsors, and the Archdiocese and making possible joint action aimed at improving the hospitals' *market competitive positions*, promoting *governance continuity*, and ensuring *maximum mission effectiveness*.


JO. BAPTISTÆ
MORGAGNI
P. P. P. P
DE SEDIBUS ET CAUSIS
MORBORUM
PER ANATOMEN INDAGATIS
LIBRI QUINQUE.
Multiplex præfixus est Index rerum, & nominum accuratissimus.
TOMUS PRIMUS
DUOS PRIORES CONTINENS LIBROS
VENETIIS,
MDCCLXI
SUPERIORUM PERMISSU, AC PRIVILEGIO.

G.B. Morgagni, De sedibus et causis morborum per anatomen indagatis *(Venice, 1761)*

While full acceptance of all the actions recommended by this study is not yet definitive, there is a consensus that the recommendations be pursued and steps taken toward implementation. With the number of people involved, understandably it will take some time to implement fully this collaborative effort. I personally have no intention of turning back, and I am confident that that is true of most of the others who are involved.

These are but a few examples of current efforts being undertaken in one local Church. The task before us throughout this nation is enormous, but I am convinced that we have the motivation, the creativity, and the collective strength to see Catholic health care through this time of change and crisis. I also firmly believe that collaboration — difficult though it may be — is the key to both the survival and the growth of Catholic health care institutions. Collaboration strengthens the weaker institutions and benefits the entire health care apostolate of the Church.

No one of us has all the answers to the complex problems and challenges which health care providers face today. Now is the time for all those who have a stake in and a responsibility for Catholic health care — religious, laity, and pastors — to join together. We must face the challenges together if we are to strengthen and expand the compassionate healing work which we do in Jesus' name.

CARDINAL
JOSEPH BERNARDIN
Archbishop of Chicago

Iohann Schultes (Scultetus), Armamentarium Chirurgicum, Venetiis, 1665 *(Table 33)*

Caring for the Sick is a Way of Announcing the Kingdom

"Whenever you encounter Jesus in the Gospels," writes MacNut, "you find Him either in the process of healing someone or having just finished healing someone or going off to heal someone." Jesus shows concern for the sick to such a degree that He appears to have nothing more important to do.

In confirmation of this assertion, we may state that the Biblical data at our disposal clearly show that cures represented a significant part of Jesus' ministry. To Him, healing a sick person was more urgent than the literal observance of the Sabbath. To Him, the divine and human Physician, there was nothing worse than to see people suffering and nevertheless "pass by."

When Matthew wishes to summarize Jesus' activity in Galilee, he places the cures alongside, and on the same level as, the preaching: "Jesus," he states, "traveled throughout Galilee, teaching the good news of the Kingdom, and healing all the illnesses and infirmities of the people. His fame spread throughout Syria. They brought Him sick people weighed down by various diseases and afflicted with pains — the possessed, lunatics, paralytics — and He healed them all" (*Mt* 4:23-24).

"The journalistic summary as a literary genre," writes Spinsanti, "does not invalidate the historicity of the testimony, according to which Jesus carried on therapeutic work which benefited all in healing every kind of illness. On the contrary, the abundance of cures becomes the indispensable atmosphere to grasp the Gospel Jesus.

"We are struck by the numerical disproportion between the cures narrated in the Old Testament and those recounted in the New. In the former, there are only three detailed accounts of miraculous healing (*Num* 21:9, *2K* 5:10-14, *Is* 38:1-8). The Synoptics, on the other hand, contain twenty-two detailed accounts of cures and a dozen passages mentioning collective healings."

The activity of the apostolic Church is also accompanied by the sign of cures. Among the charisms present in the community at Corinth, St. Paul names the "gifts of healing" (1*Cor* 12:9), and the Letter of St. James, in words characteristic of the Gospel tradition as well, tells us of a ministry of healing by means of which the Lord will relieve the sick as an act of response to the community's prayer (*Jam* 5:13-14).

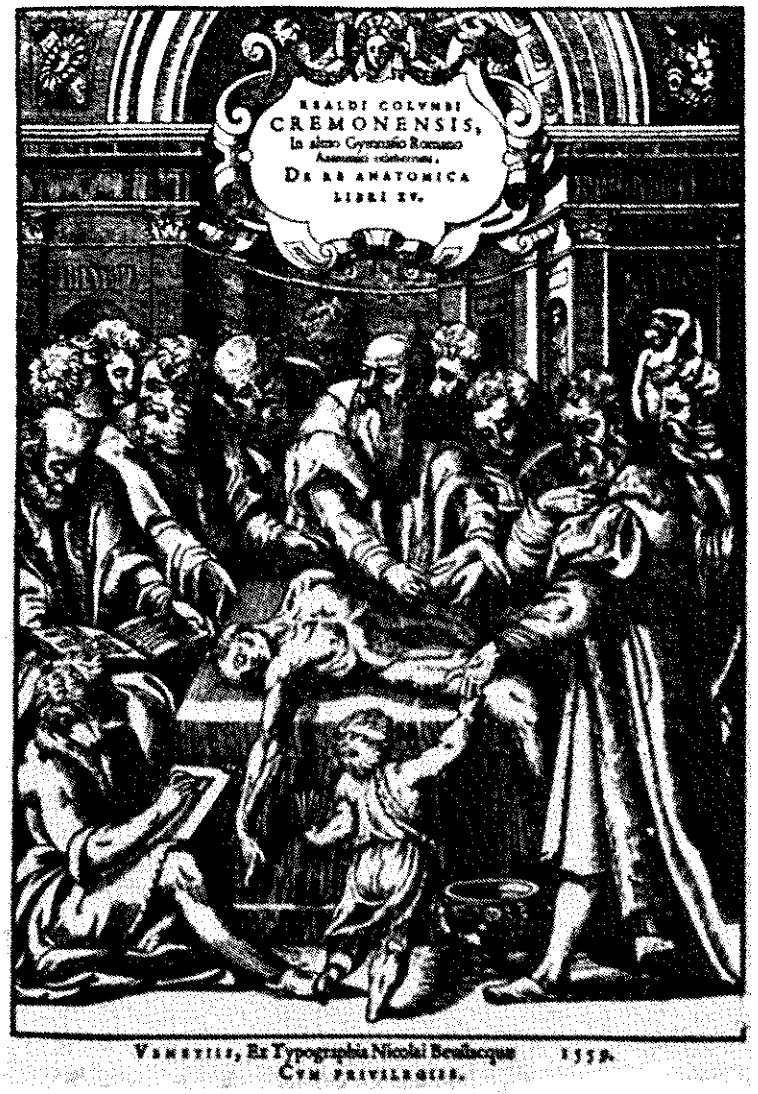
It has been noted that this therapeutic action of the apostolic Church involves an evolution whereby, as charismatic, miraculous healings diminish — without thereby disappearing completely — the stabilization of salvific ministries increases, including the sacraments for the sick. Nevertheless, the meaning and purpose of the sudden profusion of miracles in Jesus' activity and in that of the apostolic Church remain to be clarified.

It appears evident that this meaning requires delving into the specific moment in salvation history represented by the coming of Jesus. The sacred texts in fact point to a double meaning: as a *sign of the Savior's Messianic character* — that is, of the coming of the Kingdom of God in the person of Jesus — and as a *sign of the salvific gift and an anticipation of eschatological salvation* and a *sign of the power of Christ's love* as a revelation of the Father's loving providence at the service of man suffering disease and death, just as he suffers the slavery of moral evil and sin.

The reason for thus presenting our topic is mainly connected with the second meaning; but before setting it forth we shall pause briefly to consider these two aspects or values of Jesus' therapeutic activity.

1. Cures as a Messianic sign

It is clear that we cannot collect or comment upon all the texts which could be rela-



Renaldo Colombo, De Re Anatomica Libri XV, *(Venetiis, ex typographia Nicolai Bevilacquae, 1559)*

ted to this concrete facet; we shall therefore limit ourselves to recalling some of them, accompanying them with a short reflection.

If we open St. Mark's Gospel, recognized to be the oldest, we find that, from the outset, the fundamental reference centers on the Person of Jesus Christ, Son of God: "The beginning of the Gospel of Jesus Christ, Son of God" (*Mk* 1:11), and immediately after the testimony of the Baptist and the Baptism of Jesus, during which the heavenly voice proclaims, "You are My beloved Son, in whom I am well pleased" (*Mk* 1:11), the principal theme of His preaching is enunciated. "After John was arrested, Jesus betook Himself to Galilee, preaching the Gospel of God and saying, 'The time is fulfilled, and the Kingdom of God is near; repent and believe in the Gospel" (*Mk* 1:14) (Sgreccia).

In confirmation of His mission, devoted to opening the Kingdom of God, Jesus "teaches with authority." For Mark, to teach with authority means that Jesus, by way of His activity, manifests His power over evil: "He healed many who were afflicted with diverse illnesses and cast out many demons" (*Mk* 1:14-41). It may be stated that there is not a single chapter in Mark, up to the moment of the Passion, in which healings are not recalled in confirmation of Jesus' mission.

Yet the explanation of the meaning of these prodigies is offered by Jesus Himself. In Luke, when He attributes Isaiah's Messianic prevision to Himself in the synagogue at Nazareth, we read: "The scripture you have heard with your own ears is fulfilled this day" (*Lk* 4:14-21); and in

Matthew, in the reply given to the delegation from the Baptist ("Are you the One Who is to come," they ask, "or should we await another?"), Jesus, referring to the efflorescence of healings taking place around Him and at the same time to the signs foretold by the prophets, responds, "Go and tell John what you have seen and heard: the blind see, the lame walk, the lepers are cleansed, the deaf hear, the dead rise up, the good news is announced to the poor" (*Mt* 11:2-3).

2. Cures as a sign of God's love for man

It is above all the Evangelist Luke who stresses Jesus' inclination to reveal "the merciful goodness of our God, Who has visited and redeemed His people" (*Lk* 1:68), but throughout the New Testament Jesus is the One in Whom "the goodness of God, our Savior, and His love for men have been made manifest" (*Tit* 32:4).

Concretely, the Gospels often emphasize Jesus' compassion for multitudes and individuals. "Jesus went through the cities and villages, teaching in the synagogues, preaching the good news of the Kingdom of God, and curing every illness and infirmity. On seeing the crowds, He felt compassion for them, for they were weary and weighed down, like sheep without a shepherd" (*Mt* 9:36-38). In the healing of the leper, Mark states, "Moved to compassion, He extended His hand, touched him, and said, 'I do want to; be healed'" (*Mk* 1:41). Encountering the widow of Naim, who was weeping over the death of her son, Jesus "on seeing her took pity and said, 'Do not weep!'" (*Lk* 7:13). And when it is Jesus Who weeps over the dead Lazarus, people observe, "See how He loved him" (*Jn* 11:35). On Jesus' face we may discern His love and His participation in all human suffering.

Girolamo Fabrici D'Acquapendente, title page of De Formato Foetu *(Venice, 1600)*

In truth, it is not easy for the sick man, if he lacks solid grounding in the Gospel, to feel God to be near and sense that God is He Who shows mercy and saves. Disease is also a temptation for the faith of the believer. It is therefore explainable that Jesus should have multiplied the signs of His philanthropy in His life so as to disclose the true face of the Father.

One understands as well why He commands His disciples to heal the sick: "When you enter a city, cure the sick you find there and say, 'The Kingdom of God is close to you'" (*Lk* 10:8-9) and later identifies Himself with the sick people they visit: "I was sick and you visited Me" (*Mt* 25:31-46). One understands His concern for conveying to His disciples not just the mission of announcing, but also the power and task of curing all evils, so that the former and the latter virtually constitute an indivisible unity.

The Gospel proclaimed by the Church is indeed a message of life and health; according to the Bible, illness is the sign revealing a break produced between the creature and the Creator, the sign that we are living in conditions that do not correspond to God's original plan. The return to that plan demands a struggle against disease and its causes, the overcoming of disorder and pain. For such a struggle, men's action is both required and fitting, but it is not sufficient. It is Jesus,

then, Who comes to supply the definitive solution with His incarnation, death, and resurrection.

God, Who has created man because He loves him, through the incarnation of the *Verbum* thus introduces Life into human flesh and through His death and resurrection opens a way for the life and resurrection of all redeemed men: "In Him," writes John, "was life, and life was the light of men.... And the Word became flesh and dwelt among us" (*Jn* 1:4-14). "As the Father indeed has life in Himself" (*Jn* 6:40). "I have come that men may have life and have it in abundance" (*Jn* 10:10).

3. Curing the sick and announcing the Kingdom

Now, since the Christian community is called to cure disease with a view towards salvation, carrying on the work of Christ and in union with Him, let us ask where we may recognize the twofold sign of divine power and love and in what Church ministries it is still at work.

We feel we may reply that it is encountered in sacramental action, on the one hand, and in charitable assistance, on the other.

As regards the sacramental sign — with which we do not wish to deal expressly at this moment — we know that, without excluding the possibility that it may be accompanied by the charism for physical healing, it is essentially oriented towards eschatological salvation. The sacraments of the sick, together with faith and prayer, also contribute to the overall health of the patient, in the sense that they help him to undergo illness in a positive way, with the prospect of salvation and in the maturity of faith. From this standpoint, "it is possible to speak of true healing when the one who suffers and till now has been experiencing pain as a slave becomes the master of himself, affirms his own pain with inner freedom, and, if also a Christian, places his trust in God as He Who distributes and administers pain" (Von Balthasar).

As regards the service of charitable assistance, we wish to recall that, if a Church without sacraments would not be the Church of Christ, in the same way a Church without charity — without charity towards the one who suffers — would not be recognizable as the Church of Christ: "I give you a new commandment — that you love one another as I have loved you, so that you too may love one another. In this all shall recognize that you are my disciples, if you have love for one another" (*Jn* 13:34-35).

The pastoral reflection on our topic becomes explicit when we start from these last considerations: we join the new commandment to the other Gospel recommendation that "our light shine before men, that they may see that our works are good and glorify the Father Who is in heaven" (*Mt* 5:16), and we shall more readily understand the application and evangelizing force of the mandate "Go, cure the sick, and announce the Kingdom" (*Lk* 10:8-9).

"The works of charity towards the sick," St. Camillo De Lellis repeated, "are a most powerful means of converting unbelievers; the Turks, at just seeing them, will feel overcome by the divine force of our holy religion" (Vanti). It is, in fact, a matter of making the message of which we have been rendered bearers believable through the consistency of our own lives. Yet it is a consistency from which the charity of a disciple of Christ shines forth.

In its *message to the sick*, the Second Vatican Council states that the Church "senses your imploring eyes set upon her, burning with fever and dimmed with fatigue, questioning glances which vainly seek the reason for human suffering and anxiously ask when and where comfort will come." These expressions call to mind the attitude of the cripple at the "Beautiful Gate" of the Temple when Peter and John passed by and said to him, " 'Look at us!' And he looked at them, hoping to receive something" (*Acts* 3:4).

If the sick set their imploring eyes, burning with fever, upon the Church, it is because the also hope for a response like the one given the cripple by Peter and John. And we as well, like them, in the name of the Church, with our word and our aid, may say to them, "We have no silver or gold, but we possess a hope and a consolation which Christ has promised for you too!"

We may understand, then, why the Church, in speaking to the presbyters, tells them that they are "obliged to serve all, but that in a special way the poor and the weak have been entrusted to them, those to whom Jesus Himself wished to show a particular bond (*Mt* 25:35-36) and whose evangelization is seen to be a sign of the Messianic work (*Lk* 4:18)" (P.O. 16).

FR. RENATO DI MENNA
Camillian Missionary
Burkina Faso (West Africa)

Magisterium of the Church

Illuminated page from a codex (ca 1372). Bibliothèque Royale de Belgique

Addresses by the Pope

The Spanish Bishops' Document on Euthanasia

To live the ideal of true service is to build the civilization of love

The goal of the Church here in India, as anywhere else in the world, has been to proclaim the promise of life in Christ, *in whom "it pleased God to make... all fullness dwell and by means of him to reconcile all things to himself, pacifying with the blood of his Cross, that is, by means of him, the things which are on earth and those in heaven" (*Col *1:19-20).*

The Church is committed to this work of reconciliation and of service *in the spirit of Jesus himself. As the prophet Isaiah predicted, Jesus was sent into the world, but "shall not crush a bruised read nor extinguish the wick of the dying flame," but rather "as an alliance of the people and light of the nations" (*Is *42:1-6).*

In the course of past centuries and today, the Church continues this work of the Son and servant of God in this region of India through the selfless service *of innumerable men and women of faith and untiring love...*

The fervent communities of faith and of love which have flourished throughout this region, the educational institutions which have prepared so many young men and women to participate responsibly in the development of the country, the health care centers which for over a century have been caring for the sick and the needy without exception or distinction, and the multiple additional activities of the Christian community to raise up and develop the population of this region — all of this is living testimony of the mission of service of the Church of Christ.

*The Church is the pilgrim people of God advancing towards its own end, the eschatological Kingdom in the house of the Father. In her journey among the other communities and religious traditions, and together with them, the Church "recognizes in the poor and the suffering the image of her poor and suffering founder" (*Lumen Gentium, *8). She thus feels particularly called to defend and promote everywhere* the inalienable dignity of every man, woman, and child, *in all nations, and of all social conditions.*

(Mangalore Airport, India, Thursday, February 6, 1986)

The promotion of the dignity and the liberty of man is an essential dimension of the mission of the Church

Precisely so, in the programme of your work, you have established a close bond between the struggle against misery and hunger, and the affirmation of the right to life and liberty. During my recent pastoral journey to India, in meeting the leaders of the traditional religions at Madras, I expressed the same conviction: "The abolition of inhuman conditions of life is an authentic spiritual victory, because it gives man liberty and dignity".

*The promotion of the dignity and the liberty of man, which are clearly evangelical values, is an essential dimension of the mission of the Church. Man is, in fact, "the primary and fundamental way for the Church, the way traced out by Christ himself" (*Redemptor Hominis, *n. 14). That is why the Church does not limit itself to the abstract proclamation of such values, but is concerned about being united with man in the concrete reality of his needs and sufferings, his anxieties and his hopes.*

Thus, the Church does not cease to defend with all its power human life, which comes from God. Permit me to observe, with sorrow, that, in face of a very deep and, as it were, sacrosanct sensitivity to offences against life which are the result of hunger, war and terrorism, one does not find a similar sensitivity to the crime of abortion, which, however, cuts off innumerable innocent lives.

Recalling, besides, that Christ identified himself with those who suffer from hunger, thirst, nakedness and all sorts of privations, the Church is concerned with all who are struggling in misery and underdevelopment. There she is in the front line herself, and shows all men of good will the urgency of struggling against such inhuman conditions, in a commitment to justice which is the fruit of fraternal love.

The Church cannot but be concerned about another hunger: the "hunger for liberty" of men and peoples oppressed for political, ideological and racial reasons. Liberty is a property of man as a son of God; it is a good which belongs to the inviolable intimacy of the person and which cannot be trampled underfoot, without, in a certain sense, putting the person interiorly to death.

(To the Delegation from the Organization "Food and Disarmament International" which was holding its second international conference in Rome, 13 February 1986)

God is near to those who suffer

Jesus, who personally chose the most atrocious suffering for love of us, always had a particular predilection for the sick. So you know that you are never alone. God is always near to one who suffers. And also the Pope is near to you.

My prayer to the Lord is to implore for you every possible relief and comfort, as also the longed-for healing.

I would like also to invite you, however, to transform your suffering into sacrifice of purification and into gift of salvation.

You sick and you disabled share with Christ the weight of the cross. And, for this very reason, you have a privileged role in the building up of the Church; your sufferings, united with those of Christ, become an instrument of redemption and of salvation.

*There is a secret that can profoundly transform the attitude of one who is suffering in the body: it is that of trusting abandonment in God. This is not a kind of facile, consoling and, ultimately, alienating escape. It requires truly a very special grace to be capable of this abandonment. But the Lord is there, ready to grant it, so that the suffering may become a pledge of eternal recompense, and also, from this point on, a stimulus to reflection and an example for all who meet us. He who has promised not to leave unrewarded one who performs a simple gesture of courtesy for love of him (*Mt *10:42), will regard with a much more bountiful kindness one who has made the gift of his whole self in the condition of illness.*

(To the sick in Prato - Italy, 19 March 1986)

Arouse the conscience of the world to conquer the tragedy of leprosy

"He was met by ten lepers" *(*Lk *17:12). In another Gospel passage it is said that Jesus "touched" (*LK *5:13) the leper who came to him.*

Jesus thus lets himself be met, he made himself our neighbour in order to be met by us precisely on the most tragic and heavy threshold of suffering. From the Cross he teaches us to seek his countenance in those who are sick, to draw near to those who suffer, meeting them precisely where they experience their need.

(...)

Christ's example must encourage us to persist in our efforts with regard to those social environments that are still insensitive to or powerless before the tragedy of leprosy. One must not surrender, even if efforts sometimes appear to bring no results, or one finds oneself faced with social groups in which terror of the disease prompts inhuman measures of defence, the result of instinctive and irrational aversion towards the diseased.

*We must continue to work so that even these sectors, which seem the most resistant, open themselves to hope as well. Let us heed the cry addressed to Jesus by the lepers: "*Jesus, Master, have mercy on us*" (*Lk *17:13).*

At this point it seems to me fitting to recall how the Church has always been faithful to her mission to proclaim the merciful gesture of Christ, to imitate them and to translate them into concrete efforts of help, of comfort, of concrete assistance.

How could we forget the example of Francis of Assisi, who, when he encountered a leper begging on the outskirts of the city, dismounted from his horse, came to his aid and kissed him, seeing in that unfortunate the very image of the suffering Christ, loved and sought by him? How could we fail to mention once again Father Damien de Veuster, who lived with lepers and died a victim of the same disease; Father Jan Beyzjm, who laboured for the lepers of Madagascar; Blessed Peter Donders, the Dutch missionary who spent twenty-eight years in the leprosarium of Batavia as the voluntary chaplain of the diseased? And may I be permitted to name men like Raoul Follereau and Marcello Candia, who have done so much in the service of lepers in our own day. By their example, they have shaken the conscience of the world and have begun a movement to awaken people to the need and duty to assist those stricken with leprosy. In addition to them, I would like to

recall the thousands of priests, doctors, religious, missionaries, lay persons, catechists and volunteers who have wished to make themselves friends of the lepers to the point of founding and sustaining with their active presence leprosariums, hospitals and specialized centres for research and treatment. I applaud them all, extending to them my lively encouragement and gratitude. On behalf of the whole Church and of mankind. I thank them and invite them to continue their patient and courageous work.

(To Association of Friends of the Lepers, Sunday 21 September 1986)

Encounter with suffering in the cathedral of Lyon

TO THE SICK: "IN YOUR PRESENCE THE WORLD REDISCOVERS THE MEANING OF LIFE AND SELF-DONATION."

(Cathedral of St. John, Lyon, France, October 5, 1986)

Today you fill this temple of God, this magnificent Saint John primatial church which goes back to the twelfth and thirteenth centuries. It is an important historic site.....

And behold that today it is you that occupy the place of honor on this holy site: the sick in fact occupy a privileged place in the Church, which is the Body of Christ, so close to his wounded and perpetually open Heart, as we have contemplated it this morning at Paray-le-Monial.....

But, in suffering frequently from inevitable dependence, you would also like to conduct some activity, insofar as your health permits, feel useful to society, to the Church. You wish to have your own position, to have access to the network of solidarity with other patients, but also with those who are well.....

Useful? You certainly are, with your simple presence. In a world marked by anonymity, technology, feverish haste, concern for performance, the thirst for immediate sense pleasures, you are simply there with the value of your personhood, with your interiority, with your need for authentic human relationships. Then, in your presence, the world pauses, reflects, begins to consider the essential once more: the meaning of life, unselfish love, self-donation.

If you are fortunate to have faith and if you gaze at Christ crucified, then you penetrate more deeply into a great mystery hidden from the eyes of the world. After having healed the greatest possible number of sick people, Christ went from compassion to passion. He took suffering upon himself without attempting to explain it. No one has entered into it as he has. In him, suffering was linked to love, was redeemed. In being offered, it has become a redemptive power, transfigured in his Resurrection. Yes, Christ has inserted into the depth of suffering the power of the Redemption and the light of hope. Accordingly, the believing patient — in the crucible of his test which remains intact — silently unites himself to the Redemption of Christ, like Mary at the foot of the Cross. It is not a question of passive resignation or fatalism, for in such a sick person the desire to live with the aid of doctors subsists; but he is prepared to entrust his life to God when the time comes for the great passage. He lives through the grace of love. It is a gift of God. It is what I ask for you.

I can assure you: the efficacy of my ministry as the Successor of Peter for the faithfulness and unity of the entire Church owes much to the prayer and offering of the ill. I confide it to you. And you, you have a great place in my heart and in my prayer. I have dedicated a long letter to you on the Christian meaning of suffering, Salvifici Doloris, *on February 11, 1984, on the occasion of the feast of Our Lady of Lourdes, so benevolent towards the sick.*

TO PHYSICIANS: "AS DEFENDERS OF HUMAN LIFE, YOU ARE GOD'S COLLABORATORS."

(Cathedral of St. John, Lyon, France, October 5, 1986)

Together with the sick and the handicapped, I greet the representatives of all those who devote their time, their specialties, and their hearts to giving them comfort: doctors, technicians, researchers, teachers, medical students, spiritual helpers, members of the health and administrative staff who practice medical science, mental treatments, or social work and human sciences as well.

I know that Lyon is an important center for medicine in all its branches and includes, among other things, an international center for cancer research.

I encourage you to continue research valiantly, to provide treatment with the maximum competence, to combat disease in all its forms and natural or human causes as well. All of this forms part of the plan of God, who has given man intelligence and skill to progress in discoveries on the human

organism and place the fruits at the service of man. As defenders of human life, you are God's collaborators.

Today medical progress calls for broad solidarity, rigorous orchestration among you, believers and non-believers, with the help of the State and with the contribution which the Church has willingly made in the course of history, according to her possibilities. In this regard, the Gospel is an impressive appeal for mobilization. The new Commission for the Apostolate of Health Care Workers which I have instituted at the Holy See manifests this concern.

Health professionals have not only technology to offer, but a warm devotion which comes from the heart, an attention to people's dignity. Seek not to reduce the patient to an object of treatment, but make him the first ally in a war which is his war. And, in the face of the serious ethical problems confronting your profession, I encourage you to find the demanding answers which accord with the dignity of the patient's life, his nature as a person.

Your profession, dear friends, often requires exhausting effort on your part. You sometimes feel impotent before so many sufferings, before your own limitations, before the precariousness of life. But render this noble service to mankind! You are like the Good Samaritans of the Gospel. And this service has no borders, for the demands of health care are immense and urgent in the Third World.

Your patients, I was saying, need the most humane care possible. They need spiritual care: you feel yourselves to be on the threshold of a mystery which is theirs.

At the Marian Shrine in Florence, an "Embrace" of the Suffering

MARY AS THE FIRST AND INCOMPARABLE MODEL FOR VOLUNTEERS AND MERCY

(Florence, Church of Our Lady of the Annunciation, to patients and volunteers, October 19, 1986)

It is not by chance that we have gathered here today in a sacred place dedicated to the title of a Woman who has been the object of an exceptional, divine communication.

The very name of the church immediately calls to mind the chapter of St. Luke's Gospel where the archangel Gabriel presents himself in the name of God to the young Virgin of Nazareth to announce to her that the Son of God has become the Son of man (Lk 1:26-50), so that the son of man may become the son of God. Mary, after receiving the extraordinary message, sets off for the mountain village to visit another woman who is experiencing need.

In this compact, sublime page of the Gospel, Mary presents herself to the men of every time as the first and incomparable model for volunteers and mercy. With the promptness of her "Here I am, the servant of the Lord," she freely offers to collaborate in the realization of the divine plan, directed towards the salvation of all men. Open to the dynamism of God's initiative, she does not remain passive, but, in tune with the salvific design, goes into action without delay and hastens to offer her feminine, careful assistance to an elderly woman who has become a mother beyond the laws of nature.

Possessing the clear perception that the "mercy" of God extends "to those who fear him," she in fact actively enters into the history of the Church, setting out alongside men, who have become her children, to be a sign of this divine mercy. And thus, as a motherly inspirer of vocations and distributor of graces, she places herself at the head of a host of volunteers who have formed an unbroken chain of Christian solidarity at the service of their fellow men over the past two thousand years.

I cannot conclude these considerations without adding that, for the exercise of charity and social activity, Christian solidarity has always found its natural support in volunteers, that is, in those who, beyond the commitments of their own professional obligations, offer their free time, in an evangelically unselfish way, to benefit their suffering fellows.

Every believer who has meditated on the meaning of Christ's words in the depths of his heart, has no difficulty in feeling called in the first person to deal with the needs of his brother, whether it is a question of physical pain or of moral and spiritual suffering. In sweetening the ocean of human malaise, the individual's initiative is irreplaceable to reach the person of the sufferer as such.

Yet organizational activities are always useful and, indeed, necessary wherever there is a demand for large-scale cooperation and the use of technical or financial means superior to private possibilities, which rather frequently remain limited to an occasional commitment (cf. Salvifici Doloris, *29).*

Dear brothers and sisters, as words of

farewell, I warmly exhort you to draw inspiration from the model of Our Lady of the Annunciation.

Do not forget, dear patients, that pain, together with its burden of physical and moral suffering, conceals a vital force which, if offered in a Christian way, immensely contributes to the good and renewal of the world.

I wish you, dear volunteers of the different associations, the promptness and generosity of Mary Most Holy to make visible to the often distracted men of the contemporary world the love of God, who wants to give everyone the joy of his own life.

I bless you all from the heart.

HOLY MARY OF THE INNOCENTS. AN EXPLICIT REFERENCE TO THE WOMAN TO WHOM A NEW HUMAN EXISTENCE WAS SUBLIMELY ENTRUSTED FROM ON HIGH

(Florence, Church of Our Lady of the Annunciation, to the patients and volunteers, October 19, 1986)

Dear brothers and sisters, it is with profound satisfaction that we observe a vanguard in evangelical charity here in Florence with the initiative of the Confraternity of Holy Mary of Mercy, arising in the middle ages for the specific purpose of bearing witness to active, concrete faith in caring

for brothers and sisters in difficulty: the sick, the plague- stricken, young girls in poverty, orphans, widows, prisoners, and pilgrims....

One of these more emblematic institutions was the initiative in favor of the group of the smallest and most needy, lodged in a building constructed for this purpose which is still known today by the name — rich in Tuscan and Christian flavor — of "Hospital of the Innocents": the children abandoned by their own parents, as the founding text in Latin states, "against the rights of nature."

It was not the simple foundling hospital for the care of waifs, but a set of wards which harbored separate communities of little boys and girls, rooms for staff members, and the varied demands of education up to training in crafts, an experimental center ahead of its time. A unique "city of young people" was in fact created ante litteram *through a decision made by the vast majority of the People's Council of the city of Florence, as if to signify the commitment of the entire community of citizens.*

To plan the building and depict the characteristic moments of the institution's inner life, famous painters and sculptors were called. The "Hospital" thus became a monumental complex among the most outstanding in the City.

The official name of the totality was "Holy Mary of the Innocents," explicitly referring to the Woman who was sublimely entrusted with a new human existence from on high. The Mother is indeed by nature guardian of life, in the name of that God who, as the Book of Wisdom affirms, "did not create death and does not take delight in the ruin of the living. He has in fact created everything for existence" (Wis *1.13-14*).

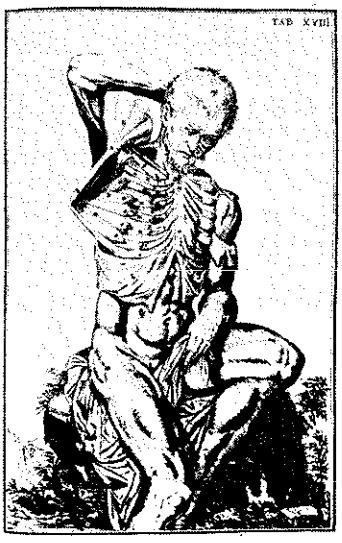
This Biblical message calls us to reflect as well on the condition of the human beings in the process of being formed, destined to the fullness of development, indeed to participate in the very life of God, who have an even greater need than others for social solidarity to attain their natural end.

Unfortunately, we are witnessing the frequent spectacle of practices devoted to cutting short the path of so many little human lives, as yet unborn, by violence. And the Christian, educated in the school of the archangel's announcement to Mary, in the reality of Christ, who is Life made human life, cannot remain indifferent or inert in the face of such a growing tragedy.

It is comforting to observe that there is no lack of men and groups committed to aiding nascent life, like the Pro-Life Movement, which had its origin, or at least its decisive impulse, in Florence, inspired by the great Christian, humanistic, and cultural tradition in the city's history.

To all these people, to all the Centers aiding life, my most cordial and deep encouragement.

Document on Euthanasia by the Commission for the Doctrine of the Faith of the Spanish Conference of Bishops



Giulio Casseri, Tabulae Anatomicae *(Padua University Library)*

When the author of the Book of Ecclesiastes twenty-three centuries ago wrote his beautiful poem beginning "For everything there is a time.... a time to be born and a time to die" (3:1-2), he was living in a period far removed from ours during which being born and dying were understood to be natural events having "their time" and scarcely allowing for intervention or modification. The rapidly accelerating progress of biomedical science is steadily altering the initial and final events in human existence. Biomedical science intervenes in the origin of human life from the standpoint of conflicting interests; on the one hand, some techniques destroy life once it has been conceived, and, on the other, ever more sophisticated, costly technology enables a significant and increasing number of people to satisfy their desire for paternity and maternity.

At life's other extreme, dying is also being altered in "its time." The life expectancy of a boy or girl coming into the world today in the technologically advanced countries has doubled with respect to the not-too-distant past Developments in medicine have made available therapies with which we may effectively fight against a great many diseases, allowing us to cure and prolong the lives of numerous patients

But, like all human progress, the advance in the struggle against disease and death also has its drawbacks. In recent literature, the term "therapeutical obstinacy" has been coined to refer to medical action which, though aimed at prolonging the life of the patient, may prove to be extraordinarily cruel if involving the prolongation of an irreversible process accompanied by serious pain and anguish. Mention is frequently made of certain famous people whose deaths have aroused suspicion as to the application of therapeutical obstinacy

Death is ceasing to have "its time" because our culture does not know how to integrate it into our conception of life. Recent literature concerning death has pointed out that in great measure death is a taboo subject, excluded and concealed by our society. Much is being written on contemporary man's difficulty in assimilating the fact of death. The prospect of death produces considerable anguish in many of our peers, making it extremely hard for us to relate to the seriously ill patient — we do not know how to approach him, accompany him in his fears and hopes, provide him with the support and warmth he so greatly needs.

An increasing number die in the large hospitals, where the standards in technical care are very high at the same time as human attention to the sick and dying is utterly inadequate. It must be stressed that not only is it health personnel that finds it hard to establish a personal relationship with the patient, but even the family itself does not manage to do so successfully, often creating an atmosphere of disinformation or deceit with respect to the ill and blocking their communication with loved ones. Within this general critique, we should also include on occasion the chaplains of the various religions, who run the risk of restricting themselves to ritual or sacramental attention without aspiring to create a climate of dialogue and companionship for the patient

1. The current polemic concerning euthanasia

The present debate on euthanasia is inseparable from the way our culture experiences death. The word "euthanasia" is of Greek origin and initially meant "good death" — without pain, in full consciousness. Its current meaning has been in existence since the sixteenth century: the acceleration or provocation of the death of a sick person effected by someone else for the purpose of putting an end to unbearable and useless suffering. The polemic concerning the legitimacy of euthanasia — which had ceased with the spread of Christianity throughout Western culture — reappeared in the nineteenth century when the first movements and associations supporting this practice were established.

Today there is once again intense debate on euthanasia. A number of factors are involved in this situation: the process of secularization, the crisis in religious values in the Western world, the absolute value attached to personal freedom, which leads to asserting that the terminal patient has the right to dispose of his own life if he so desires. There is also no question that legal authorization of abortion has had repercussions on euthanasia as well. When the law accepts the suppression of life in gestation, it is heading downhill towards the acceptance of suppressing other human lives.

In our country, voices are now being heard in favor of euthanasia. This is a matter of current concern for the entire Church wherein our responsibility as pastors requires that we direct an enlightening word to both believers and men and women of good will who are concerned about the possible legalization of euthanasia. A few years ago the Sacred Congregation for the Doctrine of the Faith made public a document on euthanasia to which Pope John Paul II has also referred on several occasions. (1) Some Conferences of Bishops have dealt with this subject in recent years as well. (2) In communion with the Catholic Church, the Episcopal Commission for the Doctrine of the Faith now addresses Catholics and Spanish society with this Note.

2. The Christian message on death and life

Neither the Old nor the New Testament directly and explicitly deals with euthanasia. The Bible, however, contains a fundamental affirmation: God is the Lord of life and death; He is the Creator, the one who has called man into existence and given him life as a gift, as a blessing which man should care for and promote, but never suppress. (3) In the Biblical tradition, there is continuous advance and progress in increasingly stressing the value of all human life and the fact that it cannot be disposed of. "Thou shalt not kill" is given broader and broader applications in such a way that the principle of the inviolability of human life is extended to every person. Jesus attaches special forcefulness to the demand that all human life be respected. The Church, deepening her insight into this principle, explicitly teaches that the inviolability of human life extends to all phases of man's existence.

For Jesus, however, the biological and temporal life of man, while representing a basic value, does not constitute the absolute, supreme value. For Him, the only absolute is God and His Kingdom. Consequently, in the service of God, his neighbor, and the community, man may devote, consume, and even shorten his life, provided he does not directly seek to destroy it.

Jesus declares that whoever wants to save his life will lose it; but whoever gives it for His sake will find it (5); no one has greater love than the person who gives his life for his friends. (6) For one who believes in Him, Jesus is the model in both life and death. (7) Jesus experiences His death as the final act of abandonment into the hands of the Father, as a definitive commitment to the mission received. The life of Jesus, shaped by the statement "Here I am to do your will," (8) ends with "into your hands I commend my spirit." (9) Jesus does not take His life, but freely, confidently, and generously places it in the hands of the Father "for us men and for our salvation." (10)

The Christian, called by his faith to follow Christ when He hands Himself over, in the proximity of death should share in the sentiments of the Lord as well. For the follower of Jesus, death is not meaningless, but the moment in which he places his life in the hands of a God Who has called him into existence, Who has providently cared for him, and to Whom he confidently entrusts himself in the end. His death is not a useless sacrifice; it is like the grain of wheat falling upon the earth which must die in order to yield abundant fruit. (11) In this way, in living and in dying we belong to the Lord. (12)

3. Different situations involving euthanasia

We previously indicated that, for Christian faith, human life is a fundamental value, but not the absolute good, which should be unconditionally safeguarded. This estimate of human life has been present in the Catholic moral tradition: the Church has never accepted so-called direct, active (or positive) euthanasia — i.e., action whose only purpose is to put an end to the life of a patient or accelerate his death. Such a practice goes against the nondisposableness of human life. (13)

But the tradition of the Church, basing itself upon the moral principle of double effect, has accepted the legitimacy of resorting to pain relievers (e.g., certain derivatives of morphine), even if their administration might indirectly occasion a reduction of life. (14) This same Catholic morality, basing itself upon the distinction between ordinary and extraordinary means, or, rather, proportionate and disproportionate ones, (15) also affirms that medicine is not always obliged to do everything possible to prolong the life of a patient. There are situations in which it is legitimate and even obligatory to refrain from applying disproportionate and unusual therapies which serve only to prolong the irreversible process of dying to the point of abuse.

The above-mentioned document of the Sacred Congregation for the Doctrine of the Faith, "Declaration on Euthanasia," expresses this view: "No one may authorize the death of an innocent human being, even if faced with an incurable or dying patient. No one may request

such homicidal action for himself or for others entrusted to his care. No authority may legitimate or permit it. It is a violation of the divine law, an offense to human dignity, a crime against life, and an attempted murder of humanity " This Declaration consequently rejects direct, positive euthanasia.

But the "Declaration on Euthanasia" affirms, in turn, that it is always licit to content oneself with the normal, habitual means offered by medicine. There are, however, therapies in use which entail serious dangers or include exaggerated expenses and whose application must not be imposed as obligatory. Not using such therapies would not amount to suicide; rather, it would mean "either simple acceptance of the human condition or the desire to avoid putting into practice medical measures out of proportion to the results which could be expected or a will not to impose excessively heavy expenses upon the family or the collectivity In the face of the imminence of an inevitable death... it is licit in conscience to make the decision to renounce treatments seeking only to prolong existence precariously and painfully, without, however, interrupting the normal attention provided to the patient in similar cases."

Consistent with the previous principles, the Declaration recognizes as legitimate "the right to die with serenity, with human and Christian dignity." It also prefers to speak of "proportionate and disproportionate" rather than "ordinary and extraordinary" means: in evaluating the disproportionateness of a therapy, not only should its cost and complexity be taken into account, but its difficulties and risks, the probability of success, the patient's overall condition and physical and moral strength must be appraised.

All of the foregoing means that what some term "orthothanasia" — i.e., death at its proper "time" — should be seriously considered, with respect for the patient's human dignity and avoidance of abusive prolongation of his life. (16) We understand that it is not easy to apply these principles to the complex, concrete situations which may arise and, above all, it is quite comprehensible that health personnel — as a result of their profession and training in service to the sick person's life — should not renounce the application of all the therapies at its disposal. But it should also be clearly affirmed that neither doctors nor nurses are obliged to do everything possible simply to prolong the existence — sometimes merely biological — of the patient; for there are circumstances in which what is most humane and most Christian is to allow the patient to die in peace and dignity, in the light of his personal option or that of his relatives

A specific case where the problem of euthanasia is more strikingly posed today is the birth of children with anomalies or congenital malformations. It is a field in which the legal and social acceptance of abortion may have greater repercussions; if abortion is permitted up to the twenty-second week or even later when there is probability that the foetus has anomalies, one is sinking into acceptance of eugenic euthanasia. The aforementioned general principles may also be applied to this problem. Without being able to deal herein with the complex cases which may arise — resorting to two extreme cases by way of example — we affirm that it is legitimate not to prolong with ordinary means, which would be disproportionate in this instance — and while never directly doing harm to — the life of an anencephalic child who, for lack of a structured brain, will be unable to develop his personality even minimally and is irremissibly condemned to an early death. On the other hand, we regard it as ethically unacceptable to refuse medical attention or an operation to a child with Down's syndrome (mongolism) when such care would have been provided if not for this illness. We are dealing with real human beings who, in spite of their intellectual deficiency, have enormous potential for developing their emotional lives and interpersonal relationships. There is a serious lack of humanity in refusing these children the attention they deserve and would never be denied if not for their illness.

4. The problem of legalizing euthanasia

There are a good many advocates of depenalizing direct, positive euthanasia in different countries. But the legal acceptance of euthanasia would constitute a most serious danger for a basic value grounding the social order which the legislator must protect: respect for human life, now gravely threatened by the legalization of abortion and a significant deterioration of moral and human conscience.

Numerous studies stress, moreover, that, underlying a patient's request for euthanasia, there is quite often a concealed plea for the human attention and warmth we do not succeed in giving him These studies also emphasize that the terminal patient typically goes through a series of psychological phases, in some of which he may request that his life be brought to an end, though such is not his real, definitive desire.

Frequently, one about to die realizes this fact in a more or less confused way. The anguish he experiences affects his physical pain, tending to augment it. It is thus necessary to treat both of them simultaneously before anguish can dominate the patient. But this is not possible if those caring for the ill allow themselves to be overcome by their own anguish. Unfortunately, in our society anguish in the face of death may be so great and so little recognized that neither the family nor the hospital personnel wishes to deal with the death of another, establish any real communication with one who is dying, or accompany him during this final stage of his life when the presence of someone else is most needed in order for a man to die humanely On the other hand, the successful results obtained at certain institutions where stress is placed upon a personal relationship with the patient and the alleviation of his pain indicate the road along which progress can be made. In addition, medicine and nursing are faced by the challenge of using pain relievers in the most fitting, rational way, for they can lessen or eliminate the suffering which frequently gives rise to these anguished requests.

The deterioration of the doctor's social image may also be a source of concern, since, if euthanasia were accepted, the physician might be seen as an agent of death, and the creation of a relationship to the patient based on trust would be interfered with. The acceptance of euthanasia might lend itself to serious abuses as a result of the economic interests deriving from the death of a good many people.

Finally, the legalization of euthanasia would constitute a grave step forward in the deterioration of respect for human life; it would

mean continuing a decline that could lead to the worst consequences. In the context of aging societies, where the elderly are refused the right to occupy a place in the social fabric, where the person tends to be valued for his performance capacity or productivity, steps would be taken to move from euthanasia requested by the patient to the same practice applied to those who are unconscious or even against people's will.

5. Reflection and final exhortations

As we previously indicated, the problem of euthanasia is inseparable from the attitudes prevailing in our societies in the face of death. It is necessary to reintroduce death into our mental framework without denying or repressing it. Death inevitably forms part of life, and its repression originates feelings of anguish in us and blocks our relationship to people approaching the end of their existence. We must clarify our compassion towards the terminally ill so as to discern therein our own fear of death, which impedes an adequate human relationship to the dying.

Christian faith should be a great help to succeed in integrating the fact of death, which is not the endpoint of life, but the way to a definitive life close to God. Whoever believes in Jesus should aspire to see death face to face as a passage towards the arms of a Father Who will fulfill the wish for perpetuity and happiness engraved upon the human heart. A healthier attitude towards death is needed as an indispensable condition for offering the seriously ill and dying our close companionship, to be able to take them by the hand affectionately and confront their anguished gaze.

We must create an awareness that the ill need much more than the application of sophisticated medical therapies. Our major hospitals are in danger of becoming dehumanized institutions where a multitude of individuals bend over the patient's bed each day without any personal, human relationship to him. But these interpersonal relations are decisive in attending the patient, even from a strictly therapeutic standpoint. The need to humanize hospitals is a great challenge and imperative task which should be of urgent concern for the professionals in medicine and nursing. Those who are believers are faced with a marvelous field of action in which to express the consequences and demands of their faith.

Both chaplains and men and women religious working at health care facilities stand before a set of unavoidable duties and exigencies in this regard; while cultivating their medical skill, they should, therefore, strive to increase their knowledge of psychology and sociology to relate better to the ill and, above all, contribute a significant witness to charity and humanity at institutions where the standards of respect and affection towards patients are seriously defective.

The Church feels specially sent to preach the Good News to the poor and disinherited; among them, a privileged place is occupied by the ill and dying, those who experience suffering, anguish, and despair in their own flesh. The sick were very close to the Lord, Who passed through this life doing good and curing them. (17) At life's close they could say to us, "Come, blessed of my Father, for I was ill and you visited me" (18) This should be the attitude of Christians in the presence of their sick brothers and sisters. "To visit" means a great deal: to remain close, to seek to provide human warmth, to share the hopes and fears of one who, precisely because he is suffering, is a sacrament of the Son of God, Who humiliated Himself, sharing our destiny and our death.

Madrid, April 15, 1986

Commission for the Doctrine of the Faith
Spanish Conference of Catholic Bishops

Presiding Bishop
ANTONIO PALENZUELA

Member Bishops
ANGEL TEMIÑO
ANTONIO BRIVA
EDUARDO POVEDA
ANTONIO VILAPLANA

Secretary
ANTONIO CAÑIZARES

NOTES

(1) Cf. SACRA CONGREGATIO PRO DOCTRINA FIDEI, *Declaratio Iura et Bona de Eutanasia, e maii, AAS* 72 (1980), 1542-1552; the Spanish version is contained in *Ocho documentos de la Sagrada Congregación para la Doctrina de la Fe* (Madrid: Secretariat for the Doctrine of the Faith of the Spanish Conference of Catholic Bishops, 1981), 145-163. JOHN PAUL II, "Address to the Bishops of the United States," in *Ecclesia*, no. 1954 (1979), 1314; "To the Members of the World Medical Association," in *Ecclesia*, no. 2150 (1983), 1448-1449; "To Two Work Groups Sponsored by the Pontifical Academy of Sciences," in *Ecclesia*, no. 2244 (1985), 1451.

(2) PERMANENT COUNCIL OF THE GERMAN CONFERENCE OF CATHOLIC BISHOPS, "Man's Right to Life and Euthanasia," dated December, 1974, in *Ecclesia* (1975), 1239-1241 PERMANENT COUNCIL OF THE FRENCH CONFERENCE OF CATHOLIC BISHOPS, "Note on Euthanasia," dated June, 1976, in *Ecclesia* (1976). BISHOPS OF ENGLAND AND WALES, "Declaration on Euthanasia," in *La Documentation Catholique*, 72 (1975), 46. FAMILY COMMISSION OF THE BISHOPS OF FRANCE, "Vie et mort sur commande," *La Documentation Catholique*. 81 (1984), 1126.

(3) Num 14:28, 27:16; 2K 2:2; Job 12:10, 34:14; Ps 104:29 and fol.; Jer 10:10; Ez 20:31, 33:11; Gen 4:10, 9:5-6; Ex 21:12; 2Sam 12:5-12; Ps 72:14; Acts 14:15, 17:25; 1Tim 6:13.

(4) Ex 20:13; Dt 5:17.

(5) Mt 16:25, 10:39; Lk 17:33; Jn 12:25.

(6) Jn 15:13; Mt 16:25; 1Jn 3:14.

(7) Phil 2:5.

(8) Heb 10:7.

(9) Mt 27:46; Mc 15:34

(10) Nicene Creed.

(11) Jn 12:24.

(12) Rom 14:7-9; Phil 1:20-21.

(13) Second Vatican Council, *Gaudium et Spes*, 27

(14) Part of the content of the "right to die in a humane way" involves providing the dying with all the opportune remedies to alleviate pain, even if this type of therapy entails shortening life and submerging the patient in a state of unconsciousness. The dying may not, however, be deprived of the chance to confront their own death or of the freedom to opt for living in full consciousness even though accompanied by pain.

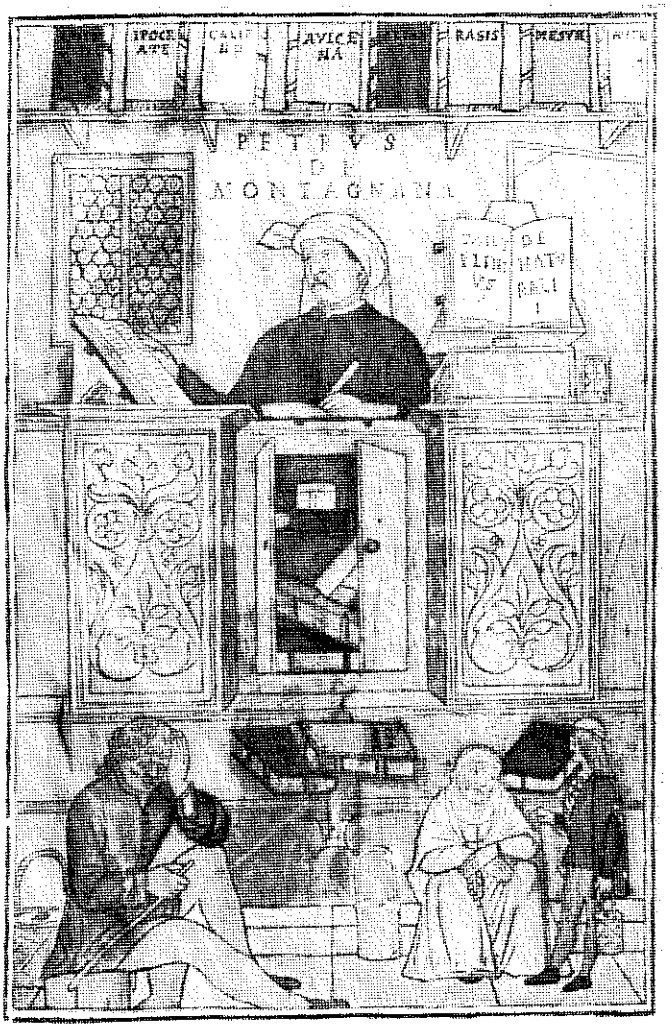
(15) We prefer to use the terminology of "proportionate and disproportionate means" rather than that of "ordinary and extraordinary" ones. We describe as "proportionate" those means which, in the concrete circumstances of the progress of medical science, are used to preserve life for the sake of humanity or justice, with pondered attention to the foreseeable quantitative or qualitative results, both medical and vital; such proportionate means may be habitual or relatively habitual. We describe as "disproportionate" those means which are not due to either humanity or justice and cannot be demanded for any reason.

(16) Disthanasia has been defined as the "practice tending to postpone as long as possible the death of a patient, an elderly or dying person who is incapacitated, deprived of all hope, with no human possibility of recovery, not only through the use of ordinary means, but also when extraordinary ones are employed, inherently quite costly" In euthanasia, the aim is to put an end to the life of a patient, by action or omission, accelerating his death therapeutically. In disthanasia, the aim is to impede or suspend the process of the patient's biological death. Between a euthanasia hastening death and a disthanasia postponing it disproportionately, we should situate "orthothanasia," death at the appropriate moment for a given individual.

(17) Acts 10:38.

(18) Mt 25:36

Topics



J. De Ketham, Fasciculus Medicinae
(Venice, ca. 1490)

Ethics and the Psychosomatic

Disaster Medicine: Past, Present, Future

Ethics from a Psychosomatic Standpoint: Considerations of a Physician

1. A problem of society

Here are two examples:

1. During a Balint Seminar for students, one of the participants cited the case of a person he knew, a seventeen-year-old girl, a guide leader, whom he had as a patient at a Scout camp. She had seriously damaged her larynx in attempting to vomit with the help of a piece of wood. We do not wish to consider the disproportionateness of such an excessive gesture — it is the ethical problem which raises objections. The patient had, in fact, renounced the doctor, thereby risking her life. Our student virtually felt torn between two poles. What was he to do? On the one hand, medical science was involved, but, on the other, he wanted to leave the patient with a certain amount of freedom, precisely because he was dealing with a human being.

The Balint meeting revealed to him a reality he had not reflected upon until then: the patient was trying to manipulate her environment. The discussion of problem cases led by a psychotherapist had shown him other solutions.

Respecting the patient's will entirely could mean paralyzing therapeutic action.

2. I shall offer you another example, the case of a seventy-six-year-old woman being treated for serious asthenic exhaustion *(Erschöpfungsdepression)* at our little Psychosomatic Medicine Service in Locarno. She unexpectedly asked me why I didn't give her the "English pill," which can kill a person in thirty seconds. She literally attacked me, minimizing our activity, which could even cure her.

The doctor does not exist without his patient. It is, in fact, the patient who defines the doctor as much as he defines himself. In the art of living, the doctor is patient, subject, and object.

The evolution of society also changes the spirit of patients. The physician must indeed deal increasingly with psychological or openly psychotherapeutic problems. The doctor can be regarded as a medicine and even as a "drug."

2. Quantity of life, quality of life

The human being aspires more and more to a quantity and quality of life. Who could blame him? But it must be seen whether or not he is willing to pay the price.

Does the notion of "progress" have meaning as long as there are unhappy children in this world? Einstein posed it that way. From a certain standpoint, we maintain that a country is civilized if its social legislation enables each individual, great or small, to enjoy progress effectively. In addition, as is understandable, philosophers, ecclesiastics, jurists, and psychologists do not always manage to grasp situations, and there is also the case of the physician, who must face up to ever weightier responsibilities.

Medicine, with its science and technology already projected towards the twenty-first century, strikes us as representing an immense power. We must ask how and to whom it will have to render an account.

Does *homo faber* not in fact become *homo pharmaceuticus, dramaticus,* or *vulcanicus?* Even if Freud's *homo psychologicus* appears to be such an unrealistic construction that it may be compared to *homo oeconomicus* in classical economics. The tendency of psychoanalysis has been to separate itself or remain at a distance from the problems posed by philosophy and ethics. It has not overlooked the fact that the human personality becomes comprehensible only in its totality.

If we consider Fromm's "global" man, we must urgently find a response to the problem of the reason for his existence. To simplify: we must give meaning to our existence. Let us not, then, be surprised if a psychoanalyst like Fromm still deals with ethical questions: he in fact assigns to psychology the task of correcting certain false ethical judgments. To him, psychology represents the basis for the most "valid and objective" norms for behavior. Since doctors and biologists began dealing with concrete cases in neonatal medicine, prenatal diagnosis, and genetic manipulations, we have realized that, on account of contradictions proper to democratic societes, *social consensus* is anything but easy.

It may be asked if the values, interests, and individual wills of the social masses coincide with those of the scientists. The answer is doubtful when people go so far as to debate therapeutic abortion, eugenism, active or passive euthanasia, and certain forms of psychiatric hospitalization.

In the United States, some medical schools have abandoned the oath of Hippocrates out of preference for that of Maimonides. In the Eastern countries, there is wavering between the Hippocratic oath and the physician's commit-

ment to serve the Soviet State. The foregoing makes it clear that society is creating a new image of the doctor, who strongly feels the need to formulate his own ethic and responsibility in a different way.

The Swiss Academy of Medical Sciences, for example, thinks that, in view of the progress of medicine (organ transplants, artificial insemination, and so on), the problem arises as to what will become of the patient's dignity and freedom in the face of techniques which are intrinsically of interest. What is the legal foundation for the steadily increasing power of medicine from birth to death?

3. The doctor-patient relationship

Now, unfortunately (or, perhaps, fortunately), we know that not only the great calamities, the large-scale epidemics cause us hardships; one out of every two people consults a physician, as is borne out by statistics. The person consulting a doctor often does not present any clearly determined symptoms, does not have any precise complaints, but does not succeed in maintaining his balance. Let down by the initial treatments, he starts to frequent doctors' offices. He lays claim to a kind of *right to health*. And he eventually expects it from society, which accords it to him only sparingly. How many facilities exist today that truly help him in this search! We may recall the exploratory means which have been perfected to such a degree that we can discover the first outbreak of a somatic infection with exactitude. There are all kinds of multidisciplinary teams "to lay bare" every symptom. Their goal is to reach a therapeutic synthesis. All of this costs a great deal. Thanks to the most advanced techniques, we now know that the therapist must grant priority to the *field of relations* to obtain the patient's confidence. We are tempted to think that technology acts as a screen between the doctor and the patient. Today it is necessary to rediscuss the problem of relations.

Psychotherapy begins precisely by "just listening" to the patient, and it is this attention which should enable the therapist seeing and hearing the latter to question himself.

In this way, every doctor constructs his own particular field of action: "Jede Praxis ist eine Welt für sich."

Degree Certificate in Philosophy and Medicine Auctoritate Veneta *of Samuel Coen (Padua, July 4, 1702)*

Different physicians treating the same set of symptoms, a single disease, have personal preferences in therapy, make individual choices in operations, laboratory tests, and medicines as needed. To a general way of acting common to all doctors there are added the particularities of each one. Medical knowledge becomes merged or amalgamated with what the physician has empirically acquired in practice, his "magic" deposit deriving from personal experience.

The patient, for his part, has his own understanding of and manner of evaluating the progress and miracles of medicine. He compares what he sees and what he perceives as changed, whatever is strange or bothersome (that lump, that palpitation, that undefinable malaise) It may become an anguished state. Starting from his phantasms, he himself constructs theories which the doctor judges to be phantasmagorical, while realizing that there exists a psychological anatomy in the patient beyond the physical one

Erich Fromm was fond of telling me that medical ethics created a good many victims. Patients concerned with being faithful to their doctors eventually pass over diagnoses or treatments which could save them. The patient as a person who is understood only if he communicates flees from the action of the therapist, who sees and grasps only what he can bear up with The doctor becomes a "translator" of the symptoms and symbols his patient furnishes him with This corresponds in part to what Michael Balint has termed "the new beginning."

The application of psychotherapies, especially confrontation, certainly poses the same problem To accept another at close range is not easy. Glances size each other up, cross, flee The face represents what is most quickly and forcefully taken as a target, and for this reason we try to leave it exposed as little as possible. In this context, language becomes a defensive weapon designed to moderate somewhat the impact produced by words.

It is of paramount importance to leave room for conversation and personal exchanges, which should be spaced out, but truly rich. The intervals between them enable them to blossom into autonomous unfolding.

4. The medicalization of the human being

Health *cannot be* the "state of complete well-being" defined by the World Health Organization. It is rather the faculty to take on responsibility and acknowledge one's own limits. It results in a dualism in doctor-patient relations. At this point there arises the problem as to whether or not we have the right to notify the family of a patient manifesting the intention to commit suicide. With the patient's consent, we have started up a "family confrontation" precisely to orient the family, which has been informed concerning the psychosocial and psychosomatic problems affecting it The patient is often just a symptom of the disorder existing in the family. As a human being the sick person is free and autonomous All the therapist's efforts are directed towards a cure regarded as the goal to be reached This notwithstanding, he continues to impose limits upon the freedom and autonomy of the patient The increased possibilities offered the therapist threaten to augment "medicalization," which cannot, however, free man from suffering and death.

From this standpoint, a "right to health" would thus seem to be an illusory affair. Jeanne Hersch says that if the patient shows confidence and has decided to seek treatment, the therapist should grant him esteem and rely upon his capacity to understand, courage, and freedom of choice

In many cases, recourse to the patient's "resources" enables him to surmount the roughest and deepest crises. Some of the most fruitful sources of energy are thereby set in motion

5. The physician: "the stranger of medical psychology" (F.G. SCHNEIDER)

It is necessary to stress the right to care and to life claimed by the patient, even if the cure may be just a hope, not a certainty. Health never depends exclusively on the therapist's science, but science is always linked to the patient's way of life. The sick also have a "duty towards health."

The patient should be sure that his right to life is being protected by the doctor. The magnitude of the patient's dignity must be recognized, though we have to deal with a medical practice presenting different facets. The right to adequate treatment cannot be placed on the same level as the "right to health." We prefer to think there is a right to dialogue, to a specific, personal relationship

We observe that all the religions on earth are concerned with the same problems: sickness and death. The patient's right to be respected also implies the right to die in a worthy way He has a basic right to the truth as well But how can we speak of a right to the truth for cancer patients precisely from a therapeutic standpoint? (*Wahrheit oder Wahrhaftigkeit*)

Saner plainly states, "The hopes entertained by the therapist are exaggerated if his treatment suppresses the patient's freedom."

The human being considered as a subject ever remains the master of himself. There are patients who manage to rise above their own illnesses while others succumb to them.

Medical progress must make up accounts with the innate dignity of man.

When seen in this light, the problems examined also imply the following question: How can we develop medical science in such a way that progress does not threaten, but protects human dignity?

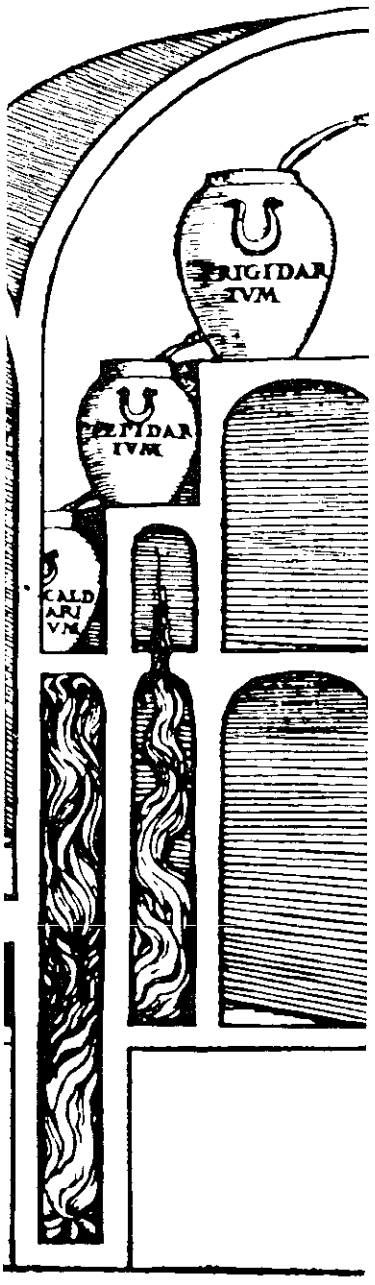
6. Professional norms and contradictions

Today the respect due the human being is universally regarded as a valid rule.

With the most advanced techniques in treatment available now, it is hard to respect the patient's dignity and right to self-determination without making restrictions. It is precisely as a result of this continuous evolution that both doctor and patient find it so complicated to know how to act judiciously.

Schultz states, "Since it is up to the patient to decide upon his manner of living, it depends on his consent to discover whether and how he wishes to be treated."

When the patient is temporarily incapable of expressing himself on a treatment which is being administered — either because he has lost consciousness after an accident or because of a disease — and has no legal representatives, recourse is had to "untitled management of affairs," which authorizes the physician to make decisions on



From Girolamo Mercuriale's "De Arte Gymnastica" (Venice, 1573)

measures tending to preserve life or restore health.

It is ethics which should dictate our behavior. If these rules are observed, our credibility is saved. But if we trumpet them only occasionally or take inspiration from them in an almost abusive way to facilitate things materially, then we are no longer worthy of faith.

Even if the doctor is not always aware of them, his professional activity is unfailingly marked by specific rules. Medical ethics in principle regulates the relations — in the broadest sense of the term — between the doctor and his patient. The obligation of *absolute secrecy* regarding everything the patient may have revealed to him constrains the physician to defend this basic principle in all respects over against the diverse current demands for information.

We may also be asked if there is not a contradiction in the use of psychoactive drugs in an attempt to influence the patient's state of mind. But it is perhaps well to remember that the term "psychopharmaceutical" is linked to the old definition established over a hundred years ago: "Psychopharmakon id est medicina animae."

In the practice of psychotherapy, contradictions are very often experienced which leave us perplexed. But man is at once weak and strong.

In a play offering a very free treatment of the trial of Jesus, Simon Peter responds with sorrow to those who in the courtyard of the High Priest reproach him for his cowardice regarding Christ: "Despise me! But what you cannot grasp, what, unfortunately, I can't manage to make you see, is that at the same time one may believe and betray, love and deny. Yes, I tell you, it's possible. And while I was speaking, in the courtyard of the palace of Anna there was heard, 'I do not know him. I have never seen him'; and precisely as I was saying these things, I was loving him."

If man can join together so many contradictions in himself, it is not only because he has an intelligence capable of reasoning and a will which aspires to good and evil, but because he also possesses a heart.

8. Affectivity and the appeal to living in a better way

Ethics does not measure human acts as do other sciences. Psychiatry and psychotherapy sometimes wish to express unappealable judgments on human acts when they are really not called to measure the merit or demerit of our behavior.

I must not be the judge of my patients. A good many sociologists would like to establish a community-based system grounded upon the following assumption: "It is better to do evil together with other men, my brothers, than to do good alone, far from others."

Good sense definitely tells us to seek to act with that cardinal virtue which is called prudence, so highly esteemed in the middle ages, and always up-to-date when one wishes to make a sound judgment on people's way of behaving.

The specifications on human behavior proposed by modern science must not suppress the data of traditional morality as if it had never existed. On the contrary, scientific observations are useful in continuing to apply moral facts, completing them, and entirely avoiding a radical break with the principles which basically remain valid at all times, for they issue from eternal truth.

St. Thomas Aquinas referred to ethics as the science dealing with human acts in the measure in which these acts aid or impede us in reaching beatitude (S. Th. I/II, 6, prol.)

All of the clarifications we are offered today by depth psychology on human acts in no way modify St. Thomas' definition as regards medical practice.

Only a psychology which respects the hierarchy of values and deduces its scientific dimension removed from all sentimentalism and false piety can come to an agreement with the theological mode of seeing reality. If current psychotherapists place theologians on their guard concerning the importance of affectivity in man, it is because they want ethics not to appear as a science of limited vision or judgments that are too hasty or out of place.

The question which in different ways is asked of one providing care, in accordance with his role or character, represents, above all, an invitation to live better, precisely because life deserves to be lived, even from the standpoint of *philobatia*, a love of risks, in opposition to *ocnophilia* (Balint). It is a question which also takes the body as its starting point: the body in illness, the body in existence, and,

therefore, the body in a complete doctor-patient relationship

Clinical psychology does not at all teach the art of nuancing to examine the circumstances of an act more precisely. It is the theologian, as J.P. Schaller says, who has the duty not to confuse charity and truth; though the former is indispensable, it cannot, indeed, replace the truth. Let us recall that Christ, while teaching love for one's neighbor, said, "I have not come to abolish the law, but to fulfill it" (Mt. 5:17).

Therapists, mainly Ferruccio Antonelli of Rome, with a perspicacity which truly deserves close attention, have considered various sins in order to discover the motive prompting a given subject to commit an unpremeditated act.

The loyal theologian should display an attitude of openness towards such efforts by medicine in the measure in which it limits its research to the objective study of facts and does not seek to work out a new morality which blindly leads to a valid ethic or a new teaching of the Gospel. The *psychotherapist*, who observes how irrational movements can dominate man, should be pessimistic about all this. The *biophile* movements tending towards happiness and well-being they can master are just the opposite; but such movements frequently do not manage to progress. We are less surprised by the number of neurotics than by the number of those who are not.

There is also a desire to establish a root principle which, according to E. Picon, could be stated as follows: The idea of an original goodness, a basic idea of Jean Jacques Rousseau, is false and dangerous; this idea has caused unprecedented harm among the human groups. The author adds that we must adequately thank psychoanalysis for having vigorously contradicted this error, basing itself precisely on the psychology of individuals.

8. Taking on responsibility

The psychotherapist takes on responsibility and specific obligations with respect to the patient. For this reason, he should be guided only by what concerns his function as a doctor. We energetically oppose psychosurgery and psychiatric abuses affecting undesirable citizens in some totalitarian states.

But ethics must not be channeled into rigid formulas — it would lose its substance. Beyond words and concepts, ethics and dignity are the expression of a personal attitude. Love is a real force — only love places us in relation to the world. The therapist should also attach less importance to an apostolic spirit in convincing the patient (by giving him good advice) and seek, rather, to provide him with true assistance.

If man has a moral duty towards the community, such a duty should not be a constraint for him, but enable him to become useful in full freedom. This is a norm of human dignity as well. Let us borrow a thought from Dr. Schweitzer — physician, theologian, and organist — on the respect that should be shown life which can also be most successfully applied to ethics: "In whatever situation man finds himself, ethical respect for life forces him to be continuously concerned about the fate of those surrounding him and give his human support to every being who has need of it. Human ethics is a genuine reality if life — that of plants and animals, along with that of man — is sacred to him and if, in the face of all needy life, he shows himself to be a helping being."

A professional incident comes to mind. I was in the Caribbean, in an extremely poor Haitian village. A colleague of mine was attending patients, and I was present at his side. He was writing all the prescriptions on slips of paper with the following words included next to his name: "The doctor treats. God heals." Man too often waits in vain. "Man is in crisis, but he will survive," Erich Fromm would repeat to me in our weekly meetings. In genetic terms as well, man exists to produce the action of life. An abundance of things does not give "certain" abundance. There is no future without hope. The man who does not hope or who is no longer capable of hoping is a sick and depressed man. Anguish paralyzes him. Even from a biological standpoint, the life development of man seems to be a function of the hope he must never abandon, not even in old age, especially if he has inwardly nurtured new ideas, changed affirmatively, and tends towards additional ideals.

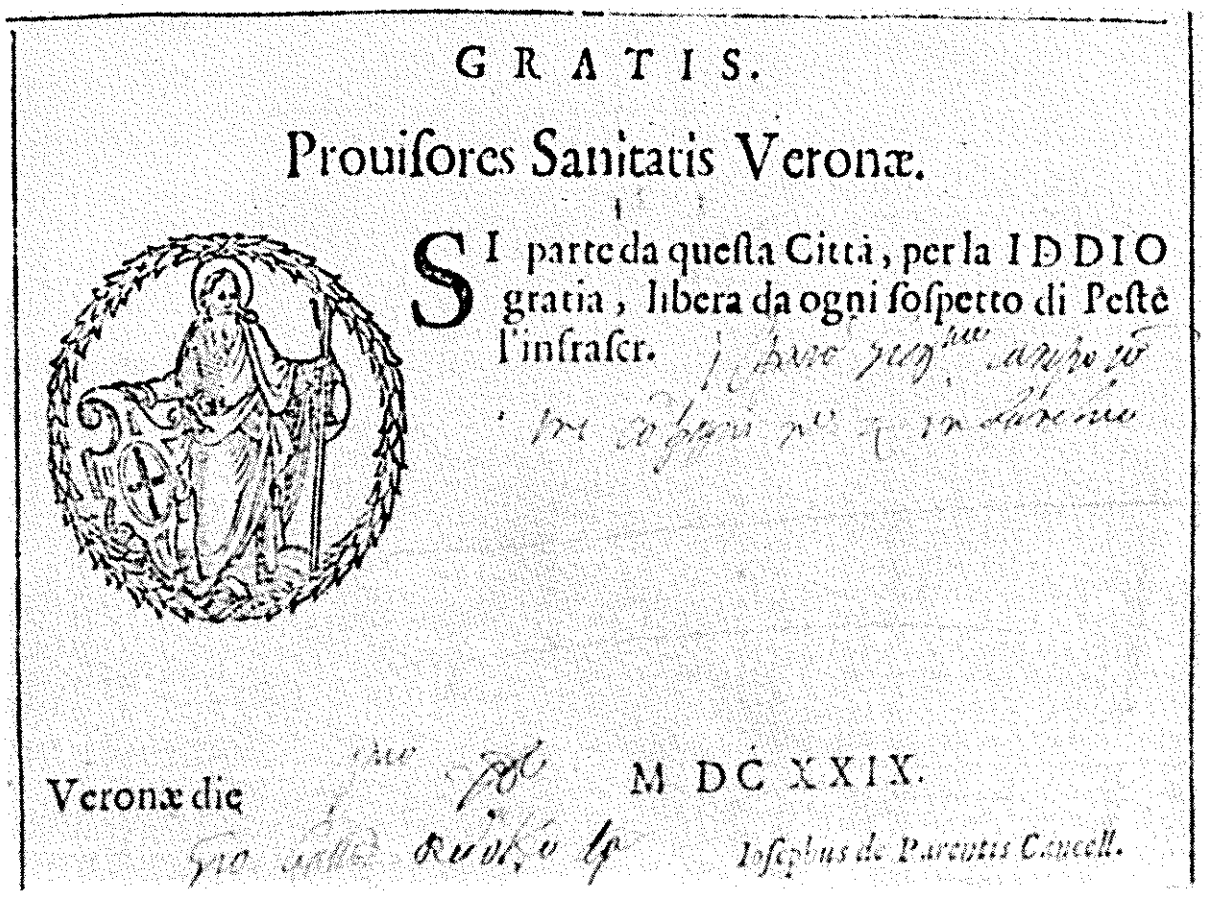
Man has all the strength needed to love and to hope. *Homo viator*, he must succeed in believing and living in a conscious, ongoing effort. The door to the future otherwise remains closed.

Man, who is hope, must make his faith in the future be felt.

But we are capable of hoping if we are capable of assuming our own responsibilities.

PROFESSOR
B. LUBAN-PLOZZA,
M.D.
President of the European Union of Social Medicine

Dioscorides, Greek manuscript, fourteenth century, Padua, Library of the Episcopal Seminary



GRATIS.

Prouiſores Sanitatis Veronæ.

SI parte da queſta Città, per la IDDIO gratia, libera da ogni ſoſpetto di Peſte l'infraſcr.

Veronæ die M DC XXIX.

Ioſephus de Parentis Cancell.

Health Certificates, Verona, December 1, 1629

Disaster Medicine: Past, Present, Future

Introduction

The Notion of "disaster" or "catastrophe" is primarily socio-centric, anthropocentric, for a natural disaster that did not affect man, society and the environment, would remain a mere geological or meteorological event.

Thus mankind and human welfare are the focus of concern. A disaster, then, is the result of a vast ecological breakdown in the relations between man and his environment, a serious and sudden event (though it can be slow, as in drought) on such a scale that the afflicted community needs extraordinary efforts to cope with it.

In the first part we will present a modest attempt to outline historical disasters that had an impact on the development of medicine worldwide and which, particularly in recent centuries, were influenced in their management by the discoveries in medicine; in a second part we will outline modern society's response and indicate the main trends in the development of the new field of Disaster Medicine.

I PART:

History of disaster medicine

1. Naturally occurring disasters

Whereas in modern times we are exposed to an increasing degree to potential disasters resulting from technological advances, especially in transportation, our ancestors were tested more in coping with naturally occurring disasters. Perhaps the most spectacular and instantly terrifying of these is

1.1 The volcano

Historical volcanic activity has been limited to well defined areas. Most have occured (62%) along the boundaries of the Pacific Ocean. While it is recorded that volcanic eruptions caused the death of approximately 190,000 people from the year 1500 to 1914, the mortality figures before this are unknown. It is also recorded (4) that nearly 1000 deaths a year result from volcanic eruption. The first recorded death from a volcano, that of Pliny the Elder, occurred in the Vesuvius eruption of 19 AD. Sixty years later the ancient cities of Pompeii and Herculaneum, situated southeast of Naples, were destroyed by the eruption of Vesuvius.

Pliny the Younger recorded that Pompeii was covered with volcanic debris and ashes to a depth of seven meters. While it was felt by young Pliny that noxious gases were the main cause of death, later research (1) suggests that the dominant cause of death was asphyxia in the

Pompeii disaster, and that because Herculaneum was covered in meters of mud, asphyxia was also the cause of most deaths.

Vulcan, the god of fire, has always been associated with the connotation of volcanic death by fire from red-hot larva. However, this is a rare cause of death in a volcano, as most of the larva flows are slow moving and some could be diverted(2) Volcanoes are often accompanied by earthquakes, another factor contributing to the death tolls.

More recent evidence, particularly from the Mount St Helen eruption in 1980(3), has shown that volcanic death was largely from suffocation which took only a few minutes, and to a lesser extent from burns or blunt injuries. Of interest is that the distances of the dead from that volcano were between 7.2 and 28.2 km

From a study of both early and recent volcanic disasters, it has been concluded(4) that modern resuscitation and primary care would have been too late to save the asphyxiated victims of Pompeii and Herculaneum if it had been available at the time If such disasters had occured today, all that could possibly have been done to save life would have been evacuation of the population by use of early volcanic rumbling monitoring. For many of the others who died of burns, there would of course have been a greater chance of survival with modern burn treatments

1.2 The earthquake

Of all the natural disasters, the earthquake stands alone for its power to cause the immediate destruction of thousands of people, cities and land. Lives lost as a result of a single earthquake range up to hundreds of thousands. While crushing injuries have always been known to be the dominant cause of death in earthquakes, recent research (5) has identified from modern earthquake disasters the types of injuries involved and the causes of death.

It has been assumed (5) that the rate of mortality to morbidity will be approximately 1:3 in earthquakes, and that this ratio is most likely to coincide with a Richter magnitude in the range 6.5-7.4.

This research shows the following breakdown of injuries with the expected proportions of patients receiving them: Soft tissue injuries (wounds and contusions) 32-68%, limb fractures 16-44%, head injuries 4-37%, injuries to the thorax 3-15%, and spinal injuries 3-9%.

It was also shown that neurogenic shock (nontraumatic) is a significant consequence of earthquake disasters, and that the proportion of victims with multiple injuries varies from 3 to 66% or more. New research (6) shows that the 5-9 age group and those over 60 are most vulnerable in earthquake disasters.

1.3 Infections

With the exception of sporadic outbreaks of cholera in underdeveloped countries, infections today are seldom regarded as an aspect of disaster medicine Before the advent of disease control and treatment however, epidemics which swept across nations unchecked, untreated and escalating, were disasters of great magnitude.

In *The Black Death*, historian Robert Gottfred traced the uncontrolled rampage of this legendary disease across Europe. Historians using tax records and church documents have recorded this epidemic, which struck Europe in 1347, lasted over 300 years, ruptured the bonds of feudalism and dislodged accepted medical practice.

In four early years of the epidemic, from 17 to 28 million people died of this infection, and this should be compared to the 8 1/2 million casualties during World War I. In cities where sanitation was primitive and vermin rampant, mortality reached up to 60%. Deaths in London, whose medieval population was no more than 50,000, averaged 290 per day during the summer of 1549 alone.

The black death of the 14th century was a typical example of what can happen when an unfamiliar infection attacks a population for the first time with no resistance, no cure and little relief from suffering. The cholera epidemics of the 19th century constitute a second but far less destructive example.

Imperfect records make it impossible to begin to appreciate the scale of earlier diseases, let alone the significance in a community lacking acquired immunity

Historians have often failed to appreciate the enormous difference between an outbreak of a familiar disease amid an experienced population and the effects of the same disease on a community which lacks this immunity.

It is well known that modern outbreaks of disease could determine the outcome of military campaigns, and change the course of history.

The disease liability was also influenced by the development of new skills to transform the balance of nature, as for example with weapons made to kill large-bodied herbivores that abounded in the grasslands of the African Savannah and in similar landscapes in Asia. This transition may have begun as long as 4 million years ago. New diseases were met as evolution developed For example, sleeping sickness was and remains so devastating to human beings that the ungulate herds of the African Savannah have survived to the present. Without modern prophylaxis humans can't live in regions where the tsetse-fly exists.

Patterns of communication were slowly developed that allowed increasingly effective mutual support in moments of crisis, and hunting efficiency improved human survival chances

Drought, grass fires, torrential rains and other potentially serious states set limits for all forms of human life

The rise of cities meant that the concentration of large populations in communities offered potential disease organisms a rich and readily accessible food supply Even the ceremonial bathing shared by thousands of pilgrins gathered to celebrate a holy festival offered human parasites an opportunity to adopt new ports.

In Yemen, for example, ablution pools attached to a mosque were found to harbour snails infected with schistosomiasis and in India it is well known that the propagation of cholera was and is largely a sequel of religious pilgrimage.

In Africa, agricultural development with clearing of rain forest environments multiplied breeding places for a kind of mosquito that feeds by preference on human blood

By 500 BC new diseases had begun to manifest themselves in many major civilized centers. Among the disasters mentioned in the Babylonian Epic of Gilgamesh as preferable to death from flooding was visitation from the god of pestilence.

Ancient decipherable writings in China dating back to the 13th cen-

tury BC showed awareness of epidemic disease

The plagues of Egypt are described in the Book of Exodus, where it is recorded that Moses brought down plagues upon Egypt — "sores that break into pustules on man and beast."

An epidemic suffered by the Philistines as punishment for their seizure of the Ark, the pestilence that killed 70,000 out of 1,300,000 able-bodied men in Israel and Judah, and the fatal visitation that "slew in the camp of the Assyrians 185,000" overnight and caused the Assyrian King Sennacherib to withdraw from Judah without capturing Jerusalem are also cited.

The writers of the Old Testament, when they put the text into its present form between 1000 and 500 BC, were quite familiar with the possibility of a sudden outbreak of death from disease and these epidemics were interpreted as acts of God.

Modern translation used the term plague for such events since the principal disease that continued to erupt in Europe until the 18th century was bubonic plague. However there is no reason to suppose that these ancient outbreaks of disease were in fact bubonic plague. Any of the new familiar diseases such as influenza, measles, smallpox, typhoid or dysentery could have provided the type of sudden outbreak of epidemic deaths recorded in the Bible.

The conclusion is that such diseases were familiar to ancient Middle Eastern populations well before 520 BC and played a significant role in reducing populations, though not to a level below that necessary for buildings empires; otherwise the Assyrian and Persian Empires could not have flourished as they did between the 9th and 5th centuries BC.

Fevers, including regularly recurring fevers (probably malaria), figure very prominently in ancient Chinese medical writings, and it is now clear that the Chinese had considerable success in combating early disease.

Hippocrates, the father of Greek medicine (460-377 BC), recorded case histories with enough precision and detail to prove the existence of a great variety of infections in ancient Greece such as tuberculosis, influenza, diphtheria, and malaria.

It is known that by the beginning of the Christian Era, there were four divergent civilized disease pools that had come into existence (India, China, Western Eurasia, and the Mediterranean), each sustaining infection that could be lethal if let loose among populations lacking any prior exposure or immunity. In the first two centuries of the Christian Era, regular trade between these four areas implied exchange of infections as well as goods. It was still not appreciated that disease traveled less easily overland than by sea.

By the second century AD a great number of epidemics had struck Europe. One striking in 165, brought to the Mediterranean initially by troops that had been campaigning in Mesopotamia, was probably smallpox. It remained epidemic for 15 years and killed up to one third of the affected population.

From 251 to 266 AD, 5000 a day were dying at the height of this epidemic.

From the 3rd century on, the diseases that ravaged the Roman population were probably measles and smallpox. One great advantage that the Christians had over their pagan contemporaries was that the care of the sick even in hours of pestilence was for them a recognized religious duty. Simple provision of adequate food, water, and good nursing was all that could be offered to help control these disasters.

The effect of these disasters was to strengthen Christian churches at a time when other institutions were being discredited. For the Christians the grounding of their faith helped considerably in their disaster management and made life meaningful amid sudden deaths.

By far the most important epidemic with a far-reaching influence on future disasters of infection was the plague.

1.3.1. The plague

Daniel Defoe wrote *A Journal of the Plague Year* in 1721. It was to be recognized not only for the quality of his descriptive brilliance but for its message of a disaster so frightening in its devastation that few could believe that they were not reading fiction. Defoe recognized the "black death" as the greatest environmental event in history and one of the major turning points in western civilization.

The epidemic which lasted over 300 years from its initial impact on Europe in the 14th century, swept across Europe in 1665. Its effects on human suffering, on social and anti-social behavior, on governments so anxious to seek its control and elimination, were meticulously researched by Defoe and recorded for posterity.

He spoke of the problem still dominant in modern disasters that those most affected are always the poor, the undernourished and the underprivileged. He spoke of the preying of the rich on the poor, of the looting, of selling of remedies, of superstition involving foreigners, and the lack of communication, again a dominant problem in 20th century disasters.

By 1721, when the plague swept across Europe from the East and reached Marseilles, it was recorded that adults and children began to die like flies.

His account of the plague was an excellent example of public health education based on sound observation. He wrote of the flight of the poor to the woods and forests — the ability of the rich to buy isolation by chartering boats (up to 10,000 lived on ships) — of the isolation of houses thought to be dangerous by marking with a red cross, and of the greater increase in

Stamp of the Verona Health Directors 1629

the spread of the disease in hot weather. He observed that infections came into homes by way of servants sent into the streets to buy food, and that people were careful not to touch money. Breath, sweat and the stench of sores were regarded as major means of spreading the disease.

Defoe wrote that John Haywood, a gravedigger, and his wife, a nurse to infected people, never caught plague. And when this was put down to the use of garlic, tobacco, and vinegar, it was yet to be realized that many were building up immunity to this and other infections.

As with modern disasters, secondary causes of death became evident (eg. because so many midwives were dead, more babies died at birth or were stillborn). While it was clear that infection was usually spread by people who had been well, but who had been in contact with the sick, there was always doubt as to how well people could harbor the disease.

The sick could not be easily distinguished from the sound because the "incubation" period was not recognized

It was not until 1894 that the plague bacillus (pasteuralla pestis) was discovered. After the great plague of London in 1665 the bacillus withdrew from north western Europe though it remained active in the Eastern Mediterranean and Russia throughout the 18th and 19th centuries

There was of course no cure for the disaster of plague, only relief of symptoms with nursing, adequate food and water, bleeding for fevers and the application of a wide variety of substances to the erupting wounds. Infection was minimized by quarantine, present even in the 14th century and stemming from a biblical passage prescribing the ostracism of lepers, and by treating plague sufferers as if they were temporary lepers. Other public health measures included the construction of houses with stone or brick rather than wood and the replacement of thatch roofs with tiles, all measures limiting rodents

In Italy especially, local governments responded quickly to the plague by efficient organization of burials, by safeguarding food supplies and deliveries, by setting up quarantine and by hiring plague doctors, especially between 1350 and 1550


BANDO PER OCCASIONE DI PESTE

"Plague Decree" with a list of the places quarantined and banned (Venice, April 15, 1630)

By the 16th century throughout Europe there were emerging standard rules of quarantine and other prophylactic measures against the spread of plague

Three centuries later the containment of plague through international medical communication and cooperation marks one of the most dramatic triumphs of modern medicine

1.3.2. Cholera

As a world disease, the rise and fall of cholera belongs to the history of a single century — the nineteenth. Before 1817 it was largely a local disease of India, but within 6 years it had spread to Japan and Europe. In India alone, cholera killed more than seven million people in 20 years of the present century.

Until the development of the vaccines to increase resistance to cholera, the prevention of cholera focused largely on hygiene — cleaning up the privies, drinking water, hog pens, rag and bone shops and garbage stores. Again, like modern disasters, it affected those most at risk — the poor, hungry, and underprivileged. The first outbreak of cholera in Britain promoted the establishment of local boards of health with specific functions to improve public sanitation and sewage disposal

International medical cooperation was especially generated by the disease of cholera, and after 1850, when medical conferences became common in many countries, there was greater communication on all aspects of its control. It seemed that cholera was capable of by-passing any man-made obstacle and any quarantine.

In 1883 Koch found the bacillus responsible for cholera and by 1890 a London doctor, John Snow, showed how cases could be traced to a single source of drinking water. In 1913 compulsory innoculation against cholera was first established

In terms of disaster management of cholera outbreaks, the most important primary care function was to replace lost body fluid and to improve water supplies and sanitation The serious effects of dehydration from diarrhoea were often not appreciated by those caring for the victims, and it was not until later that the value of simple, cheap, oral electrolyte powders and solutions was appreciated in mass disaster management of cholera.

1.3.3. Influenza

The influenza of 1918 and 1919, known as "Spanish influenza," killed more victims in a few months than all the armies in 4 years. In the United States alone 500,000 died.

In India, six months of influenza accounted for nearly as many deaths as 20 years of cholera. This pandemic of 1918-1919 ranks with the plague of Justinian and the black death as one of the most destructive outbreaks of disease known to man. However, the chance of surviving influenza was good. While the black death killed 9 out of 10 when it attacked, cholera sometimes 4 out of 5, influenza in 1918 killed only 2 or 3 out of 100. Treatment relied mainly on good nursing care and nutrition with occasional vaccines. Crowd contacts were limited, schools were closed, wearing of masks became compulsory, e.g., in San Francisco.

Plague, cholera, and influenza have been discussed because they represent a range of disasters occurring over some five centuries. Many others, including smallpox, typhus, typhoid, and yellow fever, could have been mentioned, but their history and control are well documented, and their influence on disaster management has been lesser than that of the three diseases discussed.

1.4. Water

There has been little reliable information recorded on how many have perished in historical flood disasters. Historians have recorded the major floods of Paris (1658 and 1910), of Warsaw (1861), of Frankfurt am Main (1854 and 1938), and of Rome (1530 and 1557), but the mortality from these is unknown.

Floods may result from ice jams during the spring rise, from tsunamis, or from summer thunderstorms in mountains — the so-called flashflood — probably the most dangerous of all floods. With floods, the common cause of death is from drowning or blunt injury of the body against rocks or debris.

With ship disasters a further hazard is, of course, hypothermia, when the body is immersed in freezing water.

While primitive means of resuscitation were used involving gravity removal of inhaled water from the lungs, the recognition of hypothermia and its treatment, and the efficient techniques of resuscitation appropriate for the nearly drowned victims were triumphs of this century, especially of the past 25 years.

They were largely developed through a worldwide improvement in surf life saving and the teaching of resuscitation techniques to surf life savers and first aiders.

2. Man-made disasters

2.1. Wars

Of all the types of disasters that have most influenced modern disaster preparedness and management, wars surpass all other disasters, whether natural or man-made.

War is understood to be an armed conflict involving more than 50,000 combatants.

It is beyond the scope of this paper to outline a history of wars, but rather we concentrate on those historical issues which most influenced morbidity and mortality in the mass casualty situation of wars. To achieve this a series of topics will be presented related to injury patterns and their treatment, starting with

2.1.1. Weapons

Since man first learnt to shape clubs, injury types have changed progressively with the development of weaponry. Spearing, clubbing, slinging, shooting arrows and trampling from horses dominated the warfare tactics used in the ancient world of the Greeks and Romans. Death resulted largely from hemorrhage or blunt injury to the head for which there was no effective treatment.

Explosives possibly originated in China in the 10th century, but certainly were used by the Arabs in the 14th century, when the first real gun was developed, which fired an arrow from a bamboo tube.

Firearms were probably the invention of a 14th century German monk named Berthold Schwarz.

Explosive injury from firearms or black powder changed the pattern of injury to include not only internal and external hemorrhage, but also untreatable destruction of vital internal organs inlcuding the heart, lungs, liver, spleen, and bowel. Death, if not immediate, soon came with infection and chemical imbalance from shock, which was unrecognized and beyond any healing skills.

With the discovery of the physiology of the circulation of the blood by William Harvey in 1628, greater understanding developed of the importance of hemorrhage control, for there could be no replacement of what was lost.

Thomas Spencer Wells gained first-hand experience of the nature of gun-shot wounds when he survived in the Crimean war in 1854, and from this experience he invented hemostatic artery forceps which bear his name and which replaced the traditional use of fingers to control bleeding during an operation.

Shells were first used extensively in the Swedish thirty-year war of the 17th century and created their own types of injury with infection from metallic fragments and large soft tissue wounds which soon became infected.

Chemical warfare with the use of poison gas brought with it during World War I major problems affecting the respiratory tract, often permanently.

As the means of war transportation developed with a great number of men confined in fixed areas such as tanks and ships, their vulnerability to fire which developed from shelling increased.

Thermal injuries rose dramatically from World War I to World War II, and this was compounded by the fires which resulted from air battles.

2.1.2. Tactics and strategies

A study of wars both ancient and recent shows how tactics used greatly influenced survival chances, which were independent of physical combat. Napoleon has a preeminent place in the history of strategy. Deception, surprise, and fear of numbers all lowered resistance and were part of psychological warfare. The tactic of keeping enemies constantly moving without rest or adequate food lowered their resistance to both disease and injury and made them more vulnerable when the conflict became physical. One of the most destructive forms of war disaster was that of hypothermia, where thousands of troops could perish in a few hours following exposure to freezing temperatures. This state was also influenced by and often resulted from strategies designed to move the enemy away from shelter. This was just one consequence of the "strategy of exhaustion."

2.1.3. The hazard of numbers

Wars added another series of risks to survival because thousands of soldiers were often confined to one area, subjected to a lack of sufficient food, to severe exposure,

and to disease It was well recorded how the plague destroyed more soldiers than were killed in armed combat. There was another risk with wound cross infections so easily spread where hygiene was poor and the means to cleanse wounds inadequate or absent. It was much harder too for immediate aid to be given to hundreds of soldiers or sailors who were confined victims of explosive warfare, unable to escape readily from their attacked area, let alone sort out their dead from their injured.

The hazard of numbers was particularly evident in water accidents during many wars where a few lifeboats were inadequate to cope with soldiers and sailors suddenly exposed to freezing water.

3. Treatments

It is beyond the aim of this paper to give anything but a brief description of those historical medical developments which influenced survival in early disasters. With all disasters, ancient or modern, the most common causes of death have been massive hemorrhage; airway obstruction; infections; dehydration and starvation; multiple injuries; crushings. The essentials of immediate care are now recognized simply to be airway control, restoration of good circulation and pain relief. In any disaster this immediate care cannot be competently delivered without a system of disaster preparedness, disaster management, good communication, casualty management, and appropriate transportation. It is in this area, of course, apart from the lack of medical aid, where previously even small disasters could not be managed without communication or transportation and soon developed into major disasters.

The history of bacteriological advances with the discoveries of causes of epidemics is well documented in numerous publications, and has been referred to briefly in section 1.2.

The outline which now follows is a brief account of the major surgical and medical advances which most influenced disaster management as they were developed.

3.1. Circulation

John Hunter, the brilliant Scottish physician of the 18th century, contributed most to the understanding of the circulation of the blood — the fact that venous blood was dark and arterial blood florid. His observation contributed much to the early understanding of the nature of gun-shot wounds and stabbings.

Previously, William Harvey (1578-1657) had shown that blood continuously circulated, and Michael Servetus (1511-53) had shown that blood had a separate path through the lungs.

Harvey demonstrated that in the lungs blood was changed from venous to arterial "Respiration," exchanging gases between air and blood, was identified as the key to understanding the reason for blood circulation some time later.

The major step in replacing lost blood, that of transfusions, did not develop until the 1920's and 1930's, following the brilliant work of Landsteiner in describing the main red blood cell types.

Suggestion that blood could be given back into veins was first suggested as early as the 17th century, notably by Johann Daniel Major of Padua.

The necessity for urgent transfusion in blood loss resulted from not only warfare, but also the increasing trauma of road accidents.

3.2 Surgeons

Biblical information on medicine is limited, though there is reference to surgery for circumcision. In the second to sixth centuries AD, Jewish writers discussed means of reducing dislocations and the management of injuries to many organs.

It was not until the 18th century, following the scientific study of anatomy, that surgical developments progressed rapidly.

In 1743 a royal decree in France forbade barbers from practicing all except minor procedures in surgery. A half century later the Royal College of Surgeons was granted a charter, and surgery became a skilled and controlled speciality.

The surgeon soldiers became the first group to bring disaster medicine delivery to the front line of battles. In World War I, particularly with the development of antiseptic techniques and front line surgery, many soldiers who previously would have died survived through early surgical skills.

This was disaster medicine in action — early action to separate the casualties and decide who required immediate care, field hospitals, well equipped to cope with an influx of many casualties.

Costanzo Varolio, De Nervis Opticis, *1573*

The finest and best researched account of early war medicine is to be seen in *Medical and Surgical History of the War of the Rebellion (1861-1865)*, which refers to the American Civil War. This work documented for the first time treatment protocols for mass disaster problems based on well kept statistics.

Of those within the Union Army who died in this war, 44,238 were killed in action, 40,205 died of fatal battle wounds, 186,298 died from disease or disease-related causes, and 24,103 died from unknown causes. Within the Confederate Army, documentation was not accurate, though it is recorded that some 200,000 died and that three-quarters of the deaths were due to disease.

Immediate first aid in the battle field was primitive, transportation of the wounded unplanned and only available when a vehicle was not needed to haul military supplies.

The injured were treated in makeshift hospitals located far to the rear of the battle zones in abandoned schools and churches.

However, within two years of the outbreak of this war there had been a significant improvement in disaster medicine. This was brought about by a number of factors, both organizational and medical.

The first of these was the improved efficiency of military medical departments with better training of doctors, ambulance corps and nurses able to cope with the greater demands of front line care, as well as improved efficiency of medical supply delivery. The second was the number of medical advances occurring about this time which improved survival rates of the injured

These included Pasteur's discovery of the role of bacteria in 1863 (Lister by 1867 recognized their relation to wound infection and proposed his method of antisepsia).

There was no asepsis in the 1860's, so infections were a serious problem for wound and surgical management up till the time of Pasteur's discovery.

Chest and abdominal wounds were nearly always fatal. Records showed that more died from war conditions and disease than from battle injuries, and these diseases included predominantly smallpox, scurvy, and diarrhoea. Other medical advances developed at this time included improved dressing materials, surgical instruments and syringes, as well as recognition of good

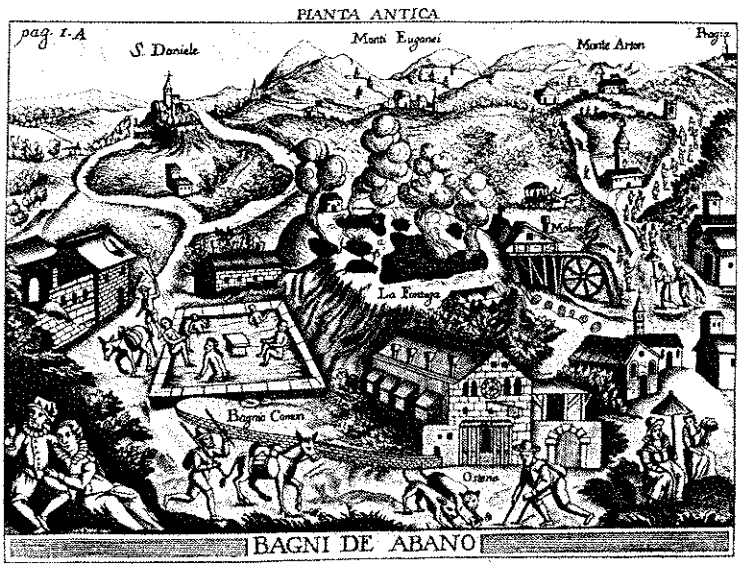


Table from Salvatore Mandruzzato's
On the Abano Baths
(Padua, 1789)

Pieter Pauw, Succenturiatus
Anatomicus


ADRIANI
SPIGELII
BRVXELLENSIS
Equitis D. Marci olim in Patavino Gymnasio
Anatomiæ et Chirurgiæ Professoris primarii
OPERA
Quæ extant OMNIA
Ex recensione
IOH. ANTONIDÆ VANDER LINDEN
Med. Doct. et Professoris in Academia Franekerana
AMSTERDAMI
Apud IOHANNEM BLAEV
cIↃ IↃc XLV

nutrition as being important to survival under such unsanitary conditions.

New drugs, including purgatives, opiates, mercurials, drying agents, and emetics, were used in the military hospitals, and a number of fermentations and poultices developed to relieve pain

While general anaesthesia, especially chloroform, was widely used, local anaesthesia was still not to be available for another 4 decades.

Blood transfusion was used on two occasions in this war, involving transfusions of 2oz and 16oz with no hazard recorded.

By 1863 front line care had developed markedly with a recognition of the need to administer immediate first aid and start resuscitation on the battle field. This marks a most important development in disaster medicare — the recognition of basic life support within minutes of the accident

The regimental surgeons would apply dressings of lint or linen to a wound, perform minor surgical procedures, and sort out priorities of transportation and care. Serious cases were transportated in so-called "ambulances" to the nearest field hospital, where wounds were explored and metal and other foreign bodies removed from them. Because the legs were so often injured, with resultant damage to blood vessels and bone, amputation was common — there was little splinting for serious fractures.

There was a mortality rate of 26% with leg amputation, and over 90% died following fracture of the femur. There was a total of 29,980 amputations performed in this war involving fingers, hands, and limbs

Hemorrhage on the battle front was controlled by tourniquets or by the local application of styptics, including silver nitrate, tannic acid, and iron solutions. If surgical ligation of blood vessels failed, amputation was undertaken to save life. Other causes of death listed in the official war history included tetanus (505 reported cases), gangrene (2642 cases), erysipelas (1097 cases), and septicaemia (2818 cases), with close to 100% mortality.

The Civil War of 1861-1865 has been considered in this paper in greater depth because of its significant impact on improving many aspects of disaster medicine delivery.

These included particularly the development and training of the front line ambulance corps, rudimentary triage, front line surgical care of severe hemorrhage, and improved pain relief and surgical care.

This war disaster was well recorded by the military historians and the lessons of its management and mismanagement were remembered fifty years later in World War 1

3.3. The anesthetist

Pain, as old as mankind, is perhaps the most constant and most feared aftermath of any major accident. It is a symptom never neglected by the historians of disasters, who have recorded that Napoleon's painful piles are reputed to have sealed his fate at the battle of Waterloo, and that Magellan was tortured with war wounds.

Early remedies for pain were often in the hands of priests who relied on prayers together with what natural remedies were available at the time (Hippocrates wrote that "divine is the work to subdue pain").

While many ancient writings refer to a state similar to anesthesia as we know it, pain relieving drugs are of recent origin Alcohol, opiates, and plants containing hyoscyamus had been known for their pain relieving properties for thousands of years before inhalation anaesthesia was discovered in the 18th century It was known that some amputations were carried out under the sedative powers of alcohol.

Hippocrates knew of the value of cold in causing pain relief, but it was not until the middle of the 19th century that this was used as a skilled tool in regional anesthesia. In 1807 Napoleon's Surgeon-General, Baron Dominique Jean Larrey, observed that amputation could be painlessly performed on soldiers who had been lying for some time in the snow.

In 1792 in Bristol England, Thomas Beddoes set up a small hospital laboratory and later developed techniques to administer medications by inhalation.

Humphrey Davy, appointed by Beddoes as superintendent of the Pneumatic Institution, about this time discovered the pain relieving properties of nitrous oxide (previously discovered by Joseph Priestley in 1772), an agent which to this day has a most valuable place in disaster medicine.

It was not, however, until 1831 that Dr. Crawford Long applied it to surgery.

The value of ether and chloroform in bringing pain relief and improving surgical efficiency is now well recorded in the history of disaster medicine. These two, together with nitrous oxide, have been widely used in wars and other disasters since the 1860's. While the popularity of both ether and chloroform has now been surpassed by other safer anesthetics, nitrous oxide is still widely used.

Since their maturation as a speciality worldwide anesthetists have played a significant role in disaster management through their skills of resuscitation and pain relief.

3.4. Moving the sick

Almost every means of transportation has been used over the centuries to move the sick and wounded: mules, camels, horse-drawn ambulances, trains, and ships.

The Civil War raged for 2 years in the 1860's before effective ambulance systems and hospitals evolved.

From Girolamo Mercuriale's
De Arte Gymnastica
(Venice, 1573)

It took about another century for medical science to agree that an ambulance was not so much a transport vehicle as a treatment vehicle and that the severely injured should never be moved until their shock is treated and they can stand the hazards of transportation.

In dealing with disasters of such magnitude as earthquakes and flooding, which may occur in remote and underdeveloped areas, normal transportation for the carriage of the victims may, of course, be nonextant, as it was with many early disasters before the development of aero medical evacuation. Essential too is effective communication which was also lacking till this century.

Modern disaster medicine has developed only through wise observation of many crippling disasters. It will continue to develop only if we are prepared to remember the mistakes of the past.


THERIACA
ANDROMACHI SENIORIS
D. ANTONIO MOLINETTO
D. SERTORIO VRSATO
NATIONIS PLONÆ
D.D. GEORGIO YANDALINO

Bill on the publication of the Theriaca (Padua, 1657)

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PART II:
Society's response to major disasters and future trends

As we have seen the frequency and magnitude of natural and man-made disasters in steadily increasing throughout the world, imposing a heavy strain on the essential services of most countries. Drought, famine, war, refugees, epidemics, and technological accidents, whether happening singly or, worse still, in conjunction, are events and dangers that threaten growing numbers of people. There is, at present, a "disaster belt" — of earthquakes, cyclones, or desertification — extending over most of the non-industrialized world and affecting some 90 developing countries, few of which have the technical knowledge, planning capacity and necessary resources to cope with the disaster that can strike any time.

Yet a single disaster can destroy laboriously constructed services and instantly annihilate costly attempts at development. Hence the need for concerted action by society and the international community.

By "international community" we mean not only the classic organizations that come to mind automatically, such as the UN and the Red Cross, but also the community formed by a host of institutions, official or benevolent, large or small, governmental or non-governmental (the NGO's), religious or lay, each founded with a well-defined purpose, each with resources, large or small, all pursuing humanitarian aims of different kinds.

It will, however, be seen that in total disaster management all sectors of modern society — health, public works, agriculture, economy, politics — are very interdependent.

Disaster management

Research and field surveys over the past decade have shed new light on the effects of disasters and therefore have indicated better ways to provide the appropriate response and emergency care.

The following are basic principles:

1. The greater the preparedness for possible or foreseable events, the more effective relief operations will be.

2. Such preparedness comprises (a) the practical organization of every element needed in providing assistance and (b) planning, such as the construction and siting of housing or hospitals in a rational way.

3. Although in many ways no two disasters are alike, the problems that a certain kind of disaster will create are quite foreseeable — qualitatively if not quantitatively.

4. Planning and preparation on an international scale are essential to effective international relief.

5. Mobilization of the profession must be so organized as to be able to respond immediately to the probable needs when disaster strikes.

6. There must be adequate evaluation of the risks and of the effects of intervention, and a study of the post-disaster situation.

7. The post-emergency phase offers an opportunity for taking steps to mitigate the effects of a subsequent disaster.

8. The reconstruction phase starts at once.

9. Total management needs research, teaching, training of skilled personnel and a workable cooperative network.

The effects of disasters on health

Knowledge of conflict disasters is, we are afraid, much more advanced than our knowledge of the effects of natural disasters. The consequences of war and military medicine are well known, whereas disaster medicine has only recently become organized as a discipline. But this organization is proceeding rapidly.

For example, surveys have shown that each kind of disaster has its own epidemiological profile and pathological characteristics, and these differences and similarities are very important in planning, in prevention and in relief operations. Such surveys and epidemiological information have also helped dethrone long-established myths, like the assumption that typhoid frequently follows disasters.

The effects of natural disasters on health can be looked at under four different aspects:

1. availability of medical and health facilities in services, personnel and equipment;

2. immediate casualties and deaths due to the disaster;

3. disease and deterioration of health following upon changes in the environment;

4. damage to medical and health centers or services.

a) **Immediate effects**

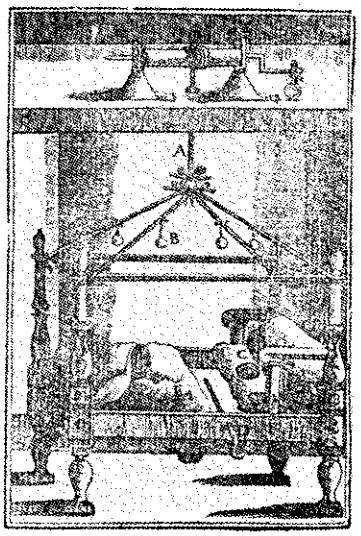
Earthquakes cause three times as many injuries as deaths The urgent need here is therefore for surgical and resuscitation services rather than, for example, antibiotics; very useful information in the appropriate deployment of scanty resources in an emergency situation.

In this kind of disaster the age group is significant too; morbidity is higher among the very young and the elderly.

Flash floods, on the other hand, present a different picture — the dead (by drowning of course) number more than the injured, of whom, as in *cyclones,* there will be few. But diseases can follow quickly in this case.

b) **Secondary effects**

Besides causing immediate damage or casualties, disasters give rise to other health problems, such as communicable diseases, psychological disturbances, and the danger caused by food shortage or damage to the environment.



Sanctorii... de Medicina Statica (Rome, 1704)

It is often believed that epidemics follow disasters, but in fact they are rare (another myth exploded by disaster research!) Knowing this, the meagre resources available can be used for more realistic and useful purposes than unnecessary vaccinations.

Preconceived ideas about psychological disturbances also need changing. Disasters do not appear to produce major psychological problems. A certain degree of confusion and stress may be regarded as "normal" and is usually temporary. But some forms of neurosis and depression may appear later in predisposed individuals

Statistics show that far from causing psychological upsets or antisocial reactions, such as flight, disasters appear to promote a sense of solidarity and mutual aid among their victims. In a way, they seem to bring out the best in people.

On this encouraging note, let us consider the action of the international community in disasters.

Action against disasters

The increasingly organized and scientific approach to disasters makes prevention more effective, relief more appropriate, and management more efficient

But it must be stressed that, whatever its scale, international aid is never more than a tiny part of the total effort in a disaster.

It is always the afflicted country that bears most of the burden — up to 80% of the efforts for relief and reconstruction. It is only fair to say this, for there is a false impression, a myth, that the rich countries are the ones that save disaster-stricken countries:

Having paid this little tribute to the unlucky ones, let us come back to international aid.

International aid

International aid can be looked at from three angles — planning, mobilization and co-ordination.

Following a disaster, international relief is expected and often provided generously. Plans, therefore, have to be made in advance to organize the division of tasks and maximize the effort.

Generally speaking, four different systems are involved in international aid — historically most of them arising from disasters — to alleviate disasters. The ICRC was born on the battlefield of Solferino, the League as a result of the First World War, the United Nations after the Second World War, Oxfam as a result of the Bangladesh famines, and Caritas Internationalis as a means to alleviate suffering worldwide.

International aid may be represented by the following diagram:

This shows the four separate mechanisms — (1) the United Nations, (2) the International Red Cross, (3) the Non-Governmental Organizations, and (4) bilateral direct assistance

ACTION OF THE INTERNATIONAL COMMUNITY IN DISASTER

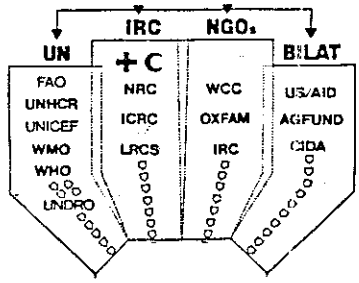


FIG. 1 *Schematic representation of society's coordinated response in case of major disasters*

TABLE I.
WHO EMERGENCY HEALTH KIT

Contains:

2 Drug Lists (A & B)

List A: 25 simple drugs for use by auxiliaries
List B: 31 additional drugs for use by nurses or doctors

and

1 Equipment List (C)

List C: 67 items of standard clinic and simple laboratory equipment

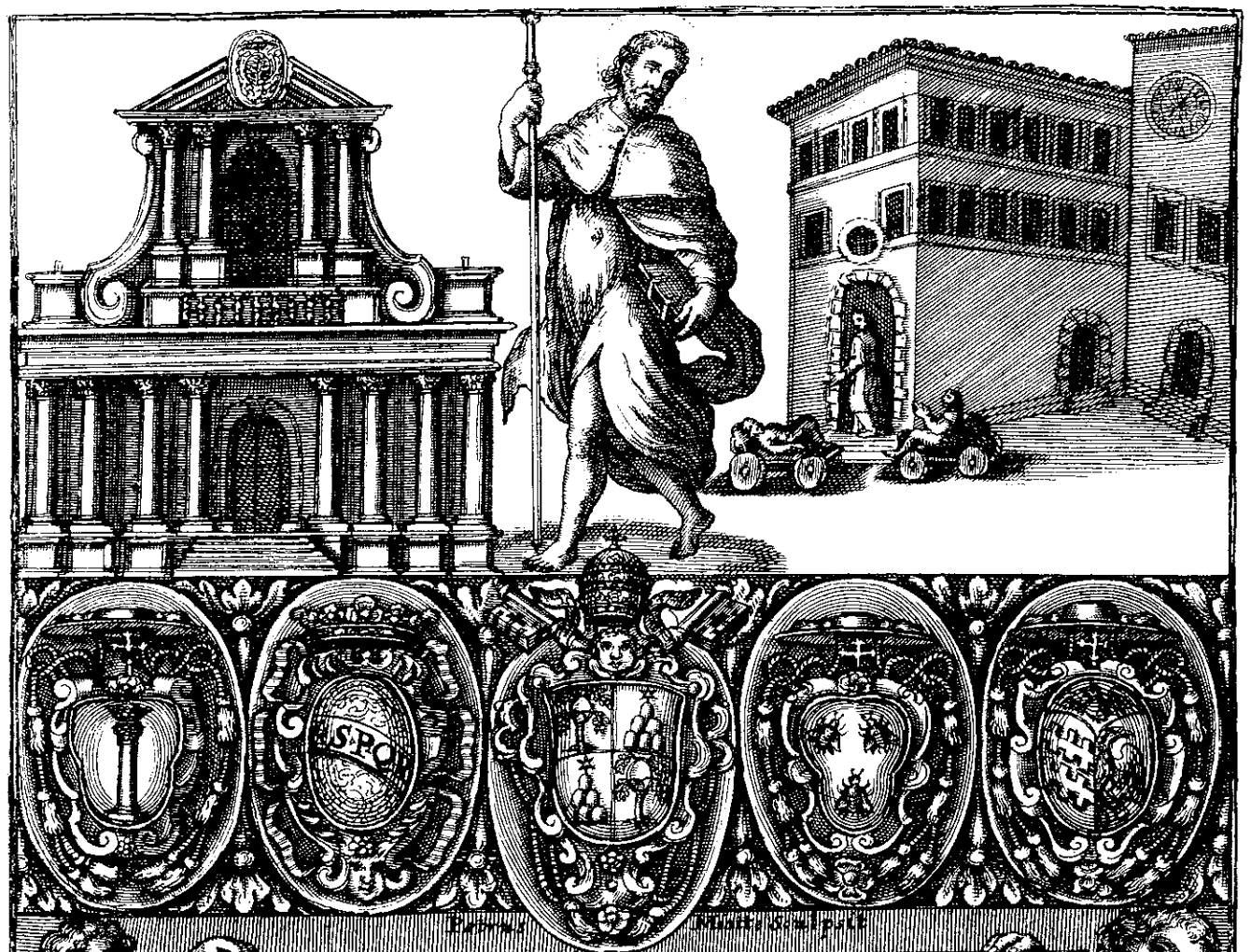
1. The United Nations

Each Specialized Agency in the United Nations system has a task of its own — FAO deals with food emergencies, UNEP with environmental disasters, UNHCR with refugees and mass migration, UNICEF with children, and WHO steps in whenever health is endangered. Its work covers the two separate activities of emergency aid and prevention

There are, as you see, large numbers of agencies Their work has to be co-ordinated, and UNDRO, the Office of the United Nations Disaster Relief Coordinator is, as its name implies, responsible for this, at least within the UN system.

2 The International Red Cross

There is sometimes confusion about the various Red Cross organizations. The International Red Cross is made up of three components:
(a) the International Committee of the Red Cross (ICRC)



STATVTI
DEL VENERABILE ARCHIOSPIDALE DI SAN GIACOMO IN AVGVSTA NOMINATO DELL' INCVRABILI DI ROMA

Appreſſo gli Stampatori Camerali
M·D·C·L IX·

Con licenza de Superiori

Rutilio Dandini del.

(b) the League of Red Cross and Red Crescent Societies
(c) the National Societies.

The ICRC is an entirely Swiss organization and intervenes principally in conflictual disasters and wars and in matters of humanitarian law.

The League is the international federation of all the National Societies and is concerned above all with natural disasters.

The third element is the National Societies, such as the French Red Cross and the Egyptian Red Crescent, whose activities are primarily geared to the needs of their own countries

It is important to realize that although the Red Cross is a non-governmental organization, it enjoys official status in every country. This distinguishes it from the general run of NGO's and gives it special importance.

3. The Non-Governmental Organizations (NGOs)

There is a host of voluntary humanitarian organizations doing good work in disasters. The Catholic Church's Caritas Internationalis, Terre des Homme, Médecins sans Frontière and Oxfam are just a few of the better-known examples out of the several thousand aid agencies. Some specialize in specific fields, such as nutritional assistance or providing orthopaedic support to amputees

4. Bilateral aid

This is direct assistance between a donor government and a beneficiary government, for example between France and Chad or Switzerland and Nepal.

Some countries have permanent machinery for such aid; for example, the Corp Suisse pour l'Aide en cas de Catastrophe (Swissaid) works under the Swiss Federal Ministry of Foreign Affairs, and CIDA, the Canadian International Development Agency, is a governmental body for aid to the Third World.

As can be seen form the diagram, the systems overlap, and the arrows show constant interaction among them This is intentional and very real and makes the work more cooperative, productive, and truly international.

Tangible action

And now, from general remarks on organization we shall go on to two practical examples of international activities that are specific, coordinated and useful in time of disaster. We shall take standardization of medicines and training of qualified personnel.

Standard medicaments and equipment

In every disaster donor countries or organizations provide large quantities of medicaments and health equipment, solicited or not. Their usefulness is often reduced by various factors, such as failure to assess real needs, unrealistic requests, unsuitable gifts, superfluous pharmaceuticals, an excessively wide range of medicaments, the dispatch of unsorted articles, unintelligible labelling, expensive products, perishable or outdated goods, late arrival, customs restrictions etc. In short, there is an aid disaster on top of a natural disaster.

After several years of study and trial and error we established standard lists of medicaments and medical and health equipment that do much to alleviate these difficulties and facilitate urgent action. The *WHO Emergency Health Kit* was produced jointly by WHO, UNHCR, the League and the University of London, and is now in almost general use. It is a reliable means of obtaining medicaments and equipment essential to an emergency clinic, is prepacked and kept in stock, and is calculated to cover the needs of 10,000 persons for three months. (Table I)

Training

Disasters are becoming more frequent and more serious. There is a growing need for qualified personnel to cope with them. Several universities in France, Switzerland, and elsewhere have introduced teaching and training programs in this very complex sector, and disaster is now becoming a full-fledged discipline. The Council of Europe has established a Center at San Marino.

There are specialized publications on the subject (Fig. 2), and the bibliography is already substantial

These, then are two examples of tangible concerted action.

In conclusion we will indicate the future trends in the development of disaster medicine that include the following:
With lifesaving potential for everyday EMS and conventional wars, we should insist on adding resuscitation potentials to the so far mainly public health oriented disaster medicine planning-preparedness-response systems.

Let us use DM as a carrot for pushing worldwide life supporting first aid training of the public.

Let us use DM as a carrot for establishing regionalized highly specialized trauma center hospitals, capable of sending advanced trauma life support medical teams to disaster scenes.

Cope with multicasualty incident type disasters by developing local-regional systems, worldwide, first for basic and then for advanced cardiac and trauma life support (in developing countries, the latter is more important than the former).

Foster for coping with mass disasters the development of national disaster medical systems (NDMS's) to reinforce the local-regional EMS systems. Draw the military into NDMS planning-preparing-responding Consider a fusion of military and civilian medicine, as in Israel. Design the NDMS separately for each country, with a major earthquake scenario in mind. This would also meet the needs of local wars and natural mass disasters other than earthquakes Have a radiation injury component, including evacuation plans, for nuclear accidents — maximally for the explosion of a small nuclear device by a terrorist — no preparedness for the explosion of even one major nuclear warhead (nuclear war is out). Shelter programs for fallout in nuclear accidents, as planned in Switzerland for localized nearby nuclear war, is a debatable "civil defense" issue. Get rid of the word "civil defense," as it smacks of war. Use the term National Disaster Response System (NDRS), to include NDMS and to be planned jointly by the medical profession, the nation's public health institution (government), overall national disaster planners (civil defense, NDRS), and the military.

Endemic-epidemic disasters are a totally separate issue, to be managed through economic-political mechanisms (e.g , East Africa).

NDMS for an earthquake scenario, in our opinion, should not include field hospitals, which cannot be set up rapidly enough, but rather mobile ICU type surface vehicles and aircraft staffed by ATLS teams, including physicians experienced in traumatology-resuscitation-anesthesia, etc.

At the next WAEDM meeting in Rio, experts who have had first-

hand experience in earthquakes, particularly from Latin America, will be called together to see whether they can develop international guidelines for a resuscitation component to be inserted into NDMS planning.

It should be stressed that the capacity to deal effectively with the possible future catastrophes of modern civilization will be closely linked to the progress of Disaster Medicine.

Unfortunately, a positive evolution in emergency health services is accompanied by a negative evolution in the kinds of disasters

Natural disasters (earthquakes, volcanic eruptions, floods) as well as those caused by man (technological accidents) have until now affected more or less limited areas, involving regions or nations. There are grounds for assuming that in the near future certain disasters (nuclear and industrial accidents) may affect entire continents, to such a point that the term "planetary disaster" will be justified.

The possible effects of this kind of catastrophe, the organization of relief, and intervention planning were extensively analyzed during the Third Emergency and Disaster Medicine World Congress, held in Rome in May, 1983. [9]

In the course of that meeting, emphasis was placed upon the alarming increase in risk factors related to major technological (chemical, bacteriological, nuclear) disasters.

Events have unfortunately confirmed some of the concerns expressed on that occasion. The Chernobyl accident has demonstrated that human labor has succeeded in creating risk situations superior to the possibilities of human control

Luckily, the immediate consequences were not so dramatic as might have been expected, but the accident represented an experimental model of a type of disaster where man is not in a position to intervene to contain the immediate and secondary effects involving future generations as well.

We have thus seen how Disaster Medicine has only recently found its definition and delimited fields of action. This new scientific discipline has contributed first of all to underlining the fundamental importance — we could say indispensableness — of cooperation among diverse national and international organisms and, in addition, ascertained the still sadly limited resources to face such events when they reach a degree of extremity.

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Testimony

J. De Ketham, Fasciculus Medicinae
(Venice, ca. 1490)

Experiences in a Missionary Land

Testimony of a Patient Consecrated to God

Providing Medical Attention in a Missionary Land

To prepare oneself to carry out useful missionary work, one must get into a particular state of mind. I feel the best attitude to take involves not having any prior, immutable assumptions on how one should inexorably act before making decisions in another environment, when one still does not know the focus and area of action and the needs of the time and the place.

We have experienced a valid demonstration of this view in the company of a medical team of Conceptionist religious in Cameroon.

In 1970, a little group of Conceptionists made up of individuals trained in providing medical assistance at the Immaculate Mary Dermopathic Institute in Rome journeyed to Cameroon to attend a leper village at Sangmelima.

It was an environment of poverty and abandon, with all the problems entailed by these centers, which spontaneously take in people belonging to different tribes and coming from various areas.

We well know how strong the tribal bond is among the diverse ethnic groups of Africa; membership in a tribe is thereby a much more solid link than those provided by a language community or a nationality. At these centers of artificial community life — which were specifically called leper villages, but which substantially amounted to camps for excluding or isolating the victims — individuals from varying points of origin were brought together.

In addition to minor objects of prime necessity, they also brought with them nearly their entire families, wives and children. Healthy people as well were thus forced to live together with other persons, other families coming from different areas and belonging to different tribes.

Life together in the village was thus decidedly precarious; quite often, aside from the difficulties of the disease itself, uncomfortable situations and misunderstandings could arise, when it was not a question of outright clashes and reprisals. This state of affairs predominated at the leper village in Sangmelina as well. Treatment of the lepers was therefore effected in genuinely unstable surroundings, with unreliable hygiene and notable sacrifices on the part of the scanty personnel providing assistance.

The little group of Conceptionists consequently found itself resolving some very demanding problems, above all to achieve greater efficiency in treatment and improved facilities, but also to integrate these disordered, scattered aggregates into a single society so that community life would be as unruffled and peaceful as possible.

From a humanitarian standpoint, what was most precarious was the fact that in these environments patients who had already suffered inexorable damage from cutaneous dystrophies or irreversible mutilations were forced to live with the temporarily ill in an acute phase or re-entering one.

Promiscuity was thus an obstacle to providing better attention. There were no adequate or sufficient means of isolation to offer guarantees against the danger of infection.

At that time, the World Health Organization was structuring treatment for lepers in a completely specialized manner, much more efficient and reliable, and much more manageable, for it did not permit any evasion of guarantees against infection.

Different frameworks for health care were being recommended — there were no longer to be villages and concentrations of lepers and their families which created so many medical and social problems, but only treatment for patients who were not self-sufficient, those with already irreversible mutilations and damage, who required either dermatological care for their wounds or orthopedic and surgical attention for their mutilations. But in these cases it was not necessary to provide any assistance beyond outpatient care which could be effectively supplied in their own villages.

Inpatient care was strictly called for only when patients had just become infected or were in an acute phase.

The leper village could thus be eliminated by sending the ill back to their original places of residence and seeking to organize efficient medical attention there.

To update information from different villages on the chronically ill and evaluate cases of new infection or reentry into an acute phase, we charted a clear course, heading in the direction of each village with patients

Johann Schultes (Scultetus), Armamentarium Chirurgicum, Venetiis, *1665*. *Table 33*

registered. The "check-up," in addition to providing for the treatment and study of known cases, disclosed other infections and especially acute cases or new infections coming to light in a quick examination.

During these check-ups, all the medicines needed by the patients at a given point were also supplied.

This check-up enabled us to keep under control not only the unrecoverably and chronically ill, but also, and most especially, the new cases appearing while at the same time ensuring a supply of necessary medicines adapted to every individual.

In this way, difficulties of a social and tribal nature diminished, and the patients remained in their own home villages.

Early detection of sudden spreading of infection and early treatment were thus guaranteed.

Cameroon was one of the first countries to adopt the decisions on care for lepers of the World Health Organization with a solid commitment, thereby providing noteworthy benefits in the increased effectiveness of this kind of prophylaxis.

The small group of Conceptionist religious which was carrying out its activity in more than one village-center with over five hundred leper families rapidly adjusted to these new frameworks for medical assistance, and it did not take long for the results to become visible — a decreased work-load and, therefore, greater availability to deal with other health care needs.

The medical centers which had in the meantime been instituted in the leper villages continued to serve both to attend the chronically ill and to initiate specialized care, gradually turning into hospital centers for general medicine and surgery which had previously been entirely lacking in these areas.

Some of these hospitals, like the one at Ndem, which no longer attended lepers, evolved into major institutions that were extremely useful in those regions so far removed from other centers.

But new situations in which to apply this unexpected increase in availability were in the offing.

One of the health problems which was growing in a truly alarming way in these countries was the spread of poliomyelitis and its consequences, with a considerable number of paralyzed children.

There was a pressing need to develop a range of tests and obtain data so as to be able to supply medical assistance.

For this reason, the little team devoted itself to identifying and registering individuals incapacitated or in some way affected by this disease at the different jungle centers, organizing orthopedic and surgical rehabilitation, water massage, and all other suitable treatment for them at the facilities already dedicated to lepers and at new residences established for this purpose. This care quickly proved to be both useful and efficient.

Today these centers — run by missionaries, but basically in the hands of natives — are of great utility in furnishing this kind of attention, which would otherwise not be available.

But another need appeared before the watchful eyes of this company of health care providers.

Infant mortality was unusually high in the region. Infections, along with every other type of complication associated with the common illnesses, were due to poor sanitation, particularly to water pollution in the villages and huts.

The first commitment to be undertaken was, therefore, the purity of the water used for drinking, cooking, and cleaning house.

Thus the so-called "opera-

tion wells" commenced and was adequately organized.

In lower Cameroon, the streams and rivers in the midst of the jungle are extremely numerous. Under the initial guidance of a missionary, representatives of the centers in villages with a small number of men then dug wells in rather elevated sections of each locality, finding water and extracting it for use. Once a pure water source had been created, it was intelligently protected against new pollution by locating washing and cleaning areas for the entire village population further down the slope.

Toilet facilities for both men and women were also set up well away from the water sources and washing areas so as to avoid the possibility of future pollution.

All of these elementary structures were created with the villagers' full approval so that they would be perfected and efficiently maintained.

At the same time, other missionary collaborators taught village women to provide basic diets, particularly for children, and to sterilize the water used for drinking and cooking; everything was illustrated with drawings and slides which greatly facilitated assimilation of these essential concepts of family hygiene.

Most importantly, however, in every village, after receiving the missionary's contribution, certain groups committed themselves to offering this same assistance to another nearby village so that it could implement similar reforms.

It thus became possible to create a production chain for digging the wells and setting up washing and toilet facilities around them which in a few months' time resulted in over 200 wells for over 200 villages — a truly outstanding achievement.

Shortly thereafter a sharp decrease in infant mortality was observed, and hygiene-related complications and intercurrent illnesses considerably diminished.

In this context, it was much easier to introduce the prescription of simple medication for possible intercurrent illnesses likely to appear.

Our description of the missionary commitment of the team of Conceptionist religious acting so dynamically to meet the needs of each environment shows that being present in mission areas, especially in terms of medical care, means quickly adapting oneself to the population's demands and requirements, bringing one's contribution to bear in a functional manner where it is most necessary.

As regards the region neighboring their field of activity, an urgent need later materialized.

In what formerly had been Spanish Guinea, a despotic regime was rooting out all traces of community life and all religious and civil assistance. This land is today completely abandoned.

The group of Conceptionists working in Sangmelina in lower Cameroon are not far from Spanish Guinea. They are now rebuilding a whole network of social services with basic aid for this region where everything is lacking while continuing to provide the same assistance in their place of origin.

The collaboration of carefully selected and trained natives will gradually allow these efforts to become autonomous and leave the Missionaries free to take on new commitments.

Lepers with incurable mutilations are now being expertly and efficiently attended by indigenous personnel, as are the handicapped as well; and in the same manner well-construction and hygienic prophylaxis are autonomously developing in a chain reaction throughout southern Cameroon.

I believe the unfolding of the Conceptionists' activity offers an elementary paradigmatic demonstration of how much it is possible to do in a missionary land with a few people and quite limited resources.

PROFESSOR RINO CAVALIERI
Department Chairman
Immaculate Mary Dermopathic Institute
Rome
Consultor of the Pontifical Commission for the Apostolate of Health Care Workers

A Medical Missionary in China

When they call him the "Schweitzer of the Far East," he nearly gets offended, for, in both mentality and character, he feels and knows himself to be different, quite different.

At the age of thirty-three, Dr. Janez, at that time a recognized surgeon, gave up a promising "career" to go and work as a medical missionary among the Chinese — four years in Mao's China and thirty-four in Formosa (Taiwan).

He has never returned to Lubiana, where he was born more than seventy years ago, or set foot outside of Taiwan.

He is celibate. "How could a woman live with me?" he laughs. "She'd suffer too much on that account!"

He is jesting, but in the easygoing reply there is a bit of truth. He in fact grants himself no rest — 365 days a year, 24 hours a day.

No one knows how, when, and how long he sleeps; he takes his meals alone in his room, close to the telephone, ready to respond to any call. An impossible, absurd pace — one might say that of a slave if one were not familiar with his great love for the sick.

The assistants take turns in the operating room, in the ward (200 beds), and in the out-patients' department, but they find it hard to withstand — their strength does not hold up.

"You'll see," I confronted him one day; "you'll end up caving in, falling to the ground!"

"Perhaps."

His tone was ironic. I replied, "You've got no right to force your capacities beyond their limits."

"Oh, you're certainly right! It's necessary to save one's strength!"

He laughed long and deeply, with gusto and the grimace of a rebellious youngster.

"I'll be a missionary," he said, and he enrolled at the faculty of medicine.

As a youth, he thought of becoming a priest. His mother, extremely religious, enthusiastically supported him, but it was not long before the lad realized that the priestly path had not been made for him.

In informing his mother of his change of mind, he consoled her by saying, "I'll be a missionary," and he enrolled at the faculty of medicine.

During the war years, hospital work and political events completely absorbed his time and energy.

The vicissitudes of government forced thousands of Slovenes to flee. Dr. Janez, by then a recognized surgeon in Lubiana, was among them.

He emigrated to Argentina. When on the point of resuming surgical practice in Buenos Aires, with clear prospects of rapid success, he received a humble request from China, from his fellow countryman Salesian Joseph Kerec, who asked him to go and take charge of a little hospital in one of the poorest parts of Yunnan.

He experienced a moment of understandable excitement and then made the great decision: "I'll come as soon as possible," he wrote the missionary, and left immediately.

In Mao's China and Formosa

On arriving in Yunnan (April, 1948), he was surprised to find the quadrant of history centuries off the mark.

He found it hard to get the popular mentality to accept the scalpel. Hard and dangerous, because of the lack of equipment and, above all, the numerous taboos. Nevertheless, he gradually managed to dissipate the halo of mistrust which had taken shape around him. With patience and tenacious work, he won their trust — miracles always impose themselves in the end.

Unfortunately, the political storm caught him just at the beginning of an exceptional expansion destined to save millions of human lives.

Expelled in April, 1952, he retreated to Formosa along with the Camillian Missionaries, who had decided to open a small hospital in Lotung (pop. 40,000), on the eastern coast of the island, 100 kilometers from the capital, Taipei.

Thirty years ago, Formosa (at that time with eight million inhabitants and an annual population increase of 5%) was scarcely more developed than continental China. There was a lack of roads, means of communication, industries, energy, and so forth. The health-care situation was a little better, but the deficiencies were numerous and impressive.

The day after their arrival (June 15, 1952) they started work on a modest surgery sec-

tion of twelve beds. On July 17th, the first operation took place.

Within a week's time, the whole vast area of the district (2,000 square kilometers, 40,000 inhabitants) was familiar with "Dr. Fan" (Dr. Janez' Chinese name). The number of beds was increased to forty, and a year later another fifty were added.

Year by year St. Mary's Hospital has continued to grow until becoming the current medical complex of 600 beds in five specialities: Surgery and Medicine, 200 + 200; Pediatrics and Gynecology, 50 + 50; TB Sanatorium, 100; and a general surgery with an average of nearly 1,500 consultations a day.

Over 70,000 operations

Dr. Janez has made a name for himself in Formosa. He holds a world's record which it will be hard to break: 75,000 major and middle-range operations in thirty-four years!

If he had to narrate it, he would be forced to fill volumes, but he is allergic to propaganda. Journalists and all others wishing to interview him find him "touchy" — they call him a "character."

With the sick, however, he is totally different: understanding, open to "dialogue," in spite of the daily stress of his work and the isolation of his little world.

Among the common people, he is already a legend. You hear some curious stories, from the simplest and most obvious to the strangest and most exalted; reality and imagination are fused into an artificial synchrony which nevertheless fascinates and wins us over — not through the events in themselves, but as a result of the spontaneity and conviction with which they are narrated.

In the early years, when transfusions were still regarded as "heroic," Dr. Janez, taking turns with the Camillian Missionaries, resolved emergency cases by offering his arm for direct transfusions. He was, however, immediately forbidden, for he was sometimes forced to suspend an operation and sit down for a few minutes so as not to fall in a faint.

It was not, of course, just a question of donating blood; he was obliged to operate in an airless room, under the hot light of a powerful common lamp.

Today the surgery ward is endowed with four large operating rooms, air conditioning, scialytic lamps, adequate equipment, and a little team of young assistants.

But the throng of patients is always the same: fishermen, farmers, laborers, simple folk, the poor.

One of the most meritorious figures in Formosa

Some time ago, in the course of a friendly conversation, he unexpectedly stopped short and became thoughtful; after a few moments, he said, "I sometimes think that people regard me as a lunatic!"

He was not, of course, convinced of it; but those words pronounced in haste, out of context, made me reflect. In a fraction of a second I recalled the impressions received in my daily contacts with the sick.

"Look, Doctor," I replied, without altering the friendly tone, "it's extremely difficult to get an exact idea of how people judge us. I know for a certainty that everyone is surprised and moved and esteems you. They obviously can't articulate the supreme motivations prompting you to sacrifice yourself in this way.

"But what difference does it make? I think that the majority opinion can be reflected and summarized in the revealing expressions I frequently hear:

'There's no one so good-hearted as he!'

'We could never manage to be so generous and unselfish!'

'He has saved thousands of Chinese!'

'I owe my life to him!'

'I would never have thought that there could be men capable of loving people they do not know like this!'"

Visibly moved, he slowly walked off towards the operating room to resume the routine of his enervating work, which, day after day, hour after hour — from 4 p.m. to midnight — keeps him bent over the most complex, demanding "cases."

The words of a high-ranking government official came to mind; not long before, referring to the doctor, he had said, "He is one of the most meritorious figures in Taiwan."

Without fear of contradiction, he added, "I believe he belongs to that restricted circle of men who work not just for a people, but for all humanity."

Like Schweitzer? Dr. Janez has a distinct personality, not modeled after precedents — he shines with his own light.

History — the history of goodness — shall not delay in assigning him the prominent position to which he is entitled: lofty, exemplary, worthy of imitation.

FR ANTONIO CROTTI
Camillian Missionary in Taiwan

Spain Testimony of a Patient

1. What have your main life experiences been during illness?

For me, illness has been a visit by God which has joined me more closely to Him I had known for some time that I would need an operation on both feet and a knee, followed by three more operations on one foot I was very afraid of it all, to be quite honest. But I entrusted myself to the Lord and repeatedly told Him that I blindly accepted His will And acceptance brought me peace. I have since undergone five operations and been forced to wear a cast for many months every time. It has certainly been hard for me. But I have experienced the closeness of God's goodness in the love I have received from my sisters in the Institute and in all the kindness of the doctors and religious who have cared for me. I should also add that it has been an intense experience to find myself alongside so many other patients in much worse condition than I at San Rafael Hospital and realize how much people must bear As a result, in spite of my difficulties I have thanked God for my situation and prayed with faith that God may continue to inspire the doctors with wisdom so that, by their patient and selfless effort, they will be able to rectify so many defects and malformations. And I ask that He repay them for the long, wearisome hours in the operating room with the success they achieve and the gratitude they arouse in our hearts

2. What has helped you most during illness?

In an illness, everything proves to be an experience. It is a question of observing and meditating. I would say it all is a divine trick to inspire a marvelous practice of charity in health care. To explain my situation in the face of illness, I ought to state that I belong to a Secular Institute. I have, therefore, been consecrated to Jesus Christ since my youth, and what has helped me most during my prolonged immobility is my consecration, living it out, increasing my union with the Lord. I offer Him my privations And from Him I have received encouragement, particularly this past Lent, when I meditated on the sorrows of Jesus and the solitude of the Virgin Mary much more deeply. And I have regarded the suffering and pain accompanying all illness as a precious coin which I can offer God for the needs of the world, with the intention of collaborating, in my inactivity, with the apostolic missions being carried out by my Institute.

3. Has your undergoing illness changed your way of seeing life and "your life," your way of seeing others and relating to them, your way of seeing God and relating to Him? How?

Suffering illness has for some time made my life shift from intense activity to immobility But it has also awakened special feelings of love towards all my sisters; though I always sought to devote the greatest attention to them while working as a cook, today, in standing in need of their loving service, I have realized how generously they have offered themselves, showing interest in me on all sides, eager for my swift recovery.

In addition, as I mentioned in response to the first question, I have experienced the closeness of God and have sought to put into practice an example I heard my Foundress, Magdalena Aulina, cite on saying that an illness for the soul should be like when you take a car to a mechanic for a check-up I have tried to make a good examination so that the car of my soul will not have breakdowns and successfully reach its destiny.

4. On the basis of your experience, what would you like to say to other patients and their families, to the health professionals caring for the ill, to the Christian communities and visitors, to nonbelievers?

What a pleasure it is for me now to address all the people who have surrounded me with attention. First, the doctors. Thank you for the practice of your profession, for kindness in adapting to the uniqueness of each patient. Blessed be God, Who inspired in you a career so beneficial to humanity, whose service is a true sacrament of love enabling us to receive the fruits of the gift of intelligence with which God has endowed man. I also want to direct a special word of thanks to the entire health team You are tireless! And you never tell us patients that we do get tired to the utmost That's the least of it when we burden you with the number and seriousness of our problems. Your dedication causes me to see you as the benevolent hands of God. That's what I consider you to be. And I invite you never to lose your gentle word or smile for the one who suffers. I have prayed a great deal — I have had a lot of time — for all of you.

I also accept addressing a word to other patients like me, telling them, from my wheelchair or on crutches, to regard illness, any illness, as a unique circumstance coming to inform us that here in this world, in good times or bad, we are all just passing through An eternity is awaiting us all which will be immensely happy if on earth, even in pain, we trust God I know that when faith is not mature and active, it is always hard to understand illness. And the Lord, our most loving Father, understands us well. But in this world, even if it is our lot to experience some unpleasantness in human terms, we should think of the heaven awaiting us, concerning which we must not doubt. We who are ill suffer, it's true. But if we are patient and accepting, it is up to us to fulfill a mission, to provide testimony, benefiting all who do us the favor of caring for us, accompanying us, or visiting us. We patients must be alert to succeed in remaining grateful and not let our hardships weigh upon others.

As a final point, I encourage priests at clinics and hospitals and those visiting the sick to go on offering Jesus' closeness to the suffering by stopping in to see patients, even if only very briefly at times. I have never lacked such visits, and they have comforted me; and precisely for this reason I have grasped the need we all have — and especially those who are alone in hospital rooms — to share our pain with someone

TERESA PLA BUSQUETS
Magdalena Aulina Parish Workers

Trypanosomiasis in Uganda

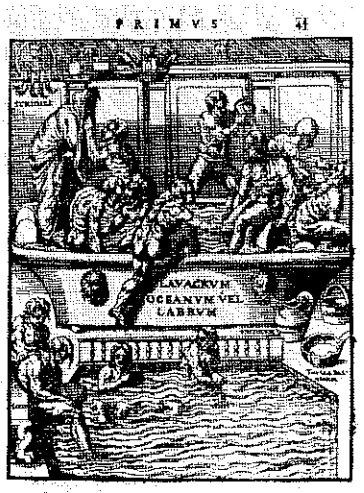
Serious internal tensions and economic collapse have caused the reappearance of a pathology which had for some time been completely eradicated in the African country.

Uganda is an observatory enabling us to realize that the greatest threats for Africa — for the life and health of its inhabitants — derive not only from "natural" disasters such as drought, famine, and volcanic irruptions, which have quite recently raged over vast areas of the continent, but also from a situation of profound political instability and deadly armed strife plaguing the existence of millions of people. Many African countries (South Africa, Mozambique, Angola, Sudan, Uganda, to name the most troubling instances) have been undergoing this tragedy for years.

Uganda is a country which has only partially — in the northeastern region — experienced the effects of drought; most of its territory is situated in a highly favorable position from a climatic and hydrogeological standpoint: the presence of two large lakes (Victoria and Albert) and the Nile crossing from the southeast to the northwest makes this country one of the most fertile lands in Africa, with an enormous potential for energy production (hydroelectric), crop cultivation, and raising livestock.

Until the beginning of the nineteen-seventies, Uganda was one of the African countries with the highest per capita income and a growing economy, endowed with an extensive network of health services and a relatively low infant mortality rate. In 1971, when General Idi Amin's coup d'état took place, this ongoing progress was interrupted, giving way to long years of terror, civil wars, and forced migrations. With the collapse of the economy and people's living conditions, the health care situation also fell into ruin. This context witnessed not only a rapid increase in pathologies typical of poverty, such as malnutrition and tuberculosis, but the reappearance of illnesses which had been regarded as almost completely eradicated, like trypanosomiasis.

Sleeping sickness has recently reappeared in Uganda in two areas separated by a considerable distance and marked by notable differences. In the southeastern region of the country a 6,000 square kilometer area infested with tsetse-flies on the banks of Lake Victoria was evacuated in the mid-forties to avoid the risk of infection. This measure proved effective since there were only a few dozen cases of trypanosomiasis reported each year. But since 1976 there has been a rapid increase in such cases, going from 52 to 3,551 in 1985 and peaking at 8,465 in 1980. The reason for this fresh outbreak may be found in a return to the "prohibited" zone by fishermen and hunters spurred by extreme indigence to seek food, even at the risk of contracting sleeping sickness, in this instance Rhodesian trypanosomiasis, an acute and highly lethal form.



Various authors, De Balneis, Venetiis apud Iuntas, *1553*

A quite different situation is observable in another part of Uganda, an area of 3,000 square kilometers located in the northwest and bordering on Zaire and Sudan, where, incidentally, Italian cooperation is present in three hospitals and a network of outlying facilities. A certain balance had been established here inasmuch as the tsetse-fly had found its ideal habitat in the humid forest zones along the rivers, whereas the population had settled in higher areas, beyond the reach of the illness. In 1979 and 1980, this region was at the heart of intense armed conflict between retreating soldiers of the dictator Amin and the liberation forces which had a devastating effect upon the life of the population; many (between 230,000 and 300,000 people) were forced to take refuge in neighboring states. At present, given the improvement in the political situation and security conditions, a counter-exodus of the refugees is taking place. In search of food, these persons have not hesitated to rush into the tsetse-infested areas. It is estimated that 1% of the refugees have Gambian trypanosomiasis (a chronic and slowly advancing form) and a good part of their livestock has contracted animal trypanosomiasis. As a result, to the already huge problem of receiving and assisting tens of thousands of people returning to their land, there is added the danger of the spread of the disease to men and animals. The Ugandan government has worked up an important five-year project (1986-1991) to eradicate the tsetse and eliminate trypanosomiasis. This project also aims to restore the 9,000 square kilometers that are now infested and devote them to basic productive activities: agriculture, livestock raising, and fishing. The task is expected to cost $21,000,000, and it will be extremely hard to perform unless there are substantial contributions — already requested — by international bodies and donor nations.

GAVINO MACIOCCO
Department for Cooperation and Development
Kampala

Is the Suffering of the Ill Salvific?

Doctors of the fifteenth and sixteenth centuries J. De Ketham, Fasciculus Medicinae *(Venice, ca 1490)*

Though our knowledge is quite limited, we hope to succeed in conveying the problematic within our African context, where we wish to be fully ourselves, with nothing that is foreign or imported. We want to speak of this ancestral Africa, animated and activated by the traditional religions. It is precisely by probing into the origins of the black world that we seek to give an answer to the question that has been posed.

We certainly need not await a reflection encompassing the entirety of African culture, but shall dwell exclusively upon that of the "Mossi," the dominant ethnic group in Burkina Faso.

At the outset, our aim is to consider the origin of illness among the "Mossi"; we shall then see how suffering is regarded as a school for the ill and thus arrive at a considered reflection touching upon our problematic.

The origins of illness among the "Mossi"

It must be stated that among the "Mossi" the conception of the origin of illness issues directly from their way of conceiving man and the world. We shall thus begin with this conception.

The "Moaga" (singular of "Mossi") is the destination point of various forces, the intersection of a great many lines. All of these forces join together in the woman.

The husband is the depository of the ancestral force (*sighré*), but this force alone is not sufficient when a human being is involved. The woman is then surrounded by spirits (*kinkirsi*) and other forebears (*yaabramba*); finally, the third force intervenes, the animal genealogical tree or totem. The totem may be regarded as the sign of recognition towards an animal for the service it renders man. The animal in question is thus identified with the ancestor saved by it; indeed, in saving the ancestor he has saved the whole family.

In short, in a broad sense, the Moaga is the reincarnation of an ancestor who returns to life, of a *kinkirga*, and of a totem; but he also possesses his own personality as distinct from the ancestor, the *kinkirga*, and the totem. He is truly himself.

Let us now see how the "Mossi" spiritual universe is made up of a Supreme Being, the ancestors, spirits, and all that comprise the human individual.

This spiritual sphere is completely oriented towards life and living better here on earth. The after-life is understood in terms of the present. In a word, the invisible world presupposes the visible one.

Man depends on the Supreme Being, on descent from the ancestors, on the *kinkirsi*, on the totem, on the whole invisible, spiritual world.

His destiny is in their hands. Everything which befalls him, good or bad, comes from them, depends on them. We can now understand how illness is conceived as an event proceeding from the spiritual realm. Evidently, the "Mossi" are utterly unaware of the biological origins of illness.

When sickness appears, for instance, the first thing to do is to hurry off to a fortune-teller, a clairvoyant, seeking to discover its cause.

Why this disease? Why this suffering?

The fortune-teller will then reveal that the illness is simply a punishment which is visibly and invisibly reflected in response to an offense committed against the spirits.

The suffering of the sick: a school for the patient

How can the suffering of the sick be characterized as a school? It should be considered under two aspects, as a school of initiation and a school of purification.

1. A school of initiation. Everyday experience on a personal level shows that man becomes an adult through

failure, illnesses, suffering, danger of death, and so on. This observation makes us regard disease as a school of initiation, an initiation which is a test; when it is over, man attains the true stature of his physical and spiritual dimensions.

Once the test has been completed, man recognizes in himself an unceasing call to make his life, his love, and his relations with others more dynamic.

Once healed, he will thank all who either directly or at a distance have accompanied him in his demanding trial, during which he has felt himself to be the center of attention of the whole family, of the whole village.

This illness has proved useful to him, for it has rendered him capable of dealing with others more wisely and in a more brotherly spirit.

It is not uncommon to hear quite profound and revealing reflections by some people: when one is healthy, the value of life and health is not adequately esteemed; it is in illness that one discovers the "road of reflection."

2. A school of purification. The aspect of purification is of capital importance in the sense that such purification re-establishes peace with oneself and with the visible and invisible realm, giving man back his true dignity.

We have already seen that the "Mossi" are completely ignorant of the biological origin of illness. Precisely for this reason, once the true origin of their malaise, their disorder, has been discovered, they set things straight again with a "redeeming" sacrifice.

In short, if it is true that illness is a punishment, it must be borne in mind that the suffering the sick person undergoes becomes a school of initiation and purification — initiation to reconstruct one's life and purification to harmonize the visible and invisible cosmic order.

3. Observation. This school of initiation and purification involves not only the sick person, but all who surround him as well.

In effect, the Moaga is not a lone individual, suspended or flung upon the banks of existence, but a being-with, a being-in-communion, a being-in-relation who wishes to be in community precisely to realize himself fully.

As a result, nothing is personal; everything is collective. At this point we grasp why the sick person's suffering is lived intensely by all those surrounding him as a school of initiation and purification. All may be explained by the respect and compassion with which the family environment remains close to the patient in his most difficult moments. A proverb indeed states, "Bumb ning fâa sê n maan talg na n maana naaba" (All that affects the common folk will sooner or later affect the chief as well). Here below no one escapes from the law of suffering. It is for this reason that the suffering of the ill makes those accompanying them wise, allows them to change their lives, to remain at peace and to confront everything with increased energy and courage.

Oriented conclusion. For the Moaga, complete well-being consists of succeeding here on earth prior to complete success in the beyond.

How does one succeed, then?

By using the necessary means: offerings, self-control, sacrifices, wise conduct, and so forth.

From this standpoint of success, suffering is understood to be an indisputable occasion to obtain well-being. In this sense, tales offer us a great many motives for reflection; in stories, orphans are always mistreated by their stepmothers, and when they flee to the woods, they encounter the good genies who save them and show them the path they must follow. The roads indicated by the genies are always strewn with obstacles, wearisome, and hard to travel, but the orphans' courageous tenacity always leads them to a happy end.

All suffering is an occasion for well-being. At the death of one who has been painfully suffering for a long time, these words will be heard: "He has suffered much; may God give him his just reward."

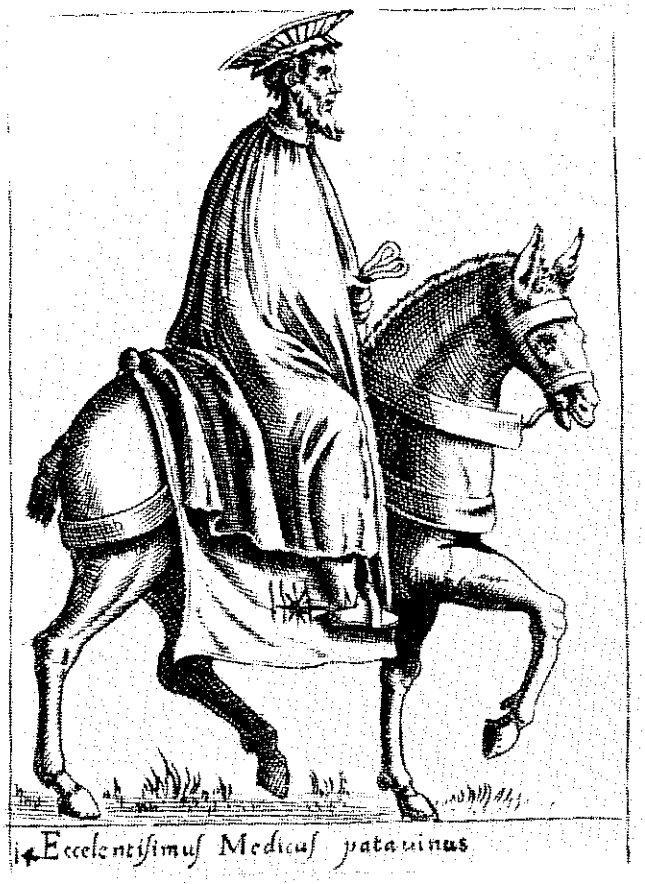
And when a sick person suffers excessively, he is wished a rapid end so that he may receive his just reward.

Here below no one escapes from the specter of suffering. But what counts is to suffer well with nobility of soul and dignity. For in our African context, suffering, whether physical or moral, is only a school of initiation and purification to arrive at complete well-being.

JEAN BAPTISTE OUEDRAOGO
JEAN PAUL OUEDRAOGO

Religious of St. Camillus
Ouagadougou Burkina Faso

Meetings



Paduan doctor of the sixteenth century (P. Bertelli, 1585)

Christians in Psychiatry

At the FIAMC World Congress

At the Thirteenth CICIAMS Congress

Depression: a Problem of Contemporary Man

The Pro-President spoke at the Fifth International Session of the Christians in Psychiatry Movement held in Strasbourg, September 15-19, 1986

I am happy to have been invited to bear the greeting and encouragement of the Pontifical Commission for the Apostolate of Health Care Workers to this Fifth International Session of Christians in Psychiatry.

1. Psychiatry: A Discipline in Transformation

Your meeting falls at a time of great interest for psychiatry, inasmuch as there is an increasingly evident need for reflection on and a summary view of twentieth century evolution in psychiatric thought and action.

This evolution has affected the very *doctrine* of psychiatry, which has gone from anatomo-pathological concerns to a stress on neurology, later coming to deal almost exclusively with the sociogenetic hypothesis on mental illness, and returning in recent years to a renewed enthusiasm for neurobiological research. The practice of psychiatric treatment has also undergone significant changes, passing from a kind of protective custody approach to electroshock therapy and the revolution made possible by altered life conditions in institutions as a result of psychotropic drugs. Emphasis has recently been placed, then, on deinstitutionalization and the problems in rehabilitating the mentally ill. Such changes in psychiatric theory and practice have in the end produced legislative action aimed at removing the regulation of mental patients from the domain of law enforcement and conferring upon them the right to vote while at the same time closing psychiatric hospitals in some countries.

2. Depression: A Problem in Our Time

Your meeting is taking place in this undefined but challenging context. The theme could not be of greater current interest for the psychiatry professional in general and the Christian in particular.

Depression is truly a problem in our time, characterized by the proliferation of neurobiological studies on this subject; the increased importance of currents in thought and artistic expression concentrating on depression as a topic for inquiry and creativity; the spread of situations in family life and society that are markedly unharmonious and thus often conducive to depressive reactions; new problems in the approach to the depressive patient determined by changed conditions in medical attention (such as opening or closing mental hospitals) which have reduced the possibility of control over the actions of the seriously ill; and, finally, the decrease in that powerful check on suicide constituted by religious practice, today manifestly on the decline. The spread of religious indifference, not to mention atheism, in addition to removing preventive barriers, makes it harder for the Christian working in psychiatry to maintain contact with the depressed patient.

3. The Importance of a Public Association of Christians in Psychiatry

I wanted to offer a brief sketch of the complex situation now facing the psychiatry professional, often subjected to conflicting pressures, and the Christian dealing with the depressed to stress the significance of your Meeting in gaining insight into these topics and investigating proposed action.

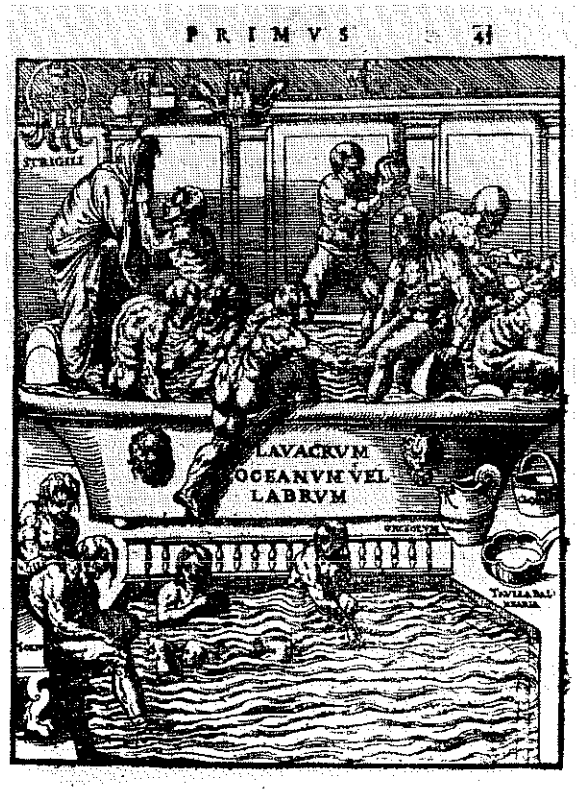


Table from Salvatore Mandruzzato's
On the Abano Baths
(Padua, 1789)

Please allow me, however, a reflection which goes further; above and beyond the moment and the theme, it is even more important than the existence of such a meeting or a Movement of Christians in Psychiatry.

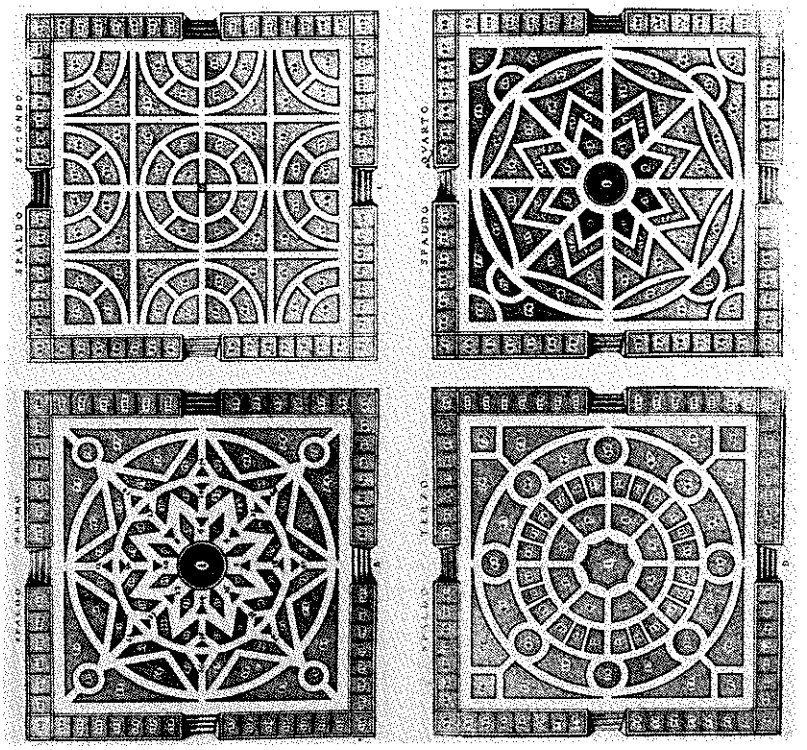
In no other field is it so necessary as in psychiatry to compare the results of scientific research with the demands of ethics, for psychiatric activity touches the very moral and spiritual sphere of the sick.

In no other field is there such a risk as in treating the mental patient — especially when seriously ill — that his dignity as a man will be forgotten, unless we manage to glimpse the real image of God, sometimes hidden by psychosis or intellectual deterioration. The history of many psychiatric hospitals and of many aggressive sociotherapies bears sad witness to this fact.

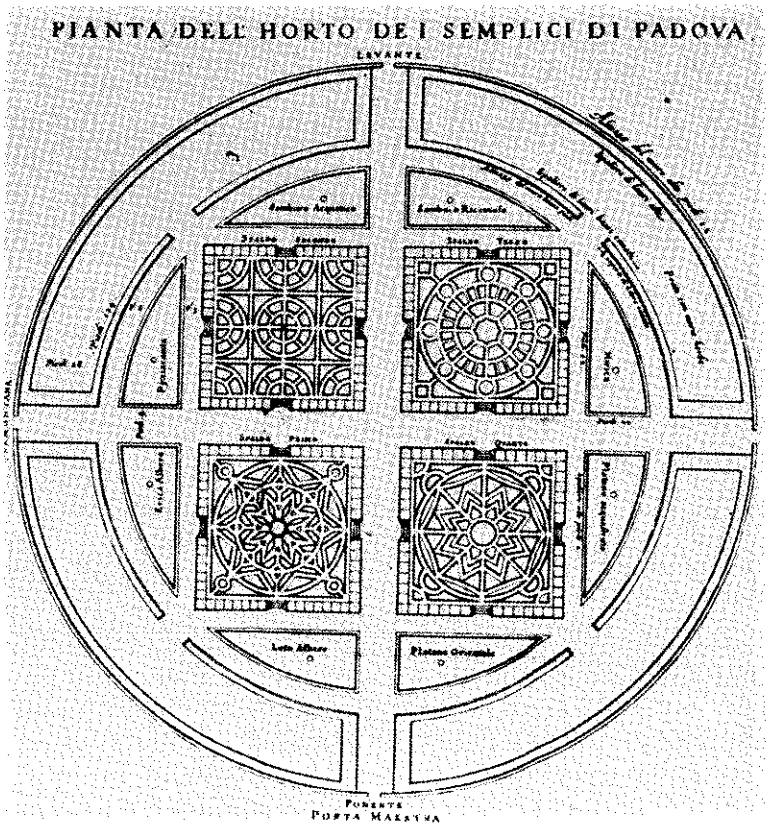
Coerced freedom, abuses for the sake of experimentation, the application of insufficiently tested therapies, violence, brutality and, on the other hand, savage abandonment masquerading as deinstitutionalization, privacy, and unselfishness demand a presence of Christian professionals capable of making their voices be heard loud and clear in denouncing all the offenses against the dignity of the mentally ill. This action will prove even more effective if it is able to rise above denunciation to cultural reflection and workable proposals, modifying structures and behavior models to make them more respectful towards the dignity of the mentally ill.

Such cultural reflection and practical proposals will be more readily accessible to associated Christians rather than individuals. In his address to the leaders of Italian Catholic Action, John Paul II recently reminded lay Christians of the urgency of an open and organized public presence in order to be in a position to judge the world, dialogue with it in full respect for our own identity and that of others, and render the Church visible therein. I apply this exhortation once again to myself while encouraging your efforts so that, through you, for the mentally ill as well faith will become culture and produce the seeds of a new civilization.

✠ FIORENZO ANGELINI



The four internal "projections" of the Botanical Garden, by G. Porro (Venice, 1591)



Plan of the Padua Botanical Garden, by G. Porro (Venice, 1591)

For a True Doctrine in the Light of the Church's Magisterium

It is a motive for profound reflection that such an authoritative and representative meeting of priests working in the health apostolate, doctors, teachers, professionals, scholars, and researchers — all of you, in any event, committed to the defense of life and health — should include moments of prayer centered upon the Eucharistic celebration, by which we are made partakers of the Bread of Life.

In the Eucharist, Christ's promise is fulfilled: "I have come that [all] may have life and have it abundantly" (*Jn* 10:10).

Life is an indivisible good: earthly life and eternal life are Life in its fullness. And precisely in the Eucharistic mystery we may intuit the profound unity of immanent and transcendent values, the link between science and faith, ethics and morality, human commitment and Christian vocation.

Our time has witnessed an extraordinary development of science. Yet our age, concretely, for the first time in man's history, has made it possible and inevitable to measure the limits of science and even the serious risks of a science and technology which are not completely in line with a defense of moral values.

The limits and risks of a science left to itself are progressively generating a new, more widespread fear. As John Paul II asks, "Isn't the world of the new age, the world of space flights, the world of scientific and technical conquests never before attained, at the same time the world that 'moans and suffers' (*Rom* 8:22) and 'impatiently awaits the revelation of the children of God'?" (*Rom* 8:19)(1).

"Certainly," the Pope has repeated, "everything taking place each day before our eyes confirms that the question of ethics is increasingly a central question of our time, in such a way that there is an ever more urgent need to mobilize all our energies to face the self-destructive impulses threatening mankind."(2)

And yet our time is a time of grace and blessing. Today more than ever men are capable of mutual knowledge, contact, and support. Distances have been eliminated. Men all over the world discover that they are brothers — what at one time seemed an unreachable goal is now at our doorstep. The different fields of knowledge no longer have limits, but move in the direction of a global awareness and science. The religious renewal manifested around the world is confirming that science and faith are not separate paths, but a two-way street leading mankind towards the truth.

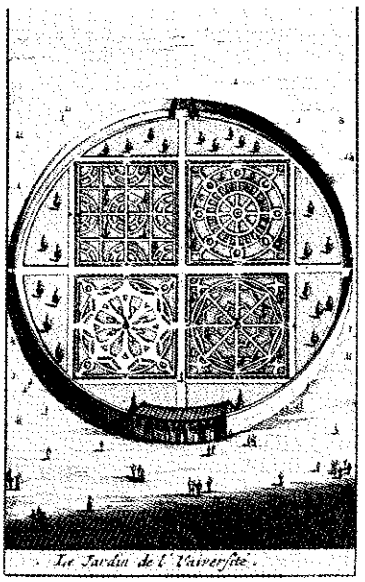
Why is this so? Because at every level humanity with inner certainty intuits that the supreme good, the faith uniting us all, is life, faith in life. It was through sin that, according to the Bible, death entered the world. Men are gradually realizing that the real evil in the world, the real failing to be avoided, is the attack upon life, every threat to life, for progress and all human conquests have no meaning unless they represent a service to life and are aimed towards promoting and defending life.

Paying close attention to the latest advances, your Congress has the merit of dealing with the most significant expressions of medicine in the various spheres of individual and social life, expressly touching upon the subjects of abortion, genetic manipulation, new therapies for hereditary illnesses with the techniques of genetic engineering, experiments on man involving such techniques, euthanasia, education and training in the health field, and teaching medicine ethically.

Medicine, so closely linked to the safeguarding, defense, and promotion of human life, is the particular science which best reveals the mission of knowledge as a service to life. And precisely for this reason it illuminates the tight bond between science and morality, between the values defended and promoted by genuine scientific and technological progress and the ethical-moral values which should guide such authentic progress.

If these considerations are later brought into the domain of scholars, doctors, researchers, teachers, and professionals — all engaged in the field of health who are inspired by Christian faith —

then a sincere and continuous effort must be made to achieve consistency in the profession, doctrinal affirmation, and practical observance of the unrenounceable moral values linked to defending life from its conception to its natural decline. Affirmation and practice must proceed in conformity with the doctrine of the Church and an exemplary human and spiritual formation, the only kind capable of guiding us towards consistent, courageous action. To be sincerely Christian entails being recognized and causing ourselves to be recognized as such.



University Garden. J. Regissard, Les délices d'Italie *(Leyden, 1706)*

1. The defense of life

A mentality often encountered as well among scientists, doctors, and health professionals seeking to be guided by Christian principles leads to regarding moral indications as a limiting factor, almost as if a weary and diffident morality were forced to accept every new scientific advance.

The field has been freed from this harmful prejudice. As John Paul II recalls, "The search for a satisfactory ethical position basically depends upon one's conception of medicine. It is a question of knowing, in short, whether medicine is at the service of the human person, of his dignity, insofar as the person is unique and transcendent.... Now, ever since Hippocrates medical morality has always been characterized by respect for and protection of the human person."(3)

Not the human person in general, but the individual human person. Consequently, no human being may be used or subordinated even to the maximum social good, for whoever is against a single human being is against all humanity.

This principle must guide the doctor, not only by virtue of Christian morality, but of natural ethics as well, and should be applied to the defense of life from the first moment of its being constituted in the mother's womb in the form of a fully human being.

All of the foregoing, when applied to the techniques used to protect *nascituri* ('those-soon-to-be-born'), may entail apparent delays, inasmuch as the road to be followed does not allow for improvisation or irresponsible attempts — all experiments which endanger life make no sense and are inhuman and, therefore, immoral.

Yet every step taken with rigorous, complete respect for the life and the inviolability of the rights of the human person will be a definitive step forward, a real scientific advance, a new threshold for civilization.

Your work, our work, is not just a profession, but a mission, as the Holy Father stressed in 1982 before the Fifteenth World Congress of Catholic Doctors — a mission at the service of life, of all life and of the life of all.

If we regard current progress in medicine in its broadest and most highly differentiated manifestations — such as advances in transplant surgery, in applied immunology, in encouraging, assisting, and comprehending the elderly — we can recognize in these gains the root of a constantly improving standard of living for an ever-increasing number of people which has been and remains possible only if no discrimination or manipulation is introduced into the commitment to and support of life.

In this sense, the civil norms legitimating contraception and abortion and approving euthanasia must be considered irrational attempts by society to arrive at practical solutions dealing with problems which have come to be social, but whose solution can in no way be found at the expense of life. They are attempts which, precisely because they are irrational, signal a serious defeat for science and civilization.

In reality, the Christian vision of man can legitimately vindicate the nobility of its own direction, which does not oppose and is not an alternative to a natural ethical vision of the human person, but an integrating element capable of enriching and ennobling the latter.

In calling life a gift of God, we give life an indestructible foundation, for we recognize therein the maximum expression of love — that is, of the love of God.

"Individual creatures are not just 'words' of the Word, whereby the Creator mani-

fests Himself to our intelligence, but they are also 'gifts' of the Gift: they bear in themselves the imprint of the Holy Spirit, the Creator Spirit."(4) And if our service to life is service to love, it is the maximum celebration of life.

2. Faithfulness to the orientations of the Church

Catholic doctors and health professionals have the precious gift of being able to receive clear and wise orientations from the ongoing Magisterium of the Church as regards the defense and promotion of life. I would like to stress two particular characteristics of the Church's doctrine in this field. The first is the care with which this doctrine seeks to respect the full harmony existing between what is known as natural morality and Christian morality.

Even when some specific indications may seem to have been inspired by an apparently excessive prudence, we must always discern in the Church a proper concern to ensure that the new achievements of science will not go against the fundamental laws of nature in their concrete applications.

By way of example, the clear orientations on responsible parenthood, those against euthanasia and against its legalization, and the wise and prudent indications concerning scientific experimentation constantly invoke the duty to respect the natural processes. It would not be difficult to recall the successive open acknowledgements of the Church's prudence and wisdom — prudence and wisdom which originate not only in faithfulness to Christ's teaching, but also in the undeniable historical fact that the Church has been a pioneer and guide in promoting health care as well, in its most complete and complex sense.

The Church, which Paul VI termed "expert in humanity," regards the psychosomatic integrity of man in the knowledge that his corporal reality cannot be harmed without involving his spiritual reality. The Church is engaged in this total defense of man and today feels called with special urgency to act as a guarantor of such defense.

"There are essential values and rights connected with the dignity and the supreme destiny of the human person, beginning with the primary right to life, to be defended throughout the span of his existence, today more than ever threatened from its initiation to the hours of its decline. To respect such norms is to become life's collaborator; otherwise we become workers of death."(5)

I believe it is necessary for our faithfulness to the orientations of the Church to possess a characteristic: it should be capable of being recognized by those with whom we work, by all who approach us and use our services.

We must strengthen or recover courage in our human and Christian testimony, without any compromise whatsoever, without fear, without human partiality.

As you are surely well aware, little more than a year after the constitution of the Pontifical Commission for the Apostolate of Health Care Workers, we completed a first, though incomplete, census of the Catholic health care institutions functioning around the world. Not

through our own emphases, but from objective evidence we know that the energies of the Church committed to this field represent the most consistent, complex, and intricate organization of its kind in existence. In some areas, it is virtually an exclusive presence.

Can we sincerely affirm that our witness to health-related moral and Christian values is on the same level? How many doctors and others working in health care who profess themselves to be Catholics are really familiar with the Church's orientations, strive to make them known in their sphere of action, and, above all, to put them into effect?

Are we truly conscious of the most serious risk of counter-witness? The Church — the Pope, the Bishops, the priests, the whole People of God — must be able to rely on the fidelity of the doctors who say they are, and wish to be, committed Catholics.

We see, then, the urgency of certain concrete initiatives which will be at the same time a demonstration and verification of our faithfulness to the Magisterium of the Church. Consistency is, in fact, the second sign of our fidelity to the Church.

3. Our testimony

I shall limit myself to a few indications capable of further development which each one can support in his own surroundings.

— In the health field, it is of paramount importance to strengthen the very close connection between medicine and morality, between medical research and practice and the defense of the fundamental, unrenounceable rights of the human person.

Catholic doctors must, therefore, become promoters of, among other things, establishing bioethics chairs at both Catholic and non-Catholic universities and centers for advanced study — in some parts of the world, they already exist. The period of training for young doctors is at once decisive and supremely delicate. Hasty preparation in this field is as harmful as ignorance, whereas an adequate awareness of Christian morality and of the orientations and indications of the Church is seen to be enlightening, particularly for the younger generations of doctors and health professionals. In all walks of life, people love to repeat that the future belongs to the young; but the world will have a future if the young have one. And the best way to provide for the future is precisely to prepare it.

Within the places of hospitalization and care, we must work to constitute committees directly engaged in asserting, spreading, and studying the principles of moral theology as applied to medicine in its most varied expressions. Such committees, acting in specific areas, will also be able to work towards training personnel and providing a more humane, more authentic approach to the ill which will allow them to verify the validity of the Christian principles put into practice in professional life and service.

Recently, the World Health Organization also recognized the urgency of general health education. This objective cannot be reached unless doctors — and, first of all, Catholic doctors and health professionals — become supporters of such education.

Training cannot be improvised — it is the result of slow, prolonged preparation, of ongoing efforts to adjust to changing circumstances. Attention to young people — which I would term "generational" attention — should be a characteristic of Catholic doctors, a typical expression of their way of feeling themselves to be a living part of the Church.

The present Pontiff never tires of encouraging young people, calling them to take on responsibility with a view towards the future. In our environment, generational differences often create insurmountable barriers. The future is also prepared by studying the past, but those who are prior in experience must — though losing modesty — become and feel themselves to be active masters and collaborators of the younger generations.

The socialization of medicine and the virtually unlimited spread of preventive medicine are characteristics of our time consolidating the *de facto* reality that all mankind passes through the hands of medicine and that doctors and professionals — and, in the first place, priests engaged in the health apostolate — are destined to encounter this humanity which suffers either because it is ill or because it wishes to prevent illness and can, within God's designs, discover or rediscover His friendship and His grace.

This is why doctors and health professionals are called to tasks which the future will render increasingly vast and complex. The commitment awaiting them is serious and urgent.

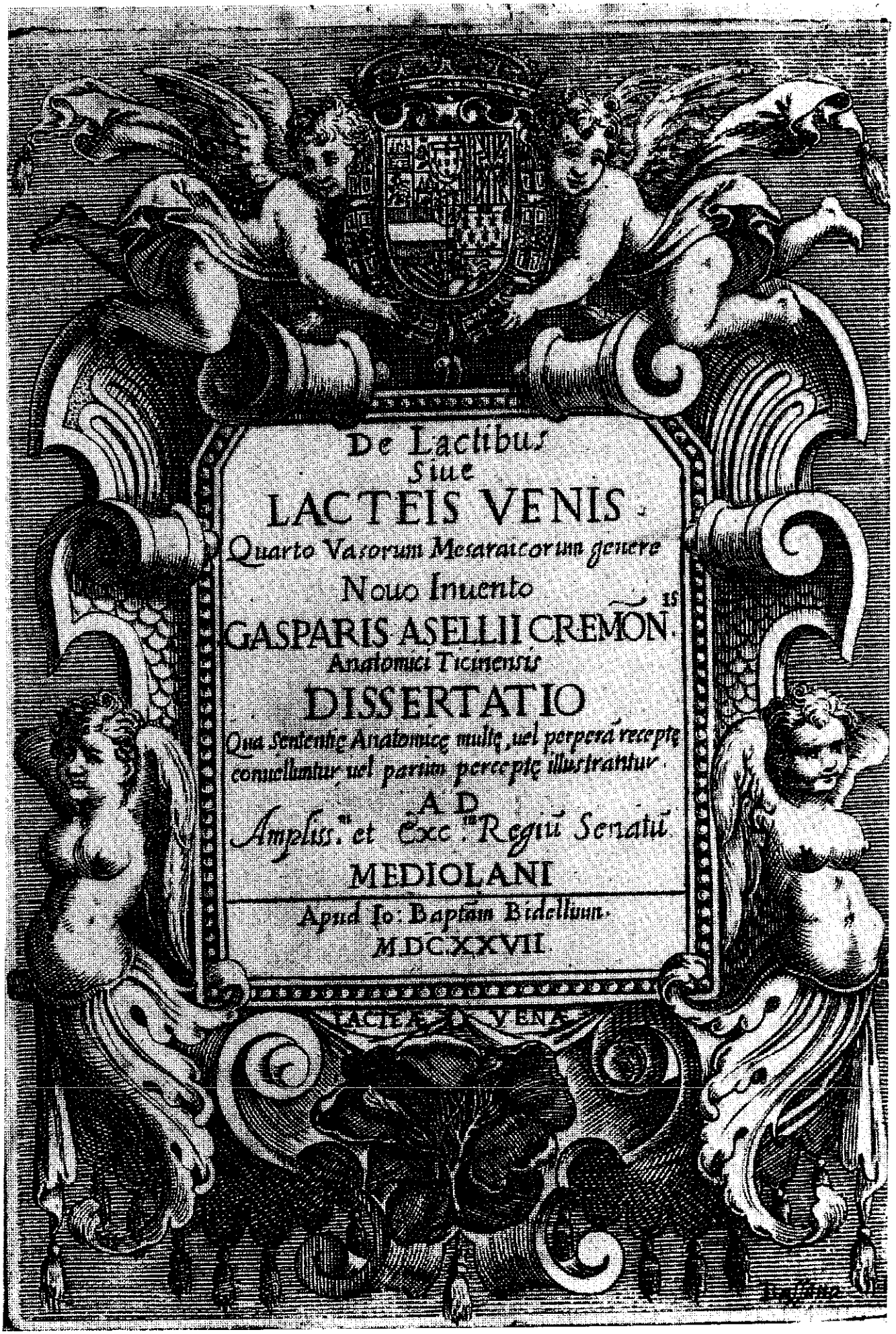
This Eucharistic celebration is not an isolated moment in the Congress taking place, but should be a living part of it. Together, before the Lord, let us take up the challenge to feel our faith and translate it into credible testimony.

May the conclusions of the Congress be an effective and well-defined program capable of offering further and more concrete occasions to demonstrate our fidelity to the Church in an affirmation of medical science which will also be a service to man on the way to his encounter with God.

✠ FIORENZO ANGELINI

NOTES

1. Encyclical *Redemptor Hominis*, 8.
2. To the Italian Bishops (May 20, 1986)
3. JOHN PAUL II, Address to the General Assembly of the World Medical Association (October 28, 1983).
4. JOHN PAUL II, General Audience (March 5, 1986). See also the Encyclical *Dominum et Vivificantem*.
5. JOHN PAUL II, Address to the Federation of Italian Pharmacists (May 26, 1986)



De Lactibus
Siue
LACTEIS VENIS
Quarto Vasorum Mesaraicorum genere
Nouo Inuento
GASPARIS ASELLII CREMON.
Anatomici Ticinensis
DISSERTATIO
Qua Sententiæ Anatomicæ multæ, uel perperam receptæ conuelluntur uel partim perceptæ illustrantur.
A D
Amplis.^mi et Exc.^mi Regii Senatii
MEDIOLANI
Apud Io. Baptam Bidellium.
MDCXXVII.

LACTEA VENA

Thirteenth World Congress of CICIAMS

The Right to Life and Its Quality

On October 6, 1986, Msgr. Angelini delivered this address at the Thirteenth World Congress of CICIAMS held in Lisbon

I am happy to have been offered the occasion, in the course of this important Congress, to convey certain reflections on the significant pair of terms contained in the phrase "the right to life and its quality."

Inasmuch as the fundamental human right to life has always suffered the gravest violations, this fact represents an acquired experience, an obvious truth. It is not the philosophers, legal scholars, or scientists who have discovered the right to life. It is a question of a radical truth in the sense that it is at the root of every other right, on both an individual and a universal level.

What has, however, been entrusted to man, to the progress of civilization, to the commitment of science, in both research and an orderly vision of the entire sphere of knowledge, is to recognize and strive to affirm an increasingly noble and fitting quality of life. In other words, it makes no sense, nor could it ever, to speak of a right to life if, in the same context, we are not thinking of its quality.

The battlefield of conflicting ideologies, different political systems, and opposing economic conceptions in the final analysis comes down to the way of conceiving the quality of life. The right to religious freedom, to freedom of thought and association; the right to sustenance, to education, to work, to health care, to well-being are just so many facets of the fundamental right to a quality of life which will make it worthy to be lived. To speak of quality of life is, in fact, to formulate a question implicitly: what life?

In one of its most insightful and touching pages, the Second Vatican Council, in its Constitution *Gaudium et Spes*, specifically confronts this problem. After pointing out that man, torn between the awareness of his limits and the greatness of his aspirations, suffers from an incurable inner dissension, the Council affirms, "In the face of the current evolution of the world, ever increasing numbers with new sharpness pose or hear the capital question: What is man? What is the meaning of pain, evil, death, which in spite of all progress continue to exist? What are these conquests achieved at such a high price really worth? What brings man into society and what may be expected from it? What is there after this life?" (*Gaudium et Spes*, 10).

I said at the outset that the right to life is an obvious truth. But it is clear that the ultimate sense of this right may be explained only by the quality of life.

I have always been convinced that all who, by profession, vocation, and, therefore, mission, have been called to work in the field of health and health care have the precious opportunity to touch with their own hands an enlightening truth, namely, that the primary, most universal faith common to all men, independently of their ideology, religion, race, and culture, is the faith in life. We possess the gift — allow me to call it the privilege — of experiencing every day what a unifying, positive, and constructive factor is the universal faith in life. But that does not suffice: precisely by approaching man in his suffering, we may intuit, or rather discover, in what direction this universal faith in life is moving. It is moving in the direction of a *quality* which involves making the most of the whole man and of all men, whatever their concrete conditions may be.

To speak, then, of quality of life means to speak of discovery, recovery of its values.

Yet speaking of values entails referring to a hierarchy of values, a scale of values. It is, in fact, the respect for and affirmation of such values which *qualify* life.

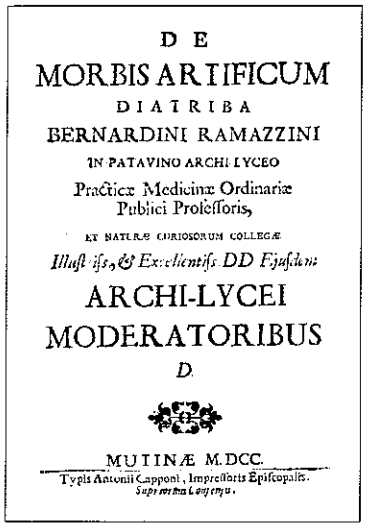
I have stated that faith in life is the most universal faith, but it must immediately be added that the Christian vision of life is capable of exalting its quality extraordinarily.

Today it is necessary for us Christians to rediscover the courage to bear witness to our faith in the quality of life. It is not a question of confessional intrusiveness. It is a matter of demonstrating through our behavior that those who consider life to be "God's gift" can give life its highest quality.

Believing, by faith, that life is not exhausted upon this earth, we do not offer an illusory alibi to those who suffer or experience an unhappy life. We, in the name of Christ, offer the key to hold every form of life in the highest esteem, to give meaning to the entirety of existence. If life is, in fact, God's gift, it is such from the first instant of its appearance up to the totality of existence in communion with the Creator. Fulfilled and definitive life in the newly conceived, in those about to be born, in its first, second, and third stages; all the span of life and the life of all, with no superiority attributed to physical endowment, race, social background, or cultural development.

This is the life we are called to live and defend, to help to mature and become enriched — in a word, to serve. Not the lives of some dispensing with others or against others or at the expense of others. Indeed, we cannot say we are properly defending anyone's life unless we are prepared to defend the lives of all.

The example comes to us from Christ. The Lord, in the Incarnation, did not assume the condition of the perfect man dreamt of by mythology and Greek philosophy, but, as St. Paul reminds us (*Phil* 2:2-9), Christ assumed the condition of a slave, of the least ones. And when Jesus initiated and carried forward His preaching, He did not at the outset seek contact with the powerful or the learned, but gave preference to His encounter with the suffering, with the infirm in body and in spirit. But there is more. When the Lord speaks of the criterion or judgment with which our existence will be evaluated, He clearly states that we shall be considered just if we have recognized Him in the sick, the abandoned, the imprisoned, the persecuted, in all those who suffer (*Mt* 25-26).


DE
MORBIS ARTIFICUM
DIATRIBA
BERNARDINI RAMAZZINI
IN PATAVINO ARCHI LYCEO
Practicæ Medicinæ Ordinariæ
Publici Professoris,
ET NATURÆ CURIOSORUM COLLEGÆ
Illustrissimis & Excellentissimis DD Ejusdem
ARCHI-LYCEI
MODERATORIBUS
D.
MUTINÆ M.DCC.
Typis Antonii Capponi, Impressoris Episcopalis.
Superiorum Licentia.

In this demanding, but realistic indication by Christ lies the clearest confirmation of the supreme value of human life, which attains its highest quality when it involves a continued transmission of love, a circulation of love among men.

In other words, the quality of life is given by the degree of love with which it is lived. And the first threshold of love is precisely the love of life.

Christianity, through the teaching and earthly experience of Christ, has shown us that the love of life and life as love are possible precisely because it is possible to value suffering, trial, and privations as well. It has demonstrated this by way of confirmation on a level which we could term exclusively human. Indeed, if man, by virtue of love, succeeds in valuing even pain, he discovers that his own life has a necessary meaning, if not a manifestly privileged one. I believe this is the specific reason why the current Pontiff, with an insistence which has become magisterium, repeats that he entrusts the exercise of his own mission to the prayers and sacrifical offerings of those who suffer. Whoever succeeds in valuing his own pain through an act of love for life as a gift of God proves to himself that life is truly worth living and that its quality is thus given by its measure of love.

It is necessary and increasingly urgent for Catholic health professionals to become missionaries of this message concerning the quality of life in their respective environments. We must dismantle the contradiction continually experienced in the world of health care above all. While, on the one hand, science and technology have immeasurably increased the possibilities of safeguarding, defending and promoting life, on the other, recourse is had to science and medical techniques to interrupt life in the process of being born, to defend the absurd right to euthanasia, to attempt morally unacceptable experiments in the field of genetics. Man, as a created being and child of God, is not the master of life, but the servant of life. By serving it, he may affirm and defend its quality.

The diverse nightmares plaguing mankind today are rooted in and sustained by grave assaults upon life. There is no image of desolation which is not the result of an assault on life. And there is also no subject about which men and peoples experiencing mutual hostility agree more readily than the defense of life. The critical moment commences precisely where the quality of life is concerned. Then clashes of interests and the most absurd blindnesses come to light.

The Christian announcement, up-to-date in every period of history, is so today in a special way, after the irreversible crisis of the myths of scientism, positivism, Marxism, and a revived paganism. The young generations seem to intuit increasingly that the world must urgently rediscover the love of life as understood in its totality. Life is at once the context and the timespan within which God has placed the human creature so that he may fulfill that divine design of love from which the world took its origin. Life descends from the Creator into the arteries of humanity to improve and heal it.

You, health professionals, are at the forefront in carrying out this task. Every day you experience how suffering and illness are not confined to physical pathology, but reach the depth of the soul. The life which is subjected to trial in the sick is a life which should be lived in its substantial value. All human conditions are open to a quality of life capable of ennobling and exalting them. Your service, accompanied by a sincere and credible Christian witness, is charged with sustaining this effort to qualify life. If your service is inspired by love, sustained by love, capable of becoming a transmission of love, it will be a decisive contribution to the quality of life of those you assist and, at the same time, will give quality to your lives.

Activity of the Pontifical Commission

A PRACTICAL VISIT TO SOUTH AMERICA WITH THREE OBJECTIVES

August 5-18, 1986

This past June we encountered the hospital situation in a rich, fully developed country, the United States, where, at least in some respects, technology and organization are at the forefront. It was a trip which familiarized us with many new facets of health care and the apostolate.

Later, in establishing contact with several South American countries — Brazil, Argentina, Colombia, and Venezuela — we were able to examine other, quite different problems in the field of medicine and health.

The contingent was made up of Msgr. Fiorenzo Angelini, Fr. José L. Redrado — Pro-President and Secretary, respectively, of the Pontifical Commission — and Professor Rino Cavalieri, one of the Commission's Consultors.

Objectives of the South American trip

The three main objectives were

1) to get in touch with the Church hierarchy and health professionals;

2) to convey to the pastors of the local churches and those working in the health field — chaplains, religious, doctors, nurses, and all others — the Church's interest in their active presence as evidenced in John Paul II's instituting the Pontifical Commission;

3) to become familiar with medical facilities and the health ministry in terms of organization, problems, and prospects.

Visits to persons and health centers

In the above-mentioned nations, we established the following contacts:

Church hierarchy:

— Apostolic Nunciatures in Argentina, Colombia, and Venezuela.

— Cardinals and Archbishops responsible for diocesan communities:

Eugenio de Araújo Sales, Cardinal Archbishop of Rio de Janeiro

Paulo Evaristo Arns, Cardinal Archbishop of San Paolo

Juan Carlos Aramburu, Cardinal Archbishop of Buenos Aires

José Alí Lebrun, Cardinal Archbishop of Caracas

Mario Revollo Bravo, Archbishop of Bogotá

Bishops recently named to coordinate the health ministry

Msgr. Alfonso Gregory (Brazil)

Msgr. Agustín Romualdo Alvarez (Venezuela)

Contact was also made with national and diocesan coordinators of the health apostolate.

Argentina: World Congress of Catholic Doctors

In presiding over the concelebration of the Eucharist, Msgr. Angelini delivered a broad, rich homily, with particular stress upon the subject of life, the ethical problems facing health professionals today, and faithfulness to the Magisterium of the Church. After the Mass, we gathered in the Congress' Conference Room, and Msgr. Angelini greeted all the participants, emphasizing their current role and responsibility as promoters and defenders of life.

Visit to thirteen hospitals

University hospitals, private hospitals run by religious, facilities for long-term patients, including charitable institutions, and a leprosarium — meetings were held in all of these centers with medical directors and administrators, and visits were made to the main departments. As regards these abundant exchanges, we wish to bear witness to the warm welcome accorded us by the Church hierarchy, ever attentive to our efforts in implementing the guidelines for the Pontifical Commission. The same occurred in our visits to both religious and public officials at health facilities. All of this served to broaden our awareness of pastoral realities at hospitals, the types of work performed, and the problems involved, just as health concerns may be viewed in other countries, in terms of citizen outreach, organization, results, and gaps. These contacts also enabled us to inform all those with whom we met in the best possible way about the objectives of the Pontifical Commission, along with some of its activities.

Meetings with groups devoted to the health field

In the course of our trip, we spoke to thirteen different groups: doctors, nurses, administrative personnel, volunteers, chaplains, and women religious

Using a lecture-discussion format, Msgr. Angelini set forth the subject-matter for all these groups, focusing upon the following ideas:

- health, pain and suffering, common ground shared by all;
- the perennial presence of the Church in health care;
- the current status of this presence and Pope John Paul II's closeness to suffering man, as seen in the Apostolic Letter *Salvifici Doloris* on human suffering and the Motu Proprio *Dolentium Hominum* instituting the Pontifical Commission;
- pastoral efforts in the health field as the responsibility of all — the tasks of chaplains, laymen, volunteers, and Institutes with the charism of assisting the sick;
- humanization and bioethics: two important challenges.

Stress on these respective topics varied somewhat according to the characteristics of each group, but emphasis was always placed on "promoting, encouraging, coor-

dinating, organizing, overcoming isolation, and serving suffering man "

We have a detailed diary of this trip in our files as well as abundant material gathered during visits to the aforementioned centers.

If we wished to select some of the most important reflections emerging from this journey, we could cite the following:

- The South Americans are a highly sensitive, receptive, and open people.
- The local churches are actively concerned with the health field.
- There are gaps in medical facilities and in the Church's presence within them.
- It is necessary to discover and stimulate vocations to the health ministry.
- We feel our getting in touch with these realities has greatly enriched us and contributed to increasing awareness, support, and encouragement for all working in this area.

Behind these concrete facts, we discovered and became more and more convinced that health, pain, and illness are universal realities surpassing time, religion, and place. And they are also common values where all converge, for all men experience them personally.

In concluding this brief report, we feel duty-bound to recall and thank those who have made our trip possible and fruitful. It is constructive to meet the different groups working in the health field so enthusiastically and become familiar with their specific problems, desires, and hopes.

In thanking the Church hierarchy for the welcome and hospitality offered us, as previously described, we are also obliged to convey our sincere gratitude to two religious Institutes, the Camillian Fathers and the St. John of God Brothers, that meticulously arranged for all our meetings and interviews with groups and individuals.

We express our thanks to the Camillian Fathers of Brazil for having prepared our visit and offering us their company and fraternal spirit.

Many thanks to the St. John of God Brothers in Argentina, Colombia, and Venezuela. Their fraternal hospitality, enjoyed within their own homes, brought us into closer contact with them and enabled us to get to know their lifestyle. Their complete generosity not only greatly facilitated the fulfillment of all our objectives, but also allowed us to include additional aspects such as visits to various local medical centers.

We would like to thank the groups we have contacted — health authorities, doctors, nurses, men and women religious, chaplains, and volunteers — underlining their enthusiasm, gratefulness to the Pope, and warm welcome for the new Pontifical Commission and its representatives.

In concluding, we wish to stress once again the sensitivity and hospitality expressed by all. In the attempt not to pass over anyone, we hereby extend our "thank you" to all those we met on the trip.

JOSÉ LUIS REDRADO, O.H.
Secretary of the Pontifical Commission for the Apostolate of Health Care Workers

Johann Wesling, Syntagma Anatomicum, Patavii, 1651 *(title page)*

STRASBOURG

Christians in Psychiatry Congress

* From the 15th to the 19th of September, 1986 the Fifth International Session of the Christians in Psychiatry Movement was held in Strasbourg.

The Congress was devoted to the topic of "Depression: A Problem of Contemporary Man." 150 professionals participated, including doctors, nurses, and chaplains.

By invitation of the Presidency, Msgr. Angelini and Fr. Redrado attended on September 16th as representatives of our Pontifical Commission. Pro-President Angelini began his talk by reading the message entrusted to him by the Secretariat of State wherein the Holy Father congratulated and encouraged the participants. He then went on to emphasize that psychiatry is a discipline in the process of transformation and associations of Christians within it are vitally important.

The day passed quickly, but was rich in diverse contacts with experts in the field.

We are grateful for the courtesy shown us by all and particularly wish to thank Fr. Albin Gebus, the meeting organizer, for the fraternal welcome accorded us. We convey our sincere gratitude to Msgr. Bressan, Permanent Observer of the Holy See at the Council of Europe, for the kind hospitality with which he surrounded our visit.

MADRID

A Church incarnate in the world of the sick

At the Meeting of Diocesan Delegates for the Health Apostolate in Spain held in Madrid, September 22-25, 1986, stress was laid on the urgency of taking the fullest advantage of the possibilities offered by the agreements between INSALUD and the Spanish Conference of Bishops for the purpose of structuring religious services at hospitals to embody a solidary Church, near at hand and salvific, in the manner of Jesus of Nazareth. Msgr. Angelini praised the pastoral work of the Spanish Church in the world of health but underlined the lack of Catholic associations in this field.

About one hundred persons, most of whom were Diocesan Delegates, participated in this

Eleventh National Meeting, devoted to the subject "For a New Service of Catholic Religious Assistance at Hospitals." The conference was chaired by Msgr. Osés, Bishop of Huesca and President of the Pastoral Commission of the Conference of Bishops, and by Fr Rudesindo Delgado, Director of the National Secretariat for the Health Apostolate.

In attendance at the inauguration were Msgr. Fiorenzo Angelini, Pro-President of the Pontifical Commission for the Apostolate of Health Care Workers, the Apostolic Nuncio in Spain, Msgr. Mario Tagliaferri, and Fr José Luis Redrado, O.H., a long-time promoter of the health ministry in Spain and current Secretary of the Pontifical Commission.

The reference point for the meeting was the agreement between the National Health Institute (INSALUD) and the Conference of Bishops, signed on April 23, 1986, which confirmed the previous Agreement on Catholic Religious Assistance at Public Hospitals signed on July 24, 1985.

The agreement guarantees religious assistance for the sick, but at the same time entails a serious responsibility for the Church in Spain. The legal aspect established requires that the possibilities offered be employed to the maximum degree in order to structure religious services embodying a solidary Church, close at hand, which saves in the manner of Jesus in His contacts with the ill.

A delay of two thousand years

Msgr. Angelini explained the goals of the Pontifical Commission he heads, "which has appeared after a delay of two thousand years," emphasizing the Church's service to the sick in the course of history, including the figure of John Paul II, "a Pope whose first gesture, the day after his election as Pontiff, was to visit a Cardinal hospitalized at the Gemelli Polyclinic in Rome"; this Pope had the happy idea of creating the new Pontifical Commission.

Archbishop Angelini praised the work being carried out in Spain in the health ministry, but pointed to the lack of associations for Christian health professionals as one of the defects observable. In this connection, those responsible for the Health Apostolate Secretariat are studying proposals for channels of association to include all the people working in the different areas of health care, though it may well be necessary to constitute subgroups for each field of service.

At the press conference, Msgr. Osés affirmed that, after the most recent agreements, "the religious service is at the disposal of the hospital and must be related to other services"; religious assistance comes under the heading of "humanizing the hospital and involves a change in mentality on the part of the chaplains themselves in cultivating an attitude of dialogue, the sense of teamwork, along with study and training in their area of specialization."

For his part, the Auxiliary Bishop of Madrid, Msgr. García Gasco, stated in his talk that "the Church must show herself to be more believable and more lovable" and that through the health apostolate "it should be seen that she knows how to love and bear witness to community love."

Marcel Carreras, in charge of the Catalan International Secretariat for the Health Apostolate, presented a document entitled "Orientations for the Religious Assistance Service at Health Care Facilities," which, in turn, after being studied, corrected, expanded, and approved by the Conference of Bishops, could serve as a reference point for religious services at hospitals.

New Commissions

The new working Commissions recently created by the National Secretariat were presented at the Meeting: the Mental Health Apostolate, coordinated by Mariano Galve; the Parish Health Apostolate, coordinated by Amalia Rodríguez; Hospital Apostolate and Chaplains; Professional Training for the Health Apostolate, coordinated by Jesús Conde; Health Ethics, coordinated by José Buj; and, finally, the Commission for Health Professionals.

In spite of the four days of intense work, many topics included in the agenda by the Group of Diocesan Delegates for the Health Apostolate remained pending, though there was nevertheless time for high spirits, a festive celebration of the fraternal encounter, and prayer.

For some years the Health Apostolate Secretariat has been promoting a plan for intensive training of those working in the health ministry, especially chaplains; mention may be made of the recent week-long course held in Madrid in which chaplains and religious from many parts of Spain participated. The course was supervised by Camillian Father Angelo Brusco, Director of the Verona School for the Health Ministry (Italy), a specialist in clinical attention.

In addition to everything described in this account, prepared by Julia del Olmo for the journal *Vida nueva* (October 18, 1986), the Pro-President and Secretary of the Pontifical Commission engaged in other activities while in Madrid: a meeting with seventy women religious in charge of the health apostolate in their respective Congregations and

Treatise on Ophthalmology and Otorhinolaryngology

Girolamo Fabrici di Acquapendente (Venice, 1559)

Dioceses; a meeting with a group of specialists made up of doctors, nurses, and volunteers; an exchange with several professors of medical ethics; and, finally, a press conference.

In all of these sessions, emphasis was placed upon specific responsibility at the service of life, health, and the improvement of assistance for the ill. Their goal was to confirm ideas on the health ministry — quite flourishing and advanced in Spain — and also stress the need to promote groups of lay professionals to constitute a specific National Federation.

Thanks to Spain and to all working in the health apostolate; thanks to Msgr. Osés, Fr. Rude Delgado, Sr. Encarnación Orden, and everyone silently laboring with unfailing motivation and a true spirit of encouragement; many thanks for your fraternal hospitality.

GENEVA

Visit to WHO headquarters

In response to the courteous invitation of Dr. Halfdan Mahler, General Director of WHO, Msgr. Angelini and Fr. Redrado, accompanied by Professor M. Racco, Director of the International Institute for Health Information and Research, traveled to Geneva to visit the General Headquarters of the prestigious world organization.

The day featured two particularly outstanding moments. The first was a conversation and exchange of views between the Pro-President and Dr. Mahler. In attendance at this meeting were the Director of Foreign Coordination Programs, Mrs. I. Bruggemann, and Dr. S. Kingma, responsible for mobilizing health relief assistance. In the course of this brief but cordial discussion characterized by broad unanimity, the main topic dealt with was "humanization, health, and assistance."

The second moment-more official and of greater scope-was the panel discussion led by Dr. Mahler on WHO activities, with the participation of four experts who explained current projects:

- Family health, including the prevention of childhood diseases (Dr. Petros-Barvazian, Director of the Family Health Division).
- Disease prevention in contemporary society (Dr. V. J. Grabauskas, Director of the Noninfectious Disease Division).
- The need to make health care more humane (Dr. J. Orley, Medical Consultant, Mental Health Division).
- Training health professionals (Dr. A. Segall, Medical Consultant of the Health Education Division).

In the subjects set forth by these specialists, stress was laid upon the aspects of promotion and prevention, family responsibility for health, public health, care of chronic illnesses, research programs, mental health in the different stages of one's life, health education in schools, and the training of health specialists to transmit values.

In the dialogue which followed, there was emphasis on the need for the Church's presence and work in this field. Msgr. Angelini underlined the importance of close collaboration between the Church and WHO, "for we are dealing with fundamental themes, like life and health, which have such universal connotations that they make every barrier of language, race, and religion disappear." Humanizing medicine means first humanizing life, reconstructing man completely. The Church so desires and is clearly manifesting her intention. The recent institution of the Pontifical Commission for the Apostolate of Health Care Workers offers confirmation of this fact.

Dr. Mahler emphasized the importance of dialogue to avoid deformations and to coordinate and train health personnel. He also stated that in the year 2000 we shall probably have more Faculties of Health and fewer Faculties of Medicine, thereby showing us how the concepts of health and illness are understood today and how society should prepare future health professionals.

At the meal hosted by Dr. Mahler were Msgr. Justo Mullor García, Apostolic Nuncio and Permanent Observer of the Holy See at Geneva, and Dr. Eric Ram, General Director of the World Council of Churches.

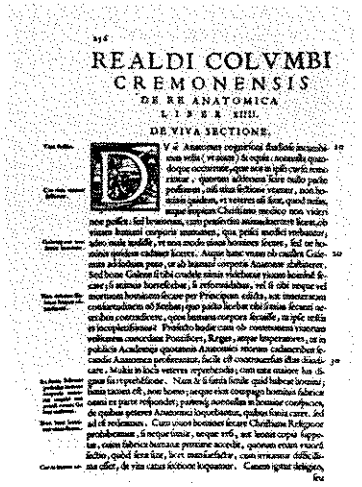
In the afternoon, accompanied by Dr. Ram, we visited the offices of the Christian Medical Commission. Instituted in 1968, it is a Section of the Justice and Service Working Unit of the World Council of Churches. Its finality is to serve as a stimulus and guide for the churches in seeking concepts of health and care proper to the Christian faith, promoting new methods of assistance, and coordinating medical programs.

We recited a brief ecumenical prayer in the chapel and then stopped by the office of Dr. Ram, who congratulated us on our visit, informed us on some of the center's activities, and set forth the possibility of collaborating with the Pontifical Commission.

We completed the intense, dialogue-filled day quite satisfied over the content of the topics, but above all by the meaning of the encounter: the World Health Organization and the Pontifical Commission for the Apostolate of Health Care Workers discussing and cooperating for the sake of the defense of life and the promotion of man.

This is a summary version of a day of work conducted on the highest level and rich in commitment.

We sincerely thank Dr. Mahler for the courteous attention afforded us and the valuable exchange of ideas and are also grateful to all the professors who participated in the meetings and so competently explained the diverse WHO activities.



REALDI COLVMBI
CREMONENSIS
DE RE ANATOMICA
LIBER XIIII.
DE VIVA SECTIONE.

Title page of Realdo Colombo's De Re Anatomica (Venice, 1559)

LISBON, PORTUGAL

Thirteenth CICIAMS World Congress

From the 7th to the 13th of October, 1986 the Thirteenth World Congress of CICIAMS took place in Lisbon.

The main topic, "Health Personnel and Human Rights," was set forth in several lectures and round-table discussions under different aspects: changes and human rights, human rights as a challenge for the Church, the right to health, the rights of health personnel, among others.

Archbishop Angelini and Fr. Redrado in representing the Pontifical Commission took part in a round-table discussion and the Eucharistic Celebration on October 9th.

In two talks, Msgr. Angelini dealt with "The Right to Life and Its Quality" and the response which must be given to the question "Who is my neighbor?" The connection between the Eucharist and the mission of service to one's fellows is a response which clearly coincides with the Gospel.

The abundant participation of specialized health professionals (2000 nurses from 42 countries), the seriousness of the lectures and the interest of those attending, and the solemn, expressive Masses all stood out at this Congress.

ethics, and participation by many actively discharging responsibilities in the health field.

The words of welcome and greeting addressed by Cardinal Poletti and Cardinal Zoungrana contributed to accentuating the importance of the Congress. Msgr. Angelini, Pro-President of the Pontifical Commission, also emphasized the destination which had been decided upon for the donations, medicines, and medical equipment already received and still to arrive: aid to the Third World and Poland.

The climax of this meeting was the Pope's visit and address in the Synod Hall. The Holy Father stated that a very rigorous moral code was necessary in experimentation involving medicine; he added that we must avoid treating man as an object of experiment. The Church is in favor of man, of his dignity, and encourages all who devote themselves with love to suffering man.

The Pope was greeted by the three Nobel Prize winners who chaired the afternoon sessions and by Dr. Rita Levi Montalcini, recent Nobel Prize Winner for Medicine. The Congress participants greeted the Holy Father with a prolonged ovation.

The Conference Proceedings will be published in the first issue of our journal, *Dolentium Hominum*, to appear in 1987.

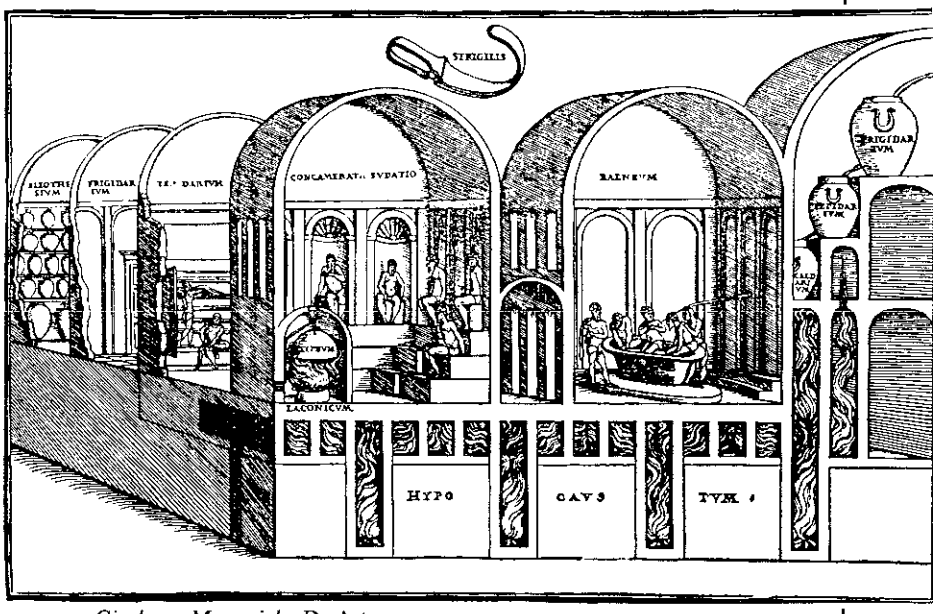
VATICAN CITY

First International Conference on Pharmaceuticals at the Service of Human Life

From the 23rd to the 25th of October, 1986 the First International Conference on "Pharmaceuticals at the Service of Human Life" was held at the Vatican City Synod Hall, organized by the Pontifical Commission for the Apostolate of Health Care Workers.

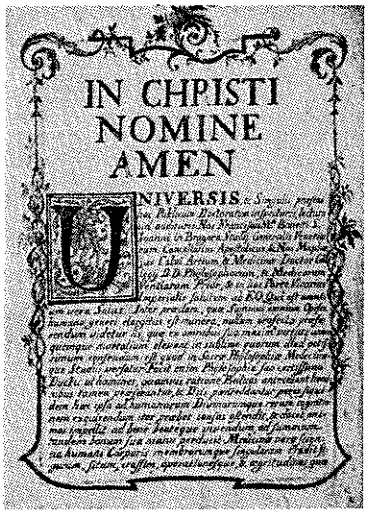
It was an extremely fruitful event, with international repercussions by reason of the representativeness of the participants (more than 30 nations) and the prestige of three Nobel Prize winners to preside over and coordinate the sessions: Professor Konrad E. Bloch, Professor K. Sune Bergstrom, and Professor Max Ferdinand Perutz. There were also lectures by accredited specialists in both medicine and

BAINEORVM APVD VETERES FORMA.



Girolamo Mercuriale, De Arte Gymnastica Libri Sex, Venetiis apud Iuntas, *1573*

John Paul II's Message to the FIAMC World Congress



Matteo Bertoldo da Trento's Degree Certificate in Art and Medicine (April 5, 1601)

TO CAR. EDUARDO PIRONIO
President of the Pontifical Council for the Laity and President of the Pontifical Commission for the Apostolate of Health Care Workers

4 August 1986

Your Eminence,

The Holy Father is greatly pleased to know that you will be present at the *Sixteenth World Congress of the International Federation of Catholic Medical Associations* which will take place in Buenos Aires, August 8-12, 1986. Through you he sends warm greetings and prayerful good wishes to the participants in this first FIAMC Congress to be held in Latin America.

The Catholic presence in the field of health care has been marked by moments of special intensity since the last Congress in Rome in October 1982. On that occasion His Holiness was able to address the Congress personally and to reconfirm the Church's *commitment to the service of life*, following "the supreme example of Christ, who was a physician of the spirit and often of the body for all those he encountered along the paths of his earthly pilgrimage" (Address to Catholic Doctors, 3 October 1982, No. 6).

Subsequently, on 11 February 1984, feast of Our Lady of Lourdes, whose shrine constitutes a privileged testimony of the faith and hope of the sick, he issued the Apostolic Letter *Salvifici Doloris* on the Christian meaning of human suffering. Exactly one year later, on 11 February 1985, the Apostolic Letter *Dolentium Hominum* established the Pontifical Commission for the Apostolate of Health Care Workers, as an expression of "the deep interest which the Church has always shown for the world of suffering" (*ibid.*, No. 1).

In the years since the Fifteenth Congress, the Federation has been active and productive. Among the many achievements deserving note, I would mention the establishment of a permanent Secretariat in Rome and the First Pan-African Congress held in Ghana in February of this year. The Federation has also been engaged in strengthening contacts with national associations throughout the world, and the efforts of these years are now culminating in the Sixteenth Congress being held in the specific context of Latin America, with the urgent aim of consolidating the Federation further for an ever more effective Catholic involvement in health care and an ever more consistent witness of Catholic doctors with regard to today's extremely delicate challenges in the area of bio-medical ethics.

The theme chosen for this Congress is indeed important: "Progress of Medicine and Respect for Human Life." At a time when, in so many parts of the world, human life is threatened both in its earliest moments and in its later stages, with the willing cooperation of some who exercise the medical profession, there is an impelling need to do all we can to ensure that the dignity of every human person and the sacredness of all human life are reaffirmed as the very center of health care and the indispensable condition for progress in medicine.

For this reason the Holy Father welcomes and encourages the efforts being made by all the Catholic doctors who are members of FIAMC to promote study

and research into ethical and moral issues in the field of medicine and health care, as well as the attempt to offer counselling and guidance in these areas to fellow doctors in accordance with the teaching of the Church.

Your Congress will be examining a wide variety of issues and situations facing physicians today as well as in the future. Your considerations and discussions will range from ethical aspects of genetics in rural Africa, European inner cities, and even in outer space.

These and many other challenges face young men and women entering the medical profession today and there are many situations which call for wisdom and courage in upholding and promoting Catholic moral principles and teaching. The medical associations that form the Federation offer ways of ensuring mutual support in giving a truly Christian witness of professional competence and ethical standards. It is His Holiness's earnest hope that in the coming years these Catholic medical associations will increase in number, vitality and effectiveness.

Your Congress comes at a time when the entire Church is engaged in preparing for the 1987 Synod on "The Vocation and Mission of the Laity in the Church and in the World Twenty Years After the Second Vatican Council." The Holy Father prays that during this providential time for the Church your Federation will, through the gifts of the Holy Spirit, be able to go forward in deep faith and with renewed vigour to give that Christian witness in society which the Council referred to as the special vocation of the laity.

Your own vocation, as Christian physicians, places you in an area of human society that has assumed ever greater importance in the course of the centuries. With the increase in life expectancy in many regions, this importance will grow further. Today the area of health care is becoming a major factor in the economics of country after country. As baptized Christians with professional competence in this field, it will be for you to lead the way in making the full health of the human person the center of professional care rather than allowing commercial loss and gain to be the criterion by which progress in medicine is to be measured.

In this task the spirituality which animates you must be that of discipleship of Christ, who came to heal and to save, and who gave his own life that we should have life. His Holiness notes that the FIAMC Congress will include a pilgrimage and Eucharistic celebration at the great shrine of the Blessed Virgin Mary at Lujan. He is united in prayer with all the participants that through the intercession of the Blessed Virgin Catholic physicians throughout the world may be ever more fully disciples of her divine Son and so radiate his love through the exercise of their profession. To all the participants in the Congress and all the members of FIAMC he imparts his Apostolic Blessing, entrusting them to the maternal heart of Mary that they may grow in wisdom and in grace to full maturity in Christ.

With personal good wishes, I remain

Yours sincerely in Christ,
CARD. AGOSTINO CASAROLI
Secretary of State

BUENOS AIRES

Archbishop Angelini's Words at the FIAMC Congress

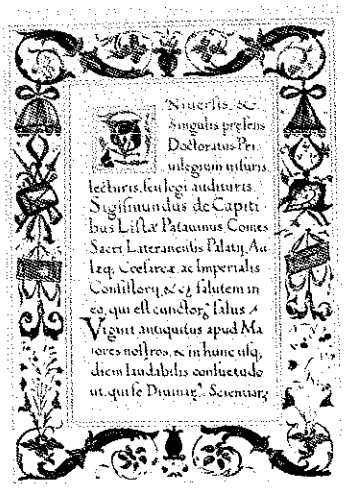
I feel this is the most appropriate time and place to extend a fraternal greeting and express my most heartfelt gratitude to the Association of Argentine Catholic Physicians, which, together with its beloved President, Professor Carlos A. Carranza Casares, has worked in an exemplary fashion to prepare the Sixteenth World Congress of FIAMC here in Buenos Aires.

I thank Professor Chicot Vas for the commitment and seriousness he has demonstrated in his post as Association President and for his exemplary devotion to the Pope and the Church. At the same time, I wish to express my sincere gratitude to the Council which has shared international responsibility over the past four years.

I want to assure the new President, Thomas Linehan, and all who have been called to make up the new FIAMC Council of my best wishes and prayer

I am also pleased to address a fraternal greeting to Msgr. Cassidy, FIAMC's Ecclesiastical Assistant, who is deeply aware of the need for an authentic health ministry, so urgent in today's world.

The work of this Sixteenth Congress and its Conclusions must reinforce the commitment of Catholic Physicians and bear witness to sincere, thoroughgoing, and fervent consistency in serving our brothers and sisters in conformity with the teachings and orientations of the Church for scientific research and professional activity.



INDIA

Forty-Third National Congress of the Catholic Hospitals in India

Hyderabad

From the 6th to the 10th of November, 1986, the Forty-Third National Congress of the Catholic Hospital Association took place in Hyderabad. After a special invitation, our Pontifical Commission participated in it, contributing its message of solidarity and hope. Msgr. Angelini and Fr. Redrado took part in the work sessions as bearers of a broad, expressive telegram from His Holiness Pope John Paul II. Msgr. Angelini blessed the imposing new offices of the Association, presided over the Eucharistic Celebration, and, with the Secretary of the Commission, shared in the Congress activities.

Over 500 people were present at the conference, including representatives and administrators of the Catholic Hospitals of India — there are more than 2000 — promoted and run by Diocese, Congregations, and religious Institutes.

At the inaugural session, in addition to our Pro-President, the speakers were Msgr. Arulappa, Archbishop of Hyderabad; Fr. Ferdinand Kayavil, President of the CHAI; Dr. John Rohde; Mrs. Marjorie Godfrey, member of the Indian Legislative Assembly; Sri Sadiq Ali, Governor of Maharastra; and Mr. Cassia, Vice-President of the CHAI.

The Congress focused upon the following important topics:

- Western health care and its presence in India.
- Health education and communication.
- Infant nutrition and survival.
- Community health and ways of making children more aware.
- Hospital projects: material and quality control.
- A new kind of hospital: the dispensary.
- "Humanized" care: pastoral attention and expectations of the health care sector.

During our stay in India, we visited four health facilities:

- A home for the aged owned by the Sisters of the Poor, a Congregation founded by Blessed Jane Jugan.
- Two general hospitals: Vijay Marie Hospital of the Sisters of Charity and St. Theresa's Convent Sanathnagar of the Institute of Jesus, Mary, and Joseph.
- A home for the physically and psychologically disabled owned by a private association and run by the Sisters Daughters of St. Ann of Providence.

Bombay

Bombay was a necessary stage of our trip, and we took advantage of it to meet Archbishop Simon Ignatius Pimenta, President of the Indian Conference of Bishops, with whom we conversed regarding our visit, the objectives of the Pontifical Commission, and its main activities.

Accompanied by three Canossian Religious, our tireless guides, we then visited the Bandra Holy Family Hospital Society, a general hospital owned by the Ursulines, and the Vimala Dermatological Centre, a leprosarium of the Missionaries of the Immaculate Conception.

Our journey to India was brief, but extremely intense, well-programmed, and rich in experiences that were not at all superficial. On departing for the East, our concern had been enormous — we well knew we would have to make up in intensity for what the shortness of the stay prevented us from achieving.

The reality observed in India is varied and complex. The role of the Catholic Church should undoubtedly be stressed in a special way. We must not forget that there is great religious diversity in this country, with 83% Hindues, 11% Moslems, 3% Christians, and 2% Sikhs. In spite of her minority status, the Catholic Church enjoys extraordinary prominence in three areas: health, education, and the apostolate. Another outstanding feature is the religiosity of the people: culture, rites, gestures, the capacity for wonder, and their serenity all predispose one for prayer and contemplation.

India is a young country, with vitality to be ordered and channeled; it is a nation with imposing prospects for the future. This is not an ungrounded prediction, but a reality which has now become externally apparent to all.

FR. JOSÉ LUIS REDRADO, O.H.

Degree Certificate in Medicine issued to William Harvey (April 25, 1602)

Information from around the World

BOLIVIA
Annual Report for 1985 on the Activity of the Health Apostolate Department

Circulars

1. Dealing with the draft text of the National Agreement between the Catholic Church and the Ministry of Social Security and Public Health and informing on the results of the Seminar-Workshop organized by this Department in December, 1984 and attended by representatives of all the Dioceses

2. Concerning a possible meeting on health care to include the Circumscriptions of Cuevo, Chiquitos, Ñuflo de Chávez, and Santa Cruz

3. After signing the National Health Agreement between the Catholic Church and the Ministry of Social Security and Public Health This Agreement seeks to provide the basis for the specific Agreement to be signed by every institution offering health care services and the corresponding Ministry

Lectures

1. On June 28, all the medical and paramedical personnel was offered a lecture on "Professional Morality" at the Mexico Clinic in the city of La Paz, whose Director had asked Sr. Begoña Martínez that it be provided.

2. On August 19, the same lecture was given for all the personnel at the National Health Laboratories Institute in response to the Director's request.

3. Throughout the academic year, as requested by the Director of the La Paz Lyceum, talks were given during class time on abortion, drug addiction, alcoholism, and prostitution.

Congresses

1. On March 20, this Department held a general meeting with national representatives of the nongovernmental organizations working in the health field in order to create a Departmental Presidency for the latter in La Paz. The meeting was also attended by representatives of the WHO, PHO, the Ministry of Social Security and Public Health, and the La Paz Health Unit

2. Departmental Committees for these nongovernmental agencies are currently being organized, with notable results already achieved in Sucre and Tarija In addition, a national meeting is being planned to establish a permanent presidency for them.

Agreements

1. Between St. Gabriel Radio, a Catholic institution, and the Ministry of Social Security and Public Health

2. Between the Congregation of Augustinian Fathers and the abovementioned Ministry to assist tuberculosis victims in the Los Yungas area

3. A National Agreement between the Catholic Church and the Ministry of Social Security and Public Health.

Surveys

Information is currently being compiled nationally on the Catholic Church's health facilities (the percentage of the population covered, the types of pathologies, and so on)

Meetings

1. On February 21, a meeting was held with the nongovernmental entities providing health services in the city of Sucre in order to create an association for this sector On October 3, another meeting was held with those working in the health apostolate in the city of Oruro to study the draft text of the National Health Agreement and establish the Departmental Health Committee.

2. On October 2, a meeting was held with those responsible for the Archdiocesan Health Apostolate to study the National Health Agreement and the data available on Catholic facilities and services in that city.

3. On October 29, representatives of the Health Apostolate met with spokesmen for nongovernmental health care entities at the Bishop's Palace in Tarija to create an association for the latter

4. On November 7, the Health Apostolate Department met with the Diocesan People's Health Committee in Coroico. A number of problems related to local health personnel were discussed, and the National Health Agreement was made known.

Publications

In the newspaper *Presence*, an article was published defending INASME, a government agency offering medicine at reduced prices which some were seeking to close for political reasons.

Projects

1. A project has been designed for the Colpani area (Alto de La Paz) to provide health education for mothers.

2. The following projects are being worked out at present:

- National Medicine Deposit.
- Educational material to train health promoters.
- National meeting of nongovernmental health agencies.
- Educational material to be used by health promoters.

Contacts

1. *International*

- *Pontifical Commission for the Apostolate of Health Care Workers* The President of this Commission, recently created by His Holiness John Paul II, is Cardinal Eduardo Pironio, and the Pro-President is Archbishop Fiorenzo Angelini. The following documents have been sent to the Commission:
  - The name and address of the Bolivian Bishop in charge of the Social Apostolate.
  - Information on the activity of our Health Department.
  - Initial data on the Church's health care institutions in Bolivia
- The Fernando Rielo Association for Health Care and Research is headquartered in Rome. It has provided us with medicines which in Bolivia are not available for emergency cases (tumors) where our help was requested To obtain them we were assisted by the Apostolic Nunciature in Bolivia, since the Association works directly with

Diocesan Caritas in Rome, providing health services for refugees, gypsies, and poor people.

• *The World Health Organization and the Pan-American Health Organization* are in contact with us by way of the nongovernmental health agencies and in requests for and shipping of medicines, along with educational material and information

• Similar contacts to the above are maintained with UNICEF and CRS

2. *National*

• *The Ministry of Social Security and Public Health*

Conversations have been held with the Minister and the Under-Secretary for Health to inform them of the Catholic Church's health care activity and to sign the National Agreement. Through Dr. Pilar La Serna and Hugo Jiménez of the International Relations Office, all our needs in the different Diocese have been channeled: the National Agreement between the Catholic Church and the Ministry, various private agreements, grants of material, hospital supplies, requests for medical and paramedical personnel by various dioceses, ministry authorization so that a woman religious from Potosí and a French doctor may offer their services in the Diocese of Trinidad.

• *National Caritas*

Health efforts have been coordinated, particularly in the Oral Rehydration Campaign for all the mothers' clubs.

• *Bolivian Conference of Religious*

Assistance has been better channeled to each and every circumscription of the Church, most especially to the religious working in health care; their needs have been met in the measure of our possibilities.

• *Health Units*

Contact has been maintained with the Health Units of Tarija, Sucre, and La Paz. This cooperation has been motivated by the need to structure the nongovernmental health agencies in each Department, resolve certain conflicts in these sectors, and service requests.

• *Church Circumscriptions*

— *Aiquile*: A census has been taken of the health centers and personnel

— *Cochabamba*: Medicines have been delivered and a health census has been taken.

— *Chiquitos*: Medicines were exchanged.

— *Corocoro*: A doctor was sought to direct local health programs. On November 28, visits were made to Ayo Ayo and Patacamaya to participate in a seminar offered to all the area health professionals and organized by the Health Apostolate Department for this Circumscription.

— *Coroico*: On November 6, 7, and 8, the Diocese was visited to make known the National Health Agreement, take a census of the Catholic Church's health centers and activities, study the health personnel problems posed for the La Paz Health Unit, provide certain supplies, and coordinate work with the People's Health Committee

— *La Paz*: Medicines were delivered. Some of the conflicts between Church centers (e.g., Villa del Carmen and Fe y Alegría) and the Health Ministry were resolved. Primary care for various areas was programed, and a health census was taken.

— *Oruro*: Medicines were delivered, and customs authorization was obtained. Information was provided on the Health Ministry's new policies on "people's pharmacies." A meeting was held with those working in the Health Apostolate to structure the Departmental Health Committee and study the Agreement. A health census was taken, top quality medicine for TBC was delivered, and other medicines were also supplied.

— *Potosí*: Medicines were provided. Projects were channeled to various institutions. Ministry authorization was obtained for the Church to offer health services. The possibility of opening an operating room is now being explored. A health census was taken.

— *Reyes*: We have received the following requests: a national medicine deposit, health-related educational material, a health census, conferences, departmental meetings, and exchange of information.

— *Santa Cruz*: An interdepartmental meeting was prepared, and a problem concerning a hospital was solved

— *Sucre*: Medicines and food for children were delivered. The nongovernmental health care agencies were organized into an association. A health census was taken, and information on the National Agreement was provided.

— *Tarija*: Financing was obtained for four health promoter training courses. A health census was taken. The nongovernmental health agencies were organized, and National Agreement information was offered.

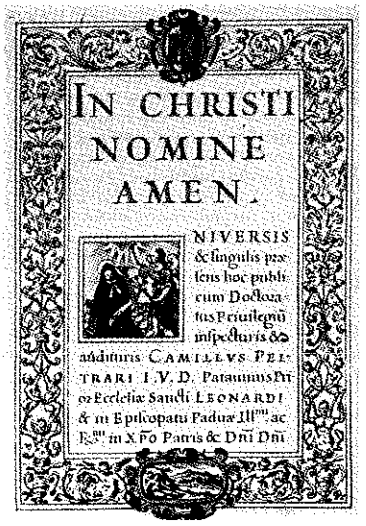
— *Trinidad*: Medicine was delivered, customs authorizations were sought, and ministry approval was secured for a French doctor.

Seminars

A Seminar was held for local health professionals in Corocoro on bronchopulmonary problems.

Visits were made to Tarija, Sucre, Oruro, Cochabamba, and Coroico.

Franco Ongania's Degree Certificate in Philosophy and Medicine (Padua, August 1, 1787).



VENEZUELA

Visit to Venezuela by Msgr. Fiorenzo Angelini, Pro-President of the Pontifical Commission for the Apostolate of Health Care Workers

Your Excellency, Brothers of St. John of God, ecclesiastical, civil, and medical authorities, and all the other guests: "Peace and Good."

Providence has wanted this Capuchin Missionary, a "mirror" son of St. Francis of Assisi, to "make his debut," so to speak, as a bishop and in his recent appointment by the Venezuelan Conference of Bishops to preside over and stimulate the health apostolate and to receive, present, and accompany Your Excellency.

Archbishop Angelini, welcome to this youthful, hospitable, and Christian nation of Venezuela, which, with your visit, wishes to renew its pastoral concern for the sick, especially as regards their spiritual health. The Church has always been concerned about the neediest of her children. Numerous Congregations and religious Institutes, like the meritorious Brothers of St. John of God, have the specific vocation of attending the sick. When the daily schedule for parish services is placed at the door of our residences, we should and do always stress that the sick will be attended at any time — and that is the way it must be.

And, if I may be allowed another practical norm, all of us should always be prepared to provide preferential attention to any sick person. The Gospel parable of the Samaritan places this demand upon us. The September, 1985 Evangelization Congress uncovered a new reality for us: the sick evangelize us; and a new demand is thus made of the world of health care: the Church should let herself be evangelized by the sick. This could be our goal at present: so feel obliged to evangelize our sick brothers, in the complete certainty that, in so doing, we shall be evangelized by them. Christ, the Divine Master and Physician, teaches us this when defining Himself as a Man of Sorrows, from the poverty of His birth to the nakedness of His death on the cross. This Jesus, God, divinized pain with His passion and death and made it an indispensable condition for salvation: "Whoever wishes to come after me must take up his cross each day and follow me, denying himself."

For the sake of this Christian exigency, Your Excellency has come in the name of the Holy Father, John Paul II, to require of us this Biblical responsibility for sharing, alleviating, and sanctifying all human pain, beyond every border, without regard for nationality, the color of one's skin, cultural level, or social and political position.

We were able to propose the following objectives for another health apostolate commission:

1. To foster communication and contact with the sick in the Christian communities so that these may be evangelized by them.
2. To help the sick to live out their evangelizing mission in the Church and the world.
3. To pray with and for the sick.
4. To celebrate their evangelizing witness to enrich ourselves in becoming more humane.

In fulfilling these demands, we find a consoling stimulus in the Gospel: all the good we do to any sick person is regarded by Christ as done to Him, and he promises us a generous, eternal reward.

During Your Excellency's brief visit, we would like to examine sincerely whether or not we have met these Christian requirements as a Church, as a State, in the Health Apostolate, in hospital service, and other areas.

We may well discover that something — perhaps a great deal — has been done in certain fields of health care and religious, hospital services, but we must admit that we have quite a long way to go together with the help of God, Who does all much better than we do.

I would like to conclude this greeting-introduction with a few verbatim remarks by patients: "Lord, I feel different from others, too dependent upon other people, but I have discovered that I too have external activity, I can contribute much in human sensitivity, in listening, in solidarity, and in witnessing to courage and faith. Lord, help me to carry out this life project. Something has changed in me I have discovered the heart of life, the courage to love and be loved."

"I thank You, Lord, for all who help me, for all who care and show concern for me, for those who come to visit me Lord, make me appreciate every gesture of goodness and pay attention to the concerns of others. And even manage to smile. Thank You, Lord, for we the sick are God's chosen ones, His favorites. We want to multiply and give back all the goodness, attention, and affection received. And, above all, we will believe more in God and His mercy. I don't want you to regard us as objects of pity, for we are persons worthy of all respect; we have our dignity. Aid us without wounding us, for we are in a situation you will find yourselves in one day as well. Give us encouragement and joy. Treat us with affection. Doctors in particular, hear us out and give us simple explanations. We would ask health professionals to treat us as persons, smile, be attentive, and keep us informed on the illness. We would ask family members not to shove us into a corner, to take us into account and let us do what we are capable of doing, to be patient with us and not hide problems from us. We would ask the communities that feel responsible for our evangelization to visit us and hear us out."

✠ AUGUSTIN ROMUALDO ALVAREZ

Titular Bishop of Nasbinca and Apostolic Vicar of Machiques

The Health Apostolate in Venezuela today

If we understand the Health Apostolate as involving those actions which tend to raise the level of faith among patients, relatives, and personnel comprising the hospital community, we must state that there has certainly not been an organized apostolate in our country.

At this time, as a result of the National Mission, there has arisen a Commission owing its existence to SECORVE, an association of men and women religious in Venezuela. This Commission opened a new period, and one of the first steps was to identify hospital and clinic chaplains.

The Conference of Bishops seconded such efforts by initially naming Fr. Clemente Pérez to promote this apostolate nationally, and, more recently, with the appointment of Msgr. Medardo Luzardo as Archbishop of Ciudad Bolívar, Msgr. Agustín Romualdo Alvarez was named Bishop of the Vicariate of Machiques to accompany and encourage us in this specific area of pastoral action.

Within the huge Caracas metropolis, there are thirteen large hospital complexes, but in some cases no chaplaincy has been created; on a spontaneous basis, priests from near-by parishes provide patients with spiritual assistance when requested.

At a number of hospitals (Military, Miguel Pérez Carreño, Magallanes de Catia, University City Clinic, Guinand-Baldó Complex) there is a full-time priest, and at Vargas Hospital a young priest was recently appointed.

There are currently ten religious congregations whose ministries include attending the sick, sometimes in fulfillment of their specific founding charism.

We have held several joint meetings to share apostolic experiences, and these encounters have proved fruitful, for the religious possess great creativity and their activities are numerous, including prayer groups, Eucharistic preparation, commentary on the Word of God, and preparing for the Anointing of the Sick and First Communions, to cite just a few.

Work has been done to motivate religious and volunteer women at hospitals, and the original team has continually been enriched with new members up to the recent addition of Dr. Gustavo Zamora to serve on our national organizing committee.

There is a notable lack of priests with a vocation to attend the sick who prove capable of stimulating a hospital community. And at present most chaplains are older men or parish priests responsible for many other activities. A genuine hospital community thus cannot be achieved on a short-range basis.

If at many secondary schools we find an educational community concerned with the complete formation of the children who attend, the hospital community should seek to assist the patient spiritually, provide moments of prayer, peace, and well-being which are so necessary in human life.

For this reason, we would go so far as to request that health apostolate professorships be established at seminaries and that all seminarians have some hospital experience and realize the possibilities offered therein; the vocations this field deserves would thereby be awakened — the spirit of love and commitment required by those who are suffering and, in some cases, dying.

We would like to avail ourselves of this visit by the Pontifical Commission to address doctors, nurses, volunteer women, and other members of the hospital community present here, asking that in the places where they work they form Evangelization Teams and inviting them to the monthly retreats which represent one of the principle means of providing this Apostolate with greater consistency and which are now being conducted at St. John of God Hospital. In this way, each hospital will receive a Team constituting a living cell capable of conveying the Word of God and allowing itself to be addressed by it, a word which enlivens the heart, gives it hope, and draws it closer to God, making it fruitful for others; in collaboration with the Metropolitan Area Commission, they will thus carry out coordinated, well organized action.

Accordingly, we shall be able to make plans on a middle and long-term basis which will gradually create the Health Care Apostolate Venezuela expects from all of us.

Sr. CONSUELO HERNÁNDEZ SERRANO
Sisters of Charity of St. Ann

COLOMBIA
National Secretariat for the Social Apostolate Report on the Health Apostolate

1. Decisions of the Colombian Conference of Bishops

During the Plenary Assembly of Bishops in 1984, reflection was carried out on the need felt by the Church to take on and reinforce the Health Apostolate within the country. By virtue of this reflection,

1.1. The Conference of Bishops entrusted to the Bishops' Commission for the Social Apostolate the task of stimulating and promoting the Health Apostolate.

1.2. The Conference of Bishops approved the creation of a National Health Apostolate Seminar and the preparation of a corresponding Directory and a Legal Statute for the pastoral workers at state-run institutions.

2. Historical Summary

The Catholic Church has played an important historical role in the integral development of the community and the health field in Colombia. Until well into the present century, the Church was mainly, and almost exclusively, responsible for educating and healing our people.

Through the selfless work of Bishops, Priests, Religious, and the Laity, intensive pastoral efforts have been made in health care since the beginning of the conquest for the purpose of humanizing and evangelizing the world of medicine and suffering.

2.2. In 1983, UNICEF, recognizing the Catholic Church to be one of the country's most influential and credible organisms and the possessor of multiple channels to approach the community, initiated contacts with the National Secretariat for the Social Apostolate to promote a project to assist children.

In the wake of this exchange, it was decided to draft a manual orienting health care for children and, through the spread of four basic strategies, reduce infant morbidity and mortality in Colombia, especially in the least protected sectors of the population.

In 1984, the government launched the National Plan for Child Survival and Development (PNSDI) in collaboration with nongovernmental organizations such as UNICEF and SNPS.

In this interinstitutional cooperation, the Colombian Bishops committed themselves to encourage and orient those engaged in the Social Apostolate in using the means offered by the plan (PNSDI) and thereby availing themselves of the positive influence and living energies of the Church in the country, to contribute to the search for integral health in the population, especially in that highly affected, important part of it constituted by children

As a result, in 1985 800 "health sentinels" belonging to the Parish Social Apostolate Committees volunteered and received training in nine Ecclesiastical Jurisdictions; these, in turn, had a multiplying effect in their respective parishes.

For the purpose of continuing support for the education and progress of the Parish Social Apostolate Committees and promoting campaigns in favor of children's health, 1986 plans call for the training of 2,000 social apostolate workers as health sentinels to reach 20,000 families.

Until now twelve jurisdictions within the country have trained 659 pastoral workers in the social-health field from among rural leaders, seminarians, and committed laymen from both the countryside and city neighborhoods; these will take the PNSDI's educational messages to their respective communities.

2.3. All of these efforts and experiences prepared the ground for the National Social Apostolate Secretariat's commitment to the new projects indicated by the 1984 Plenary Assembly: the Seminar, the Directory, and the Health Apostolate Statute.

2.3.1. The National Health Apostolate Seminar

By means of this Encounter, we hoped to promote a process of reflection on the health apostolate throughout the country within our global ministry.

In March, 1985, an interdisciplinary team of health apostolate workers was formed, with technical consultants from the National Social Apostolate Secretariat and including representatives of the NSAS, the Ministry of Health, the Camillian Fathers, and the Group of Religious

From April, 1985 to October of the same year, this team carried on intensive preparations for the Seminar, designing and distributing questionnaires for a public opinion poll, tabulating results (see Annex I), drafting working documents in collaboration with people all over the country, specifying the methodology involved, and providing permanent follow-up. The stages were

1. Working out the initial project.

2. Informing the Ecclesiastical Jurisdictions, Religious Communities, and Regional Hospitals.

3. Designing and sending questionnaires for the purpose of motivating and sampling opinion in all the different sectors: chaplains, religious communities, parish priests, laymen, and hospitals

4. A process of reflection in these circles.

5. Collecting data and tabulating results.

6 Internal analysis, interpretation, and organization.

7. Drafting work documents for the Seminar: the proposed National Health Apostolate Directory and the proposed Statute.

8 Study of the above-mentioned documents in the Ecclesiastical Jurisdictions, religious communities, laymen's groups, and hospitals. Preparation of delegates to the Seminar.

9. National Health Apostolate Seminar in Medellín.

This enormous, effective planning bore fruit in the First National Health Apostolate Seminar, held in Medellín from the 13th to the 16th of October, 1985.

This Seminar proved to be a success and greatly benefited the Health Apostolate, thanks to the generosity and enthusiasm of the Bogota Organizing Committee, the Medellín Host Team, and all those attending.

The passes and invitations were distributed by bishops, the provincials of different religious communities, the Ministry of Health, and contacts were established with laity committed to this pastoral activity.

135 people in all participated in the Seminar; there were 40 priests, 58 religious women, and 37 laymen

The Seminar proceedings were published in issue no 125 of our journal, *Documentación de Pastoral Social* (*Social Apostolate Documentation*).

2.3.2. The proposed *Guidelines* and Health Apostolate Statute.

We are seeking to work out *Guidelines* providing doctrinal orientation for the pastoral work of the members of the Church committed to the world of health.

The basis for these *Guidelines* is found in the working Documents of the Seminar, which are being restructured in accordance with the results of the latter

The following steps remain to be taken:

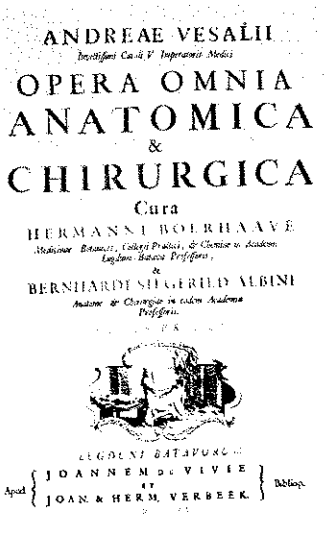
- Redrafting the proposals for *Guidelines* and a Statute in the light of the Seminar's contributions.
- Discussing the definitive proposals for *Guidelines* and the Statute within the Colombian Conference of Bishops.
- Publishing and distributing the *Guidelines*.
- Gaining legislative approval for the Statute.

Throughout this process, we have discovered the efforts of many dedicated people in the health field, along with numerous challenges which the Church must face in defending the person and his values.

August 13, 1986

FR IVAN MARIN L.
National Director

Andrea Vesalio, Opera Omnia Anatomica e Chirurgica *(Verbeek, 1725)*



ITALY

The St. John of God Brothers Look Towards the Year 2000

At their International Center in Rome (Via della Nocetta), the Provincial Fathers of the Hospital Order of St. John of God met from September 29 to October 5, 1986 The purpose of this meeting was to analyze and study the document drawn up by Fra Pierluigi Marchesi, Prior General of the Order, dealing with problems related to hospital work with a view towards the third millennium The Order asked how it might continue to be the depository of the particularity represented by the fourth vow added by the followers of St. John of God to the traditional ones of poverty, chastity, and obedience

It asked how it could remain united in the face of a world in continuous evolution, in fidelity to its own charism, with prospects at once uncertain and exciting, for in the future there await space research and new dimensions involving brothers marginalized by poverty, old age, and drugs and those afflicted with disease and the fear of death

The first part of the meeting was devoted to examining how the Order's New Constitutions, approved by the Congregation for Religious in 1984 and a source of inspiration for the Document on hospital work in the year 2000, have been received by the diverse St. John of God communities present in 42 countries at general hospitals, psychiatric hospitals, clinics, shelters, ambulatories, dispensaries, and schools

The second part of the meeting dealt with a dynamic projection of the Order towards the coming century A self-critical attitude, identifying and developing new courses, and adaptation to changing demands in the awareness of new dimensions of the post-conciliar Church will occupy the immediate future. The Hospital Order, respecting its own centuries-long experience, on October 1 marked the Fourth Centennial of the Bull *Etsi Pro Debito*, by which Pope Sixtus V instituted it. It urges its members in diverse sectors not to be afraid, but to have courage, the courage to be witnesses, moral guides, critical conscience, forerunners, and researchers. On the occasion of this anniversary, Msgr Vincenzo Fagiolo, Secretary of the Sacred Congregation for Religious, presided over the celebration of the Eucharist. In the homily, he exhorted the Provincial Fathers to observe with confidence and zeal the charism of the Institute and the needs of the ill, remaining ever faithful to the Church.

On another occasion, Msgr. Fiorenzo Angelini, Pro-President of our Commission, addressed the Order. Pointing out that the creation of the new Pontifical Office is a stimulus and source of new vocations at the service of the sick, he expressed his appreciation of the subjects being discussed and proposed the study of important objectives to be reached for a more penetrating activation and effective coordination of the delicate health care field.

Health and disease in the apostolate

At the Pastoral Institute of the Lateran Pontifical University, during the 1986-1987 academic year, a course is being offered for up-dated study of "Health and Disease in the Apostolate."

It is designed for chaplains, men and women religious at hospitals, health care volunteers, and medical professionals

The course, offered in conjunction with our Pontifical Commission, avails itself of the collaboration of the Camillians' Health Apostolate Institute, whose Director, Fr. Emidio Spogli, a Consultor for our Office, is also the Coordinator of this course for continuing education

An oculist becomes a healer of souls

Recently ordained a priest in St. Peter's Basilica by John Paul II, Diego Perrone, a 39-year-old Naples oculist, revealed his motivation to a group of surprised questioners:

"In speaking with my patients, I realized that their most serious problems, the ones with the strongest grip on their lives, were linked to the spirit. I thus decided to change my profession. I have become a priest, that is, a physician of souls. I feel I can be more useful to my fellow man in this way."

Relationship between health and vocations

Rogate Ergo, a journal concerned with stimulating vocations, has dedicated the 8/9, 1986 issue entirely to the relationship between the *health ministry* and the *vocation ministry*. An interview with Msgr. Fiorenzo Angelini and a report by Vito Magno on the document instituting the Pontifical Commission for the Apostolate of Health Care Workers illustrate the Church's commitment to man's health, a commitment which *Rogate Ergo* confirms with experiences undergone over the course of centuries by religious Institutes and charitable institutions whose specific charism is physical and spiritual assistance to those who suffer. Finally, an inquiry by Giuseppe Scarvaglieri on religious dealing with drugs points to a sector of the health apostolate which is characteristic of our time.