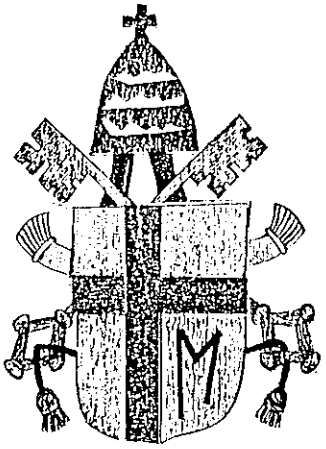

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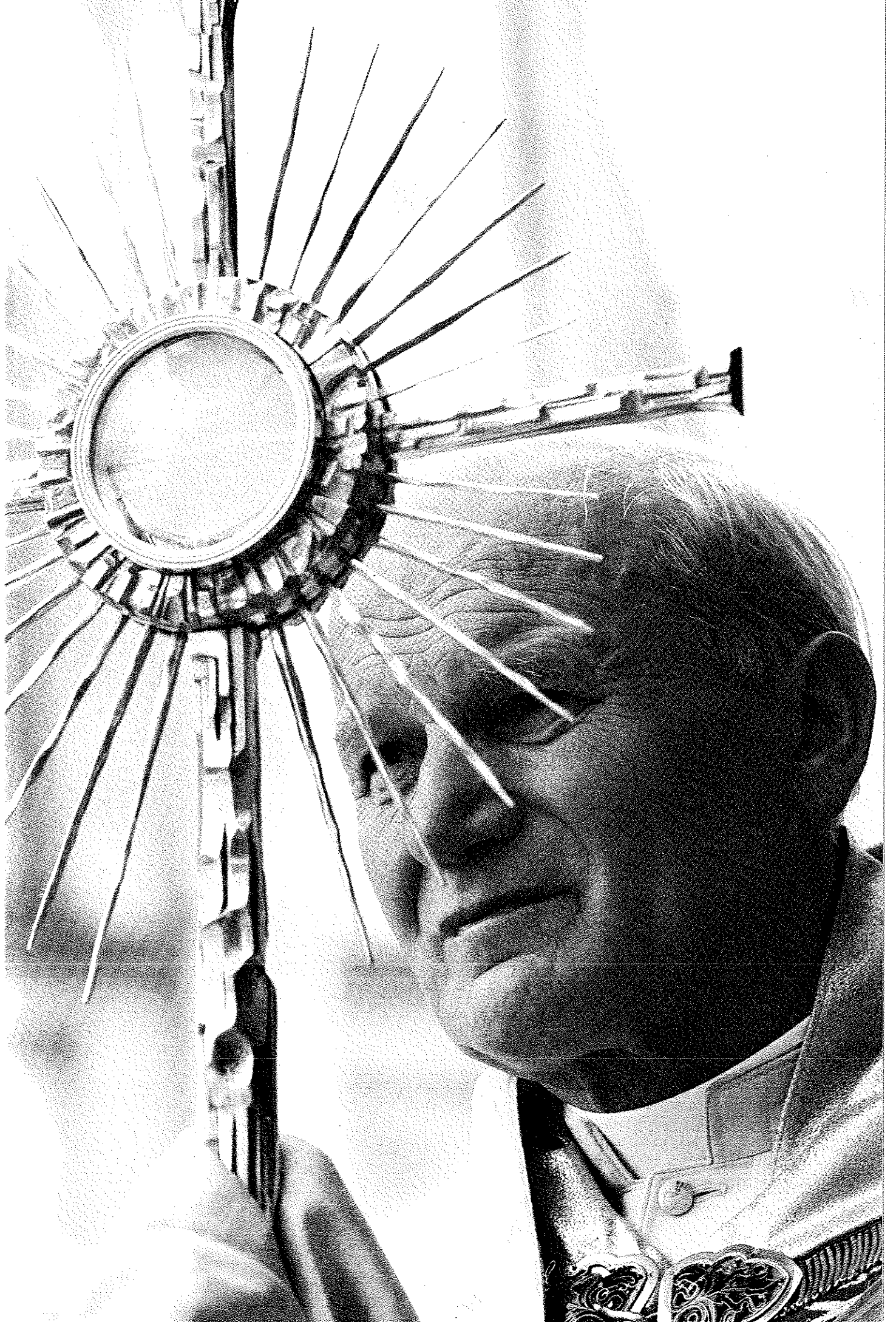
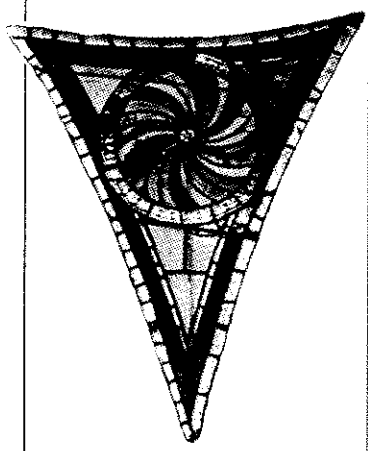
Contents

TESTIMONY

The illustrations in this issue of the journal represent details of the stained-glass windows of European churches: the French cathedrales of Bourges, Le Mans, Autun, Strasbourg, Chartres, St. Dennis (Paris), Sainte Chapelle (Paris), Notre Dame de Chalon sur Marne, Royal Chapel of Dreux; among the English churches, St. Neot's in Cornwall, Cathedrals of Canterbury, Oxford, and York, Christ Church, Merton College Chapel at Oxford, St. Stephen's in St. Peter Port, Wickhambreux Church in Kent, All Saint's of Middleton, Cheney in Buckinghamshire. St. Foy Church of Conches, Heaton Bishop Church of Herefordshire, Tewkesbury Abbey in Gloucestershire, All Hallows Church of Wellingborough, North Street Saints' Church in London; Italy's Lower Basilica of Assisi and Arezzo Cathedral; from Spain, the Cathedral of Toledo; Germany's St. Lawrence Church in Nuremburg and Ulm Cathedral; from Austria, St. Lambrecht Convent. All of the illustrations have been taken from Stained-Glass Windows: Technique and History *(Novara: De Agostini Geographical Institute, 1977), edited by Giuseppe Marchini.*



The Thought of John Paul II on Suffering



During the last decades, theological meditation, stimulated by a growing need for interpreting, in the light of God, the mystery of the world and of man in their concreteness, has moved in special directions.

There is talk of political theology, theology of hope, theology of development, and so on.[1] In more recent years, a particular place was devoted to the *theologia crucis*, which was almost officially sacred after the glorification of Discalced Carmelite Edith Stein.

In fact, the cloistered nun, who was put to death in the concentration camp of Auschwitz, left the testament of her thought and life in the unfinished work *Scientia Crucis*, a dramatic and theological reading of her sufferings.[2]

First of all, I would like to say that the thought of John Paul II on suffering is rather a deep and extraordinary elaboration of a real *theology of suffering*. The many things written, said, and experienced by John Paul II are closely related and constantly referred to the Christian meaning of human suffering.

In his first Encyclical, *Redemptor Hominis*, John Paul II, recalling a passage of *Gaudium and Spes*[3] about the deep suffering of man, constantly torn between his tendency to evil and his aspiration to good, says that this man is " the way for the Church. "[4]

In the Apostolic Letter *Salvifici Doloris*, the Pope takes the subject up again and writes: " It can be said that man in a special fashion becomes the way for the Church when suffering enters his life. "[5] And continues: " Assuming, then, that throughout his earthly life man walks in one manner or another on the long *path of suffering, the Church at all times should meet man*. Born of the mystery of redemption in the Cross of Christ, the Church has to try to meet man in a special way on the path of his suffering. In this meeting man becomes ' the way for the Church, ' and his way is one of the most important ones. "[6]

I realize that to speak of theology rather than of the thought of John Paul II on suffering implies a broad and deep study of his magisterium and ministry, so emblematically marked by suffering. Indeed, there is a peculiar welding together of thought and action related to suffering in his experience as Pastor of the universal Church. The coherence created by this welding together of thought and action makes his teaching extremely trustworthy.

I will only underline, or better, sum up, the cornerstones of the Pontiff's theology of suffering in a single fundamental assumption of *Salvifici Doloris*: " At one and the same time, Christ has taught man to do good by his suffering and to do good to those who suffer. "

After formulating this aphorism, the Holy Father continues, " In this double aspect, He (Christ), has completely revealed the meaning of suffering. "[7]

Paraphrasing in pastoral and catechetical terms the expression " theology of suffering, " we could speak of " suffering which saves, " of suffering as a way towards the complete redemption of man.

We thus see how the theology of suffering of John Paul II can be systematically summed up and organized according to the two aspects that he clearly indicates.

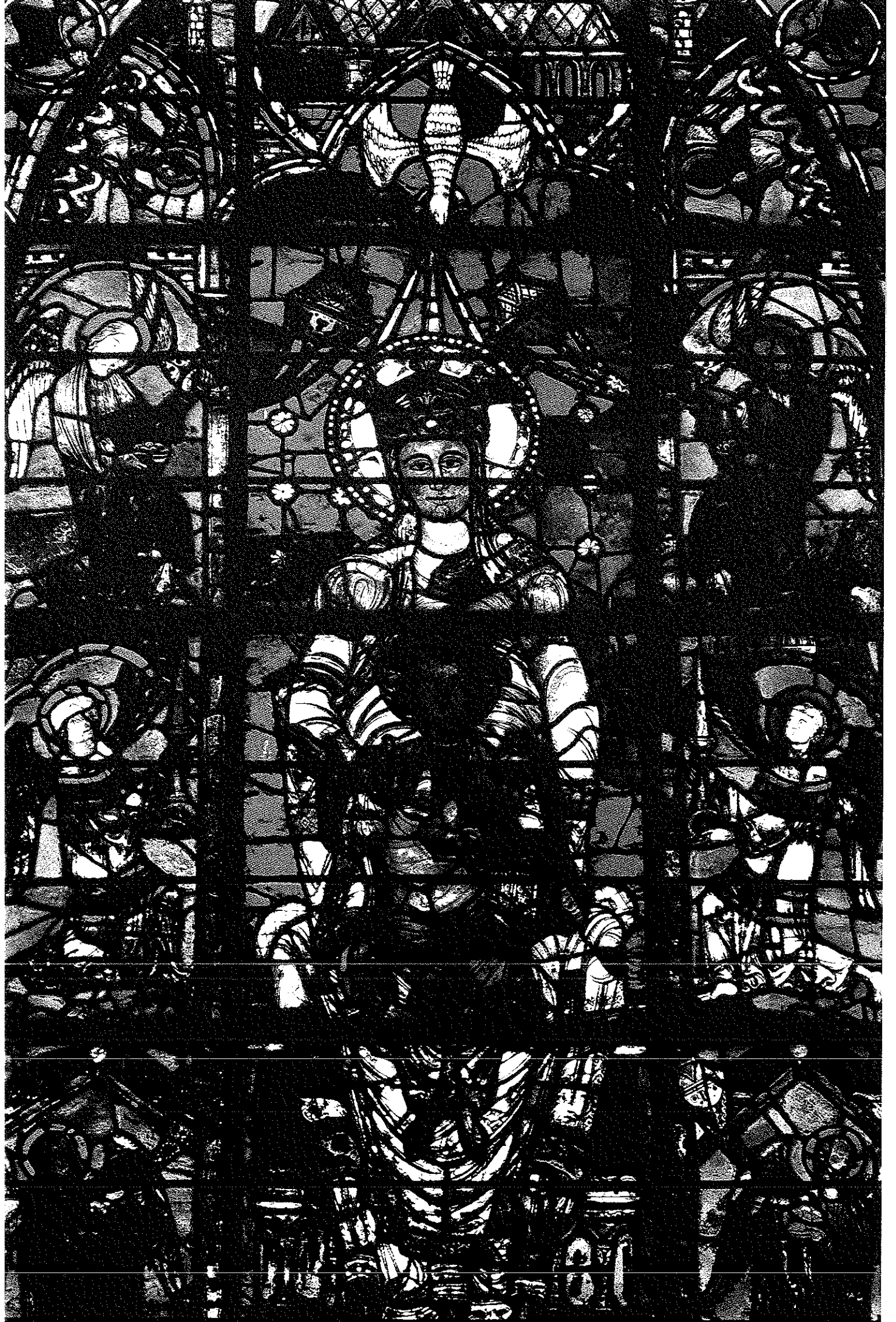
1. To do good by suffering

A whole section of *Salvifici Doloris* is entitled " the Gospel of Suffering. "[3] Gospel means " Good News, " the salvific announcement of Christ, the proclamation of the Kingdom of God. If suffering is Gospel, it is because Christ became man, announced the Father, and rose again by suffering.

It is not a theoretical vision; on the contrary, it is a historical interpretation of Christ's mission. In fact, as the Pope states, " The Redeemer himself wrote this Gospel, above all by his own suffering, accepted in love, so that man would not perish but have eternal life " (Jn 3:16). This suffering, together with the living word of his teaching, became a rich source for all those who shared in Jesus' sufferings among the first generation of his disciples and confessors, and among those who have come after them down the centuries. "[9]

One might think that the theology of suffering is just the accentuation of a certain interpretation of the mission of Christ. On the contrary, it seems interesting to me to note that the key of suffering is able to open the door to an integral vision of Christ's life and message, up to the point of embodying in itself all of their aspects. In fact, the Pope, in the consideration of suffering also includes the Mystery of Mary, Mother of Christ and of the Church, affirming, " It is especially consoling to note and also accurate in accordance with the Gospel and history that at the side of Christ, in the first and most exalted place, there is always his mother, through the exemplary testimony that she bears *by her whole life* to this particular Gospel of suffering. In her, the many and intense sufferings were amassed in such an interconnected way that they were not only a proof of her unshakeable faith but also a contribution to the redemption of all. "[10]

To do good by suffering relates to Christ's choosing pain as a tool of redemption, because the only way to escape from the destructive power of suffering is the very extolling of it.



Saint Paul, teaching us that in accepting the human condition Christ accepted becoming a slave, that is to say, the " least of men " (Phm 2:9), reaffirmed the truth of the Gospel of suffering.

Suffering is Gospel, it is Good News, it is the announcement of salvation, but only because it can be turned into good, become an instrument of good. " The Gospel of suffering signifies not only the presence of suffering in the Gospel, as one of the themes of the Good News, but also the revelation of the salvific power and salvific significance of suffering in Christ's messianic mission and, subsequently, in the mission and vocation of the Church. "[11]

The Pope speaks of extolling suffering as *revelation*: the expression does not seek to be merely emphatic but theologically exact and precise.

Thus, the Christian is called to suffer *as* Christ did,[12] to suffer *together with* Christ.[13]

" The more a person is threatened by sin, the heavier the structure of sin which today's world brings with it, the greater is the eloquence which human suffering possesses in itself. And the more the Church feels the need to have recourse to the value of human suffering for the salvation of the world. "[14]

In the past, the *revelatio* of the Gospel of suffering could appear rationally unacceptable and absurd. The path of progress and civilization is a path aiming at conquering suffering and death. The illusion of the modern era got to the point of hypothesizing the possibility of man's victory over suffering and death. Today science itself recognizes, as the Council recalls, that the fundamental questions about the reason for suffering and death not only remain unchanged but become even more dramatic and threatening.[15]

Christian intuition reveals the possibility of reconciling the rightful fight to conquer suffering and the possibility of grasping its creative and redeeming value. Nevertheless, this reconciliation, not in accord with the philosophy of Plato, who considered pain and joy as contending forces within man trying to take him in opposite directions, but in the light of the teaching of Christ, who, in accepting, though innocent, the consequences of sin, suffering, and death, annihilated the destructive power of suffering and revealed its redeeming and healing power.

That is why the Pope, from the beginning of his ministry, openly asked people suffering in their bodies and minds, for the support stemming from the *gift* of suffering accepted as a tool of redemption and life.

In all the speeches of the Holy Father, an enormous space is devoted to meditation upon suffering. In every apostolic journey, every audience, every meeting with people, the Pope gives priority to the suffering. And the root theme of his words is not primarily that of sympathetic solidarity, but the request for support for announcing the Gospel contributed by those who accept their own cross. The theology of the cross and of suffering is theory and practice joined together; it is the measure of the effectiveness of every single apostolate.

Allow me a short digression which would, however, deserve further study to note that to take into account the theological vision of the Holy Father is the only way to reach complete understanding and interpretation of his pastoral action. His most difficult and controversial apostolic pilgrimages must be analyzed in the light of this vision. For example, when he appeals to peoples for reconciliation, he

does not sing the praises of submission and a forced acceptance of suffering, but asks all those who suffer to bestow upon their suffering a constructive meaning, as a premise for redemption and liberation from the human point of view. Indeed, the civilization of love cannot exist unless suffering acquires a positive value.

2. To do good to the suffering

The second aspect which deeply reveals the meaning of suffering is, according to Christ's teaching, to do good to the suffering.

In the document instituting the Pontifical Commission for the Apostolate of Health Care Workers there is an expression which will never be studied enough and which, in the pastoral field, could play a fundamental role in Christian testimony. The Pope says that solicitude for the suffering is an " integral part " of the Church's mission.[16]

Thus, this is not a marginal or optional aspect, but rather co-essential, an integral part, as could be easily demonstrated historically, and also in the light of the very nature of the mission of Christ and of the Church.

To do good to the suffering is the response, or better the implication, the consequence of extolling suffering; it is the transformation of suffering into an act of love. In *Salvifici Doloris*, John Paul II explains this truth by means of masterful exegesis of the parable of the Good Samaritan.[17]

Let me now quote one of the most profound and insightful pages by the Holy Father on the theological aspect of this truth. He pronounced these words on March 30th, 1983, during a general audience for the Holy Year of Redemption. Let us read them together: " It is true that universal experience teaches also that suffering implies beneficial effects on many people, as it generates maturity, wisdom, good, understanding, solidarity. In this sense, it is possible to speak of the fertility of suffering. But this assumption does not solve the main problem and does not wipe out the temptation of Job, which is also part of the spirit of the Christian when he is induced to ask God: *Why?* For many people, the problem of evil and suffering is an objection against the Providence of God, if not against his very existence. Then the reality of the cross becomes a scandal since the talk is about a *Christless Cross*. The heaviest and most unbearable, terrible one, sometimes to the point of tragedy!

" *The Cross of Christ is the great revelation of the meaning of suffering and of the value that suffering has had in the course of life and history* ... The Cross is proof of an infinite love that, precisely in the Host of expiation and pacification, has placed the principle of universal restoration and especially of human redemption: redemption from sin and, basically, from evil, pain, and death.

" But the *Cross invites us to respond to love with love*. We can give to God, who loved us first, the sign of our deepest participation in his saving plan. Not always are we able to understand, within the limits of this plan, the reason for the pain marking the path of our lives. Nevertheless, supported by faith, we can be sure that it is a loving plan, within which the immense range of crosses, big and small, tends to fuse into the one Cross. "[18]

And to do good to the suffering means to respond to pain with love, to make suffering positive through love.

To do good to the suffering is the greatest, the most important and unsettling revolution that the Church is called to carry out in the course of history.

The parable of the Good Samaritan, the Pope says, " belongs to the Gospel of suffering and goes hand in hand with it throughout the history of the Church and of Christianity, throughout the history of man and humanity. This parable witnesses to the fact that Christ's revelation of the salvific meaning of suffering is in no way identified with an attitude of passivity. It is exactly the opposite. The Gospel is the negation of passivity in the face of suffering. Christ Himself is especially active in this field. "[19]

The commitment deriving from this integral part of the Church's mission is so important that we will be judged according to the good done to the suffering. " I was hungry and you gave me food. I was thirsty and you gave me drink. I was a stranger and you welcomed me. I was naked and you gave me clothes. I was ill and you visited me. I was in prison and you came to see me " (Matthew 25:34-36).

It is possible to base a complete theology of suffering or of the Christian meaning of human suffering upon the dual concept of doing good by suffering and doing good to the suffering. In this sense, we can deeply interpret the whole life, teaching, and work of Christ, the history of the Church and its holiness. All pastoral programing can be included within this simple, essential framework, for pastoral action in its real meaning is not possible if the commitment to doing good by suffering and to the suffering is missing. Without forcing ideas to fit within the confines of this Meeting, I wish to add that the theology of suffering is a form of theological reflection of particular current interest. In the course of history man, tried by suffering, has always sought the reason for pain. Nowadays the question is not only becoming more acute and generalized but also, I would say, more homogeneous and definitive. The collapse of the myths of positivism, materialism, consumerism, and an unlimited faith in the possibilities of technology poses once more the question of suffering in more universal and unanimous terms.

The appreciation of suffering reached through love, which makes us similar to Christ and, with Him, leads to the healing of all suffering, is the only prospect of liberation for man and for creation, which, together with the children of God, suffers while awaiting the definitive completion of redemption.

✠ FIORENZO ANGELINI

[1] AA.VV., *Postcouncil Theological Trends* (Rome: Città Nuova, 1974)
[2] Edith Stein (Sister Benedetta della Croce). *Scientia Crucis* Posthumous work. It. Trans. (Milan: Ancora, 1964).
[3] *Gaudium et Spes*, 10
[4] *Redemptor Hominis*, 14.
[5] *Salvifici Doloris*, 3
[6] *Ibidem*.
[7] *Salvifici Doloris*, 30.
[8] *Ibidem*, 25-27.
[9] *Salvifici Doloris*, 25
[10] *Ibidem*, 25
[11] *Salvifici Doloris*, 25
[12] *Ibidem*, 25. See *Luke* 9:23, 21:12-19, *Matthew* 7:13 and following, *John* 15:18-21.
[13] *Salvifici Doloris*, 26. See Col 1:14, Ep 6:12.
[14] *Salvifici Doloris*, 27.
[15] *Gaudium et Spes*, 10; *Redemptor Hominis*, 8; *Salvifici Doloris*, 5.
[16] *Dolentium Hominum*, 1.
[17] *Salvifici Doloris*, 28-30.
[18] See *L'Osservatore Romano*, March 31, 1983
[19] *Salvifici Doloris*, 30.

Religious in the World of Suffering and Health

This is the title of a little volume which the Pontifical Commission for the Apostolate of Health Care Workers has just published. It represents the first in a series of topics which the Pontifical Commission wishes to make available to all those who work in the world of health.

It is only fitting to initiate this collection of publications with a very specific allusion to a group of men and women who consecrate their entire lives to the service of health, of the sick, and of all the values connected with this mission.

Religious engaged in health care have distinguished themselves thoroughout the history of the Church at the forefront of such service and are now making a firm commitment to renewal and vitality. The book places emphasis upon this vocation, marked by generosity, enthusiasm, faith, and effectiveness, and poses many questions for religious which arise in medicine at this time of rapid, throughgoing change.

On this occasion we have asked four General Superiors of Institutes serving the sick to comment on the presence of religious in this field. All four are also members of our Pontifical Commission.

Their responses do not constitute a commentary on the book we have referred to, but rather serve to accompany its publication. We have welcomed their remarks and regard them as instructive for the readers of our journal, *Dolentium Hominum*. Above all, the authors stress the following ideas: religious engaged in the health ministry should be witnesses and moral guides, competent, and endowed with a great capacity to love; indeed, it is seen that these religious have always participated in the life of the Church as pioneers in evangelization and defenders of life.

I. Witnesses and Moral Guides

The presence of religious in the health field, as in all others, should be maintained under banner of newness within continuity.

We are living in a period of profound, rapid changes which often threaten to render our lifestyle, our way of being Brothers of St. John of God, out-of-date and, therefore, less effective as a sign.

Today's hospital — where new types of patients are to be found as well — is characterized by the massive participation of lay workers and by increasingly advanced technological contributions. This frequently provokes a trial for religious, arousing inferiority complexes, almost a feeling of uselessness, and even frustration over a certain loss of power.

Such changes make necessary a critical analysis of our behavior, up-to-date examination of our professional positions and relations — as individual religious and as a community — with the environment which obedience has reserved for us.

We must become aware of such demands to avoid being left on the fringe of reality. It is certainly not easy — we sometimes appear frightened by the press of recurring temptations, like that of retreating to positions of comfort, security, or mistaken resignation, for instance, or cutting out a niche for ourselves so as to carry on professional activity, even in competition with our brothers or lay collaborators, or, finally, of relegating to the laity or, still worse, to sophisticated technologies the care of the sick, triggering the trap of our own loss of identity and the patient's anonymity.

The idolatry of efficiency sometimes creeps into our framework as well; and that is the time to confirm forcefully, to manifest clearly the essence of our charism, our true physiognomy as *hospital brothers*, witnesses to merciful love in service to suffering humanity. Above all, then, men " warmed " by the fire of the Gospel who bend over other men, seeing in them not abstract, anonymous " clinical cases, " but rather brothers to be cared for and comforted in body and soul. This may be called making the hospital a humanized and humanizing structure, where the patient is our university.

In this vein, the role of us religious is more clearly defined as novelty in continuity: we are, in fact, called to be WITNESSES, MORAL GUIDES, CRITICAL CONSCIENCE, INNOVATORS, and FORERUNNERS.

Witnesses, in the footsteps of the Founders, of how to assist the sick and the needy today, appearing under new aspects: the elderly, the terminally ill, drug addicts; the emerging culture, which has removed the Christian concept of pain, death, and eternity, poses very serious problems for them for which there are no medical prescriptions or at least these are insufficient.

Moral rather than technical *guides*, as technological leadership is now the prerogative of the laity. Our know-how is drawn from the Gospel: it is a question of conveying our " passion " regarding the patient and our faith motivations to collaborators.

Critical conscience: Whenever the sacredness of man is threatened and an attempt is made to impose the fluctuating ethic of the practice in fashion, our voice and our action must emerge courageously, without yielding to pressure, with no consent or compromise. We are obliged by the responsibility of our state and fidelity to our religious profession.

Forerunners and innovators: With the speed of the transformations taking place, even just halting may mean retreating. St. John of God (and so many after him), in spite of the indifference, disdain, and hostility of the majority, managed to identify new pathways: with our Founder, the modern hospital appeared; the hospitality of the year 2000 must be originally shaped by his sons. To this end, it is necessary to meditate and project intrepidly, in the logic of the Gospel.

Fra PIERLUIGI MARCHESI
Prior General
Hospitaler Order of St John of God

II. Participation by Religious in the Church and in the World of Health Care

For some time psychophysical well-being has been defined as " health. " There is increasing awareness at present that this term possesses much broader scope, extending from conception to death.

Health concerns the *whole* man in *all* his dimensions — family, social, moral, spiritual, physical, mental, and collective.

As women religious in the world of health today we are faced precisely by those who have been stricken, wounded, in their bodies, in their spirits, or in their social relations.

We must there confront suffering, which, as the Holy Father himself has stressed, remains an " unapproachable mystery " (Apostolic Letter *Salvifici Doloris*, February 11, 1984).

A question is then posed for us: Is it important for the world, for the Church that we women religious should be engaged in health work, in this struggle against evil, against suffering?

The French Conference of Major Superiors unanimously approved the following statement in 1984: " At the center of their professional activity, where they renew the works of Christ the Savior for today's world, women religious collectively participate in the Church's mission in the field of health. "

It is this certainty which channels and animates our mission of *diaconia* needed by the Church. Three roles seem to summarize our testimony as apostolic religious sent by our Community — and thus by the Church — into the health care field:

1. *Our FAITH in life* — "life which is a perpetual birth " (Paul VI) — aims to develop life, and we commit ourselves to doing so by means of action. To this mission we must contribute not only the competence of our techniques and our devotion, but attention to the dignity of persons above all.

In dealing with the serious ethical problems posed by abortion, therapeutical obstinacy, and euthanasia, the woman religious engaged in health care must not be afraid to recall the Gospel demands; she must, in a sense, be a prophetic sign, i. e. manifest by word and deed — and sometimes through her refusal to act — that the present life has a future beginning here and now.

We must not forget that we are responsible for one of the " faces of the Church, " and the decisions we make or help to make have a symbolic importance — they reveal this " face of the Church. "

2. In dealing with the patient threatened by anonymity, by loneliness, immersed in a world of science and technique, where he is no longer considered in terms of his personhood, but only with regard to his disease, we also have a significant role to play in establishing a TRUE RELATIONSHIP, entering into contact, accompanying.....

There is a great deal for us to create in the area of relationships, support, listening. We have to speak out, testify to our acceptance of the person's human — and mortal — condition. We must ask ourselves and those around us about *respect for man's freedom*, in its twofold dimension, in the conviction that life comes first, but that in *Christ, we are called to a new life*.

3. Finally, our mission is situated within a TEAM — in working with other professionals, with health personnel, the province of each must be respected. This team has a common goal which requires broad solidarity, loyal and courageous collaboration. We do not supply answers which repeat formulas learned by rote when encountering the questions posed and reflected upon within the team, but in the light of the Gospel seek to communicate with the same zeal.

As team members in the place assigned to us, each of us must make a commitment to

defending human life.

These much-discussed points give rise to the behavior proper to a woman religious in the health field. We shall rest content simply with recalling the essential aspects:

Our missionary message is conveyed above all by *the quality of our BEING*. We are witnesses to the Good News, not only through what we do, but particularly through what we are.

Another attitude corroborates this guideline: *the gratuitousness of love*, of which we must be messengers. The instruction Mother Guillemin gave us in 1968 is always up-to-date: " Your task is to humanize technology to make it the vehicle for Christ's tenderness. "

The third exigency to which we are radically invited is CONSISTENCY — between Faith and what we do, what we say, what we live. We must never allow there to be a break between what we live and what we believe. We must " account for the hope which is in us " (cf. 1Pet. 3: 15).

This hope *which dwells in us* is Jesus Christ. " By means of Him, who has taken upon Himself the suffering of men, this suffering acquires a new dimension, linked to Love... " (Cf. the Apostolic Letter *Salvifici Doloris*). The dimension of the Redemption recalled by the Holy Father spurs us to turn incessantly towards *Christ*, recognized, welcomed, contemplated, and served in the patient we attend (cf. Mt. 25: 31-46).

Through our vocation as women religious in the health care field, in the name of Jesus Christ, in the name of the Church, following our particular ecclesial charism, we are asked to continue in some degree the mission of Christ, " who spent his life on earth doing good " (cf. Acts 10: 38).

And we ask the Virgin Mary, so intimately united to the mystery of the Redemption, to penetrate our hearts and our spirits with the very Love of the Savior so that we may learn to *love* our neighbor *as God Himself does* — become the " *sacrament* of the *Father's love*. "

Sr. ANNE DUZAN
Superior General
Daughters of Charity

III. Love and Competence

Many and varied are the Institutes of men and women religious prompted by the Holy Spirit and endowed with specific charisms to be witnesses to and the vanguard of that loving service to the sick which distinguished Jesus' activity and constitutes an essential element in the Church's mission.

Issuing forth from the heart of the Gospel and situated in the heart of the Church, these charisms of merciful love are destined to last as long as there are sick people, provided they succeed in changing to remain themselves. They have, in fact, arisen to serve the sick in the concrete situation in which they exist, to respond to their real needs, which are diversified and change according to time and place. It is quite different to become ill in Europe, South America, or Africa, just as becoming ill today is quite different from what it was in the times of our Founders and Foundresses.

All of us can readily observe the radical changes which have taken place in recent

years and which are still occurring in the world of health care in society at large, and in the manner of conceiving the tasks of the Church and government.

The drastic reduction in the number of men and women religious engaged in the health ministry has led us to grasp many things. The State, which rather hastily thought it could do without their presence, has very quickly realized that it is one thing to create facilities and turn out technicians (and government *is* in a position to do so) and quite another to train people capable of serving with love and paying closer attention to the patient than to the hands of the clock.

And we have also grasped that the quality of our presence is more important than its quantity; that it is more important to serve than to issue commands, to bear witness than to preach; that the personhood of the consecrated is of greater value than their role; that obedience does not replace competence.

We have grasped that we must offer the maximum love and the maximum professionalism if we wish to be credible. For if competence without love is like hands without a heart, love without competence is a heart without hands.

Hence the urgency of the spiritual, theological, pastoral, and professional training of our men and women religious working in such a significant and sophisticated field, where science and faith, technology and wisdom, death and life come face to face. Love spurs us to gain technical and scientific knowledge so as to serve better. Every door in the health care world — and, above all, the door to man's heart — opens to someone who radiates love and is competent.

And the Church will continue to be present in the world of health as both qualified and qualifying, with no need to multiply her own structures, for wherever there is a man who suffers, there men and women religious — bearers of life and hope — have their admission tickets guaranteed.

Fr. CALISTO VENDRAME
Superior General
Ministers of the Sick (Camillians)

IV. Religious: Pioneers in the Health Apostolate and Defenders of Human Life

What was once preached by Christ the Lord, or fulfilled in Him for the salvation of mankind, must be proclaimed and spread to the ends of the earth (*Ad Gentes* 3).

It is the mission of the whole Church to partake in fulfilling this mandate. The prophecy of Isaiah 61: 1-2 to which Jesus points as being personally fulfilled by himself (Luke 4: 21) might be summed up as the healing of all human ills. Later Jesus describes his own activity and its results: the blind see, the lame walk, lepers are cleansed and the deaf hear, the Good News is proclaimed to the poor (Lk 7: 22).

This is the Christ in whose mission all people share by their life and their words, in the family, in their social group and in the sphere of their profession (*Ad Gentes* 21). Religious by their own particular charism are called to highlight various aspects of Christ's personality, as *Lumen Gentium* puts it: Christ in contemplation on the mountain ... or healing the sick and maimed or ... doing good to all (L. G. 46). Religious in the field of health are called to

heal the sick, excluding no one. They work with all people of good will, pooling resources with them, striving to promote the wholeness of man and his milieu so as to bring about a world where true human development is fostered and human dignity and rights are respected. They proclaim the sacredness of life and the meaning of human life and death that " all may have life " and have it in abundance. In this way they are torch bearers lighting the way for their fellow pilgrims in a total pilgrim Church.

Frequently in all the Gospels we find the words: " He healed the sick and proclaimed the Kingdom. " The experience of missionaries bears out that this is a natural sequence, healing the sick is a witness to the Kingdom. It is also a sign of the love and compassion of Christ, for the poor, the marginalized and the handicapped.

Religious participating in a health service bring to it total dedication, which helps the sufferer to appreciate his own human worth and dignity and come to a full understanding of the meaning and value of suffering, and the true meaning of life and death.

History records that the Churches have established most of the health services of the world. This is especially true of underdeveloped missionary countries, many of them only recently independent. Where the resources of the country are limited,social services are meagre. The missionary looks to the total good of all the people and strives to provide incentives for them to meet their own needs. In 1936 the Sacred Congregation Propaganda Fide urged the formation of new religious Orders of Women for maternity and other health services, especially in missionary lands. The Congregation urged that such nuns be fully qualified as doctors and nurses. The Congregation also recognised that a Religious Congregation having expertise and personnel available could provide the basic team necessary to meet the health needs and maintain the long term continuity and stability such a service demands. This assistance should include a total range of services from Health Education to Prevention and Treatment, caring for the physically and mentally handicapped and geriatric patients. It also involves disaster medicine, coping with calamities such as famine, floods, economic distress, and other crises of our day.

Methods used in the healing apostolate must always conform to the varying needs of the time, and in the past religious have very often seen a need and blazed a trail for Government and others to take over. Now, above all else, religious are called to promote health and healthy living, encouraging, enabling, and facilitating people's rediscovery of their tremendous inner resources and the deeply human spiritual values touching the whole person.

Society today is scarred by suspicion and division. Human brokenness is universal. Fear and emptiness stalk our world. A ministry of listening has become of paramount importance in the field of health. So has the ministry of encouragement, enkindling and sustaining hope, not only of the patient but also of the family and community.

As well as being medical missionaries, Religious have, it seems to me, a mission to modern medicine. Elitist technological medicine, scientific research, and genetic engineering are tempted to use members of the human species as material for experimentation irrespective of the rights and dignity of the human being. It is imperative that we continue to raise a " health professional " voice in defense of humanity which Christian Ethics serves. The good of the patient is the ultimate purpose of health services. Medicine must return to being people-oriented rather than problem-oriented. The love of God and the compassion of Christ must motivate the field of health and wholeness.

Religious must continue to look at the needs which others are not meeting, to take the risk to find ways and means of responding to those needs, spearheading the response and mission of the local community and society of our day. In this way the Church will indeed respond to the signs of the times, to the needs of humanity, and continue to represent a loving and compassionate Christ in our world.

Sr. CATHERINE DWYER
Superior General
Medical Missionaries of Mary

Magisterium of the Church

Addresses by the Pope

AIDS: Some Christian Reflections

Statement by Archbishop Angelini to the Synod of Bishops

Fears for the State of Health of Polish Society

Christ is called to visit a sick person: " Sir, my servant is lying at home paralyzed, and in great pain. " " I will come myself and cure him " (Mt 8:6-7).

This is just another instance — there are so many, the Gospel is full of similar events. Christ is called to the sick; they ask for him. Christ is at the service of those suffering.

The words of Sacred Scripture that have been chosen for this meeting, are meant for each and every one of us who finds himself face to face with another person who suffers, our brother or our sister.

We are always called, all of us, in a certain sense, though in different ways. The call or request which the centurion made to Christ is being constantly repeated. In different places, people are suffering, at times finding themselves " in great pain. " They ask for someone to come, as they need his help and the comfort of his presence.

So, dear sisters and brothers, every time it happens that one of us here in Poland is called to the scene of human suffering, let this passage of Holy Writ be present before us. It is Christ who says to the centurion: " I will come myself and cure him. " At times, we feel intimidated by the fact that we are unable to " heal, " we cannot really help. But let us try to overcome that embarrassment. The important thing is to go there, to be near the suffering person. What he is primarily looking for may not be to be healed but to feel the presence of another human being, of a human heart beating for him in true compassion.

Provide Suitable Conditions for Care of the Sick

The passage we heard from the Gospel speaks in a special way to those of you who have made it your profession and vocation in life to serve those who are suffering. That is true for you, medical doctors, you pharmacists, you nurses, you technical assistants in the medical laboratories, you who help sick people to rehabilitate themselves. All of you who are engaged in the health services.

Dear brothers and sisters, you should always have before your minds the picture of Christ called to the paralyzed servant of the centurion; Christ who says: " I will come. " This is also your response: " I will come ..... , " " I will do all that is possible for your recovery ..... "

While I am speaking here, I think of all of you present before me: doctors, nurses, all the other representatives of those engaged in the health services. But I also think of your colleagues throughout Poland. I think of all the institutions dedicated to care for the sick: medical and dental out-patients' departments, hospitals, clinics, spas, sanatoriums, nursing homes.

I have always had and continue to have a deep admiration for this vocation, which seems so profoundly rooted in the Gospel, and at the same time in the whole humanitarian tradition of the human race, both pre-Christian and non-Christian.

Christ says: " I will come myself and cure him. " And each one of you should say, and does say: " I will come, I will do all within my power to restore your health. "

" All within my power " — that means that I am willing and ready, and it even fills me with joy to bring help to one who is suffering. To be near someone who is suffering and give proof of that sensitivity and compassion that the sick person needs so much, to let him feel that I am the Samaritan who gives himself for his brother.

The state of health in Polish society does give rise to serious considerations. Circulatory diseases and tumors continue to increase. Many persons, among them young people, continue to show signs of excessive dependence on alcohol, drugs, and tobacco. Not even the children show a good state of health. There is wide scope for preventive and therapeutic action in the health sector. It is a depressing fact that medical facilities are being used for large-scale interruption of pregnancy.

Modern medicine has developed enormously and become very specialized. So in order to be able to do " all that is possible " for the ailing, it is necessary to create conditions that are well adapted to deal with them, such as a sufficient number of hospitals and well-equipped health centers as well as the provision of suitable medicines. Unfortunately, the scarcity of these is keenly felt here in Poland. There are not enough hospital beds; the waiting lists at health centers are long, as well as those for operations. All this creates more difficulties for medical workers and adds to their burden of responsibility. At the same time, it de-

mands of them even greater moral sensitivity, high professional ethics and a profound understanding of their role in the service of the ailing.

The medical profession is also a vocation

At all costs, we must keep up the beautiful Polish tradition that the work of the doctor and of the nurse is not just a profession but also — even primarily — a vocation. The care of the physically handicapped and of old people, the way we look after the mentally handicapped — these are sectors of the social sphere which highlight the standard of culture of the society and of the state.

Trying to understand the daily tasks of all those engaged in the health sector and thinking of all those who place their knowledge and their whole capacity at the disposal of their suffering brethren, I wish in the name of the Church to express to them thanks and gratitude.

" My servant is in great pain. " Christ is not only the one who " heals " and is thus a model for all those engaged in serving the sick and ailing. He also says of himself: " I was sick. " These are words taken from that picture of the last judgement we find in the 25th chapter of St Matthew: " I was sick and you visited me " (v. 36).

The Gospel does not present Our Lord lying in bed in pain but we find him at the very summit of suffering: martyred, subjected to all sorts of terrible torture of body and soul. We see him during that terrible spiritual agony in the garden of Gethsemane, and the following day when he suffers the terrible agonies of crucifixion. He did indeed reach the very heights of human suffering, both physical and moral — he was despised and rejected by men. Indeed, " a worm, not a man; the scorn of men, despised by the people " (Ps 22:7). The Son of God " humbled himself, becoming obedient unto death on a cross " (Phil 2:8).

So he could say, speaking of the judgement day, " I was sick, " I have emptied the very chalice of suffering.

He could indeed say so.

His listeners were surprised at his words and asked: "When did we do this to you?" And he answered: " In so far as you did this to one of the least of these brothers of mine, you did it to me " (Mt 25:39-40).

Dear brothers and sisters, both you

present here, and all of you in our country who are sick and suffering! It is an extraordinary thing that Christ says. What is most extraordinary is the way he identifies himself with every one of you. But this is the identity card that the Gospel gives to everyone. St Paul carried the words of the Redeemer to their logical conclusion and writes: " In my own body ... I make up all that has still to be undergone by Christ for the sake of his body, the Church " (Col 1:24).

This is a fundamental point, both for individual Christians and for the whole Church, on which I have written more fully in my apostolic letter Salvifici Doloris.

" Born of the mystery of Redemption in the Cross of Christ, the Church has to try to meet man in a special way on the path of his suffering " (SD 3). Through the priestly service, the Church tries to meet those who suffer at home or in the various institutions of the health services. In the Church, the ailing person himself " is also called to share in that suffering through which the Redemption was accomplished " (SD 19). " In so far as man becomes a sharer in Christ's suffering — in any part of the world and at any time in history — to that extent he in his own way completes the suffering through which Christ accomplished the Redemption of the world " (SD 24). Thus the suffering person " discovers a new dimension, as it were, of his entire life and vocation " (SD 26). Here the priest and the doctor can together assist the sick person whose suffering has now been diversified and become multi-dimensional, just as human existence is multi-dimensional. This common service of a medical-pastoral character itself is particularly important when the ailing person is getting near the limits of earthly existence.

Human suffering is always a mystery

I am thinking of the hospice which has started to function here at Danzig and sets an example for other cities. It has its roots in the joint care of the pastoral apostolate to the sick and of the doctors present at the sick-bed, in the place and conditions suitable for the terminally ill. This care is shown by working together to tend the sick person in his home, in a willing and free gift of self. But an even greater gift is the wisdom and maturity that they experience in their patient: " When this body is gravely ill, totally incapacitated, and the person is almost incapable of living and acting, all the more do interior maturity and spiritual greatness become evident, constituting a touching lesson to those who are healthy and normal " (SD 26).

Human suffering is always a mystery.

It is very difficult for man to make his own way through this darkness.

On the horizon of our faith, there is just one point of reference left: the Cross of Christ, this summit of human suffering and of the suffering of one who is the most innocent of all, the Lamb without blemish.

During the Eucharist, just before Holy Communion we say: " This is the Lamb of God, who takes away the sins of the world. "

" Lord, I am not worthy to receive you. "

These are words uttered by the centurion. They are part of the invitation to the Redeemer on behalf of the stricken servant who is " in great pain. " " Sir, I am not worthy to have you under my roof; just give the word and my servant will be cured " (Mt 8:8).

" ... But only say the word and I shall be healed. "

The Eucharistic Congress in Poland is an occasion for every one of us to renew our awareness of these words, which on the first occasion were spoken by the centurion.

Dear brothers and sisters! You who are sick and suffering! All of you participate in this deep mystery of the faith: the Cross, the Eucharist, the Cenacle, the words of the centurion.

Remember that Christ " loved us unto the end " and showed it on the Cross, and this love of his continues in the Eucharist.

Remember that! May it be your strength in weakness. You are also called to love " unto the end. "

You, dear brothers and sisters, doctors, nurses, all of you who are engaged in the health services, you are also called to " love unto the end. "

Meditate on what this means.

What does it really mean?!

Not science but charity will transform the world

... The man whom we shall henceforth invoke as a saint of the universal Church presents himself to us today as the concrete realization of the ideal of the lay Christian.

Giuseppe Moscati, head physician in a hospital, illustrious researcher, university professor of human physiology and of physiological chemistry, carried out his many duties with all the commitment and seriousness that the exercise of these delicate lay professions *requires.*

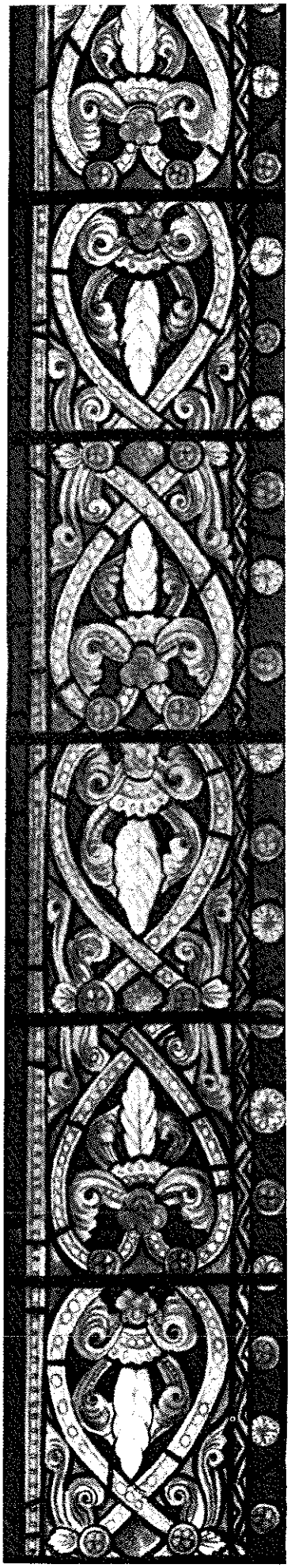
From this point of view, Moscati constitutes an example not only to be admired, but to be imitated, especially by health-care workers: doctors, nurses, volunteers and those who are involved, directly or indirectly, in assistance to the sick and in the vast world of health care. He is an example even for those who do not share his faith.

Still, it was precisely this faith which conferred upon his efforts new dimensions and qualities, those typical of the authentically Christian *layperson. Thanks to them, the professional aspects of his life became harmoniously integrated, supporting one another and being lived out as a response to a vocation, and thus a collaboration with the creative and redemptive plan of God.*

By nature and by vocation, Moscati was first and foremost a doctor who healed: *response to people's needs and to their sufferings was for him a pressing and inalienable demand. The suffering of a sick person reached him like the cry of a brother, to whom another brother, a doctor, needed to run with the ardor of love. The motive force of his activity as a doctor was not merely professional duty, then, but the awareness of having been placed in the world by God to act according to his designs; to provide, then, with love, the comfort which medical science offers in easing suffering and restoring health.*

Mindful of the Lord's words: " I was sick and you visited me " (Mt 25:36), Moscati saw Christ himself in the sick person who, in his weakness, his misery, his fragility and insecurity, turned to him asking for help; he saw the one standing before him as a person, a being possessing a body needing treatment, but also a being in whom there resided a spirit also in need of help and encouragement.

" Remember, " he wrote to a young doctor who was his pupil, " that it is not only



bodies that you must treat, but souls; with counsel — and touching the spirit — rather than with cold prescriptions to be sent to the pharmacist. "

He also stated, " *A doctor so often finds himself before persons on the verge of dying, anxious for some consolation, assailed by pain. Blessed is that doctor who is able to comprehend the mystery of these hearts and to inflame them once again. Blessed are we doctors, so often unable to heal an illness, blessed are we if we remember that besides bodies we have before us immortal souls, for whom we must feel the urgency of the Gospel precept of loving them as ourselves.* "

So the human warmth with which Moscati visited the sick — especially the most poor and abandoned — drawing near to them in the hospital and in their own homes, was such that the people sought him out; his manner was rich in that respectful and delicate goodness which Jesus Christ radiated as he traversed the roads of Palestine doing good works and healing all (cf. Acts 10:38). He was thus a forerunner and protagonist of the humanization of medicine felt today to be a necessary condition for renewed attention and assistance with respect to those who are suffering.

In his constant relationship with God, Moscati found the light to better understand and diagnose illnesses and the warmth to be able to draw near to those who, in their suffering, looked for sincere participation on the part of the doctor assisting them. From this deep and constant reference to God he drew the strength that sustained him and that allowed him to live with total honesty and rectitude in his delicate and complex setting, without giving in to any form of compromise. He was a Head Physician in the hospital, but without ambition for positions; if he was appointed to them, it was because his merits could not be denied, and when he occupied them, it was with total integrity and for the good of others. An upright man and a faithful Christian, he did not hesitate to denounce abuses, working to abolish practices and systems which were injurious to true professionalism and science, to the nurses, or to the students, to whom he felt obliged to communicate the best of his knowledge. Students are the doctors of tomorrow. Conscious of this, Moscati concerned himself with the quality of the future doctors, even taking a public stand so that their preparation and formation would be in no way weakened. He embodied this preparation and formation in the example he gave; even the moment of his death found him attending a sick woman.

Truly, every aspect of the life of this lay *doctor appears to us animated by that most typical of Christian traits: love, which Christ left to his disciples as his* " *commandment.* " *His personal experience of this central value of Christianity is shown to us by numerous passages in his writings. These are words which to us, today, seem almost a testament:* " *Not science, but charity, has transformed the world; only a very few men have made history through science; but all can remain imperishable, symbols of the eternity of life, in which death is only a stage, a metamorphosis for a higher ascent, if they dedicate themselves to the good.* "

How can we fail to note in these words a sort of echo of the Gospel we have heard today? " You gave me food ... you gave me drink ... you welcomed me ... you clothed me ... you visited me ... "

When? How?

My wish for you, beloved brothers and sisters — those of you gathered here in St Peter's Square or scattered throughout the world — is that at the end *of your lives you may be able to repeat* these questions ... *and to receive* this same response from Christ!

Then ... " *shall your light break forth like the dawn (says the prophet) ... and the glory of the Lord shall be your rear guard ...* " *(Is 58:8).*

Love " *will never end ...* "

"The greatest of these is love" (1 Cor 13:8, 14).

Amen!

(From the Holy Father's homily during the Sacred Rite of Canonization of Blessed Giuseppe Moscati, October 25, 1987).

Seventh General Assembly of the Synod of Bishops

Statement by Archbishop Fiorenzo Angelini Pro-President of the Pontifical Commission for the Apostolate of Health Care Workers

1. The faith which has always and everywhere joined men together is the faith in life. Christ, in his earthly ministry, sought an encounter with the whole man and with all men to respond to their request for life and for physical and spiritual health. The Church, following Christ's example, " over the course of the centuries has felt strongly that service to the sick and suffering is an integral part of her mission. "[1]

2. This aspect of Christian Revelation — a permanent aspect — has today become particularly significant. John Paul II affirms, " The Church born of the mystery of Redemption in the Cross of Christ is obliged to seek an encounter with man especially along the way of suffering. In such an encounter, man becomes 'the way of the Church', and this is one of the most important ways. "[2]

3. The health apostolate, by virtue of the charism of suffering which provides its substance, is very often seen to be the only moment or means to associate and communicate with a great many of our brothers who have not yet received the Gospel or who, after having received it, rediscover the way of grace: this is the forcefulness of the " Gospel of suffering. "[3] To borrow a biblical image, suffering is the truest and most compelling call which can draw men — whatever their faith, culture, or condition may be — into the net of salvation cast by Christ.

4. The history of world evangelization demonstrates that the health apostolate cannot at all be regarded as a marginal aspect of the Church's general mandate; it is essential and almost always — Missionaries bear authoritative witness to this fact — the humble but effective beginning of the propagation of the Kingdom of God.

5. The ministry or diaconate of health care involves the entire Church. The common priesthood of the faithful finds noble and lofty expression in service to those suffering in body and in spirit. The lay health professional, however, while sharing in the priesthood common to all the baptized, has for this very reason many points of contact with and resemblance to the work of those upon whom the ministerial priesthood has been conferred, though with a substantial difference in essence and degree. The historical datum, as John Paul II has stressed, offers striking confirmation. Indeed, in no other pastoral field are the three states — priestly, religious, and lay — so constantly joined as in that of medicine and health, the apostolate of service to the suffering.[4]

6. Sensitive to this priority pastoral need, to a degree unprecedented in the history of the Church, John Paul II, charting a course of further progress in the process of adjustment and renewal spurred by Vatican II, after promulgating the first broad pontifical document on the Christian meaning of human suffering — the Apostolic Letter *Salvifici Doloris* (February 11, 1984) — wished to institute the Pontifical Commission for the Apostolate of Health Care Workers (Motu Proprio *Dolentium Hominum*, February 11, 1985). This providential intuition, greeted with unanimous and justifiable enthusiasm by the vast world of health care and not only by Catholics, has become an instrument serving the entire Church, from the pastors to the laity, fully open to all who, prompted by the need for justice, are by vocation and mission health professionals: physicians, researchers, biologists, nurses, pharmacists, technicians, and administrators of Catholic medical facilities, experts on the social and health problems proper to specific groups requiring assistance: acute and long-term patients, the terminally ill, AIDS victims, and those experiencing the effects of drug addiction and also of the multiple forms of violence induced by certain irrational expressions of scientific and technological progress itself.

7. Direct contact with the Conferences of Bishops, visits by representatives of the new Office to health facilities in different parts of the world, the publication of the first catalogue of Catholic health institutions and of a journal in five languages providing formation and information, and other initiatives all seek[5] — in rigorous fulfillment of the goals assigned to the Pontifical Commission — to express ecclesial service open to all.

8. The health apostolate today is unfortunately forced to move in the con-

text of the growing practice of attempts on life: abortion, euthanasia, uncontrolled genetic experimentation, hunger, endemic diseases, ecological decay, and so on; health professionals must thus act in a border zone marked by the variety and complexity of ever new problems in bioethics.[6] Pastors and priests are called to support health care workers tirelessly, from the scientist to the practicing physician and their colleagues, teaching the doctrine of the Church and providing for their moral and spiritual training. This, too, is authentic evangelization. John Paul II,[7] in putting into effect a precise indication of Vatican II, has offered and continues to offer us an example with his magisterium and ministry. It is not proper to require Christian consistency of health professionals if we are not always guides and masters in their regard. It is our duty to have confidence in the laity, for those fully living out the sacredness of their vocation and mission are legion. Giuseppe Moscati, in the rolls of the Saints, constitutes living testimony; and many health care workers faithfully follow his example.

9. In the health apostolate, through the converging action of the pastors and the laity, the Church becomes the promoter of a service to man which, for lack of spirituality, not even the largest international public health bodies are often in a position to ensure. The places of suffering and of care are mankind's most frequently visited temple, where Christ takes on the face of our suffering brothers, whose call for assistance is, consciously or unconsciously, a call for truth, justice, and grace: a call for life.[8]

In closing, I take this opportunity to request that in this Synod's final document adequate attention be devoted as well to the Health Apostolate — that is, to the Church's effective presence, especially today, in the world of medicine and health. This presence is largely sustained by the laity. I pointed out to some Fathers who were surprised that no medical auditor was present at the Synod that doctors and nurses *are* present with another responsibility — these consecrated lay people of the Hospitaller Order of St. John of God; they belong to the health service which no one wishes to encounter, while earnestly hoping never to find their door closed.

On behalf of everyone, I fraternally thank them: they are laity providing direct service in the Church, for the Church.

✠ FIORENZO ANGELINI

[1] Motu Proprio *Dolentium Hominum*, 1.
[2] Apostolic Letter, *Salvifici Doloris*, 3.
[3] *Ibid*, 25-27.
[4] John Paul II, at the Sunday *Angelus* of March 9, 1987.
[5] Motu Proprio *Dolentium Hominum*, 6.
[6] *The Vocation and Mission of the Laity*, final statement by the Fourth Plenary Assembly of the Federation of Asian Bishops' Conferences, September 25, 1986.
[7] "Message to the Men of Science," December 8, 1965, in *Sacrosancti Concilii Oecumenici Vaticani II Acta* (Rome: Vatican Polyglot Press, 1966), p. 1089
[8] John Paul II, "To the Sick and Health Professionals," at the Gdansk Marian Basilica, June 12, 1987.

AIDS: Some Christian Reflections

Often Episcopal Conferences analyze Health Care in its different aspects: the rights of the ill, humanity in medicine, bioethics, professional training, and so on.

Recently AIDS became the subject of pastoral declarations and suggestions by Episcopal Conferences and individual Bishops. With the text issued by the Spanish Episcopacy we want to point out the concern of the other Conferences that considered the subject. We report some comments below.

SPAIN

Meditation of the Episcopal Conference

In recent years, growing anxiety in the face of the threat of AIDS has affected the whole world. The same thing is happening in Spain. According to the experts, the acquired immunodeficiency syndrome, which is spreading quickly, has reached a mortality rate practically equal to 100%.

The characteristics and the peculiar pathways of AIDS infection, together with the social reaction this disease has caused, go far beyond the mere scientific and medical aspects and give birth to moral questions about which we have to say a word of guidance and exhortation. We also want to help those who will welcome our meditations.

1) Suffering, an occasion of purification and solidarity

Nowadays, both human science and power have developed so much that we often cherish the illusion of being able to master nature, to avoid all sufferings and to achieve any goal we set ourselves.

But suddenly an epidemic disease like AIDS abruptly shows the reality of our limits. We don't know the exact origin of AIDS and don't even know how to defend ourselves against it. Its tangible consequences strike terror into our hearts.

Maybe somebody, in such a situation, is pushed to rebellion against God. Fear and suffering could prevent man from putting his trust in God. Some make this problem even more difficult by considering these sufferings, in an excessively simple way, as a divine punishment for the sins of the world.

In order to explain the existence of these and other misfortunes, it will suffice to consider the human condition, which is, at one and the same time, admirable for its greatness and vulnerable for its physical and moral weakness.

However, we know that God made us able to master the world in order to co-operate with Him in perfecting our life and the whole creation.

God wants us, with His help, to increase our wisdom and power in order to defend ourselves against all the troubles we meet along the path of our lives.

In this specific circumstance we are determined in the belief that God wants researchers to discover the cause of AIDS, wants effective solutions to the disease to be found, and wants Governments and the Church, institutions and individuals

to make a commitment to the fight against this threat to the life and happiness of many people. This belief induces men of faith to fight against the disease and to assuage suffering, each according to his skills.

Thus, for those who believe in God and trust in Him, the onset of AIDS represents a further stimulus to work, to solidarity, to inner purification and salvation, instead of being a scandal or a reason for despair.

2) To approach the ill and to relieve suffering

The fear of contagion and the characteristics of some categories of risk are causing an attitude of rejection towards people affected by AIDS. Thus it would be expedient to have a clear idea of what can cause contagion in order to control panic reactions and so that the patient will not feel he is treated in an indiscriminate and unfair way.

It is right to act with caution to avoid unnecessary risks of getting the disease. Furthermore, from a moral point of view, to take adequate measures to prevent the spreading of the virus is one of the most serious obligations to be fulfilled. After taking these measures, it is important, however, to take into account the dignity of man and the need of the patient so that an attempt at isolating the disease will not arouse humiliating situations or thoughtless attitudes of rejection. From the Christian point of view, all the suffering, AIDS patients no less than others, deserve attention and care, love and mercy. Jesus Christ, the Good Samaritan of mankind, would welcome and cure them with the same affection with which He treated and cured the lepers who went to Him (see Matthew 8: 1-4).

In his name we exhort the religious institutions devoted to health care to extend their Christian love to these brothers tried by misfortune. We know that some initiatives are under way. However, adequate structures to welcome and treat them are still lacking. There is a marked need for the elaboration of a plan at the service of this urgent necessity, under the guidance of the Church with its long tradition in the field of health care.

Every effort in this field will require our most determined support. In the name of Christ we ask Catholics, especially those who work in the medical field and in hospitals, to assist these patients at their best professional level with human and Christian sympathy.

3) Total fight against the disease

Our faith induces us to think that it is part of God's plan that man, thanks to his mental skills and his efforts, and supported by the grace of God, will conquer this disease as has happened in many other cases in the course of history. We want to thank all those who work in the field of science and research for the success of this admirable effort. They glorify the wisdom and mercy of God, the Creator, in defending human life.

But, until effective solutions are found against the disease, all efforts must be concentrated on preventing its spread. A reliable form of prevention is represented by information and awareness. It is necessary that people be well informed and it is im-

portant to know how many AIDS cases there are in our country, the symptoms that can be most easily observed, the most common and dangerous forms of contagion, the precautions to take in every single case. The information campaign must be carried out by the authorities with caution and responsibility in order to wipe out both false calm and groundless fear. The ill themselves must do everything in their power to prevent the spreading of the disease. From the first moment they know they are affected by AIDS, or they know they could propagate it, the ill, or simply the virus carriers, must notify if there is the possibility of contagion.

Up to now, health care workers have particularly insisted on certain points: to use comdoms during sexual intercourse and to use new syringes when making use of narcotics by intravenous injection. We feel the need of saying a few words on this subject. To give a few limited suggestions or to exaggeratedly repeat them could give the false impression that these few suggestions suffice to wipe out the risk of contagion and that it is not fundamental to modify one's behavior. On the one hand, behavior patterns favor indirectly the spreading of the disease; on the other, willingly or unwillingly, it is possible to instill in people's minds and in young individuals some forms of behavior that are seriously conditioned from a social and moral point of view. Actually, in this way the necessity of correcting sexual promiscuity and permissive habits in the use of narcotics is being misinterpreted. In this case, these two elements not only represent an offense to human dignity but also become real instruments of destruction.

How can we ignore the moral aspects of the question? According to the doctrine of the Church, based upon revelation and constantly announced by its magisterium, human sexuality may be consummated only in accordance with the dignity of man and the Law of God within the sphere of marriage.

This is the Catholic doctrine that the children of the Church share and try to apply to life.

It would be right to recognize that proper sexual behavior, as seen in this doctrine, represents the most suitable solution even though, unfortunately, it is not enough to act against the propagation of AIDS. Moral righteousness is an integral part of social wealth, as is clearly demonstrated by the facts we are talking about. The governments and the trustees of the wealth of society must take into consideration the moral aspect of behavior patterns in order to allow and favor the implementation of certain measures.

4) A word for AIDS patients and their relatives

We don't want to end this meditation without saying a consoling word to those who, at present, are bearing the burden of this disease, to those who are terminally ill or are victims of the rejection of their friends and relatives. Believe that God loves you, that He always forgives those who look for Him, that He welcomes us with endless indulgence and mercy. The image and the memory of Jesus Christ, dead on

the cross and resurrected, will help you to face your trial with courage and to have a hopeful view of the future.

We want to address a few brotherly and consoling words to the relatives of these suffering people. Help them by your love and solicitude to live with serenity the trial they are forced to experience. Let them know the spiritual consolation of prayer and the sacraments, together with the relief and the help given by medical care. Always remember that, even in the worst-moments, God is at your side with His love and He sows in our hearts the seeds of consolation. There is no doubt that to share the suffering of your relatives will make you more human and merciful, stronger in the face of the difficulties of earthly life.

5) Conclusion

In offering our meditation to the people affected by AIDS and to everyone else, in the solidarity of the whole Christian community, we want to conclude by expressing our wish that the Spanish Health Care Service be better organized and ready to welcome and attend AIDS patients. We hope that the citizens and our brothers find the physical and moral support they need to go on and, if possible, to recover.

If pain comes, may it be always accompanied by consolation and brotherhood. Thus, once more, the word of Jesus will be realized: " That you do to me " (Matthew 25: 40).

Madrid, 12 June 1987.

United States

The U.S. Catholic Bishops founded a Commission for the study of subjects concerning AIDS, particularly with respect to educational and moral aspects.

France

" AIDS: From Fear to Solidarity " is the title of a brief document elaborated by the Social Commission of the French Episcopacy.

Germany

In West Germany, the Catholic Church, together with the Evangelical Church affirmed, among other things, its opposition to any discrimination against AIDS patients.

Belgium

The Episcopal Conference deems insufficient the preventive information campaign against AIDS since it ignores all ethical aspects. " A change in sexual behavior could have represented a more significant contribution to curb AIDS contagion, " declared the Dutch Episcopal Conference.

Brazil

The Brazilian Church has undertaken various human and pastoral initiatives in the fight against AIDS. Among them we mention the realization of specialized hospitals.

Ireland

The Permanent Council of the Episcopal Conference made a declaration about AIDS and appealed to people for fidelity within marriage and for abstinence from extra-marital relationships. Furthermore they say " We pay homage to the chaplains, physicians, nurses and warders, and all the persons at the service of AIDS patients and their relatives. " They insist on the point that a common effort is fundamental to meet the social and religious needs originated by AIDS.

Geneva (Ecumenical Council of Churches)

The Central Committee met in January 1987 and issued the text " AIDS and the Church, a Community for Health Care, " elaborated in June 1986. The text gives medical information and reaffirms the support and solidarity of the Church to find concrete solutions in the pastoral field, in preventive education and in the social ministry.

Topics

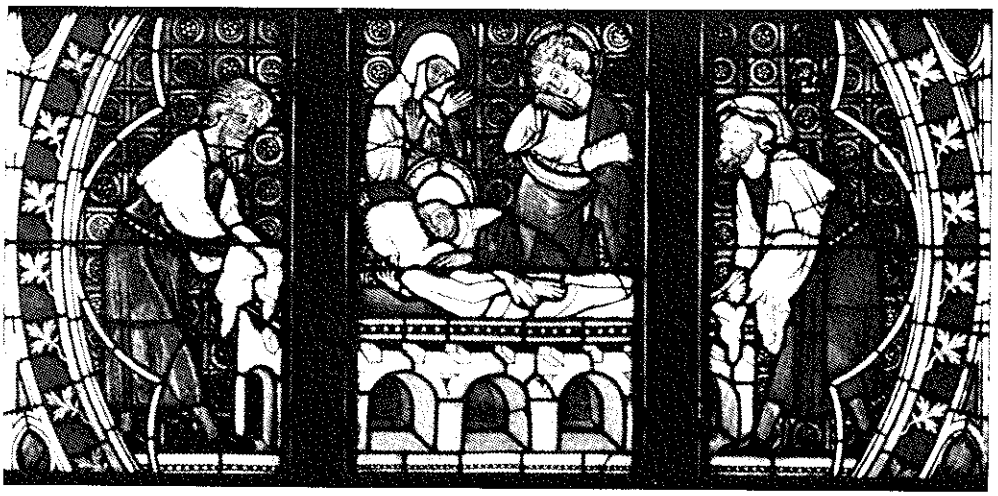
Therapeutical Obstinacy and Euthanasia

The " Not Yet Born ": A Life to Be Saved

Technology and Questions Concerning Health Care and Education

Clinical Experimentation, Laws, and Ethics Committees

Giuseppe Moscati: A Holy Physician



Therapeutical Obstinacy and Euthanasia

I cannot think of the terms used in the title of my paper as referring to two different subjects to be dealt with: obstinacy and euthanasia. As I said on another occasion,[1] nobody defends therapeutical obstinacy.

No physician wants to torture his patient. I even feel obliged to say that it would not be fair to explain by assuming technical-scientific exhibitionism or base economic interest the seeming cruelty of a physician who insists on prolonging, against every hope, the irreversible course of a process towards death.

This may, rather, be explained by the concentration of the physician's attention on the technical possibilities from which his patient could theoretically draw a benefit, and his ensuing lost of sight, in some desperate cases, of the lamentable practical consequences for this patient.

Since therapeutical obstinacy must in my opinion, be discarded along with an irrational will to prolong the life of a patient with no hope of recovering at all costs, my paper will focus on euthanasia. In the first part, I shall try to justify the great interest the subject arouses nowadays by setting forth three aspects of the problem, with their ensuing ethical and juridical questions. In the second, I shall indicate the right of the patient to live with dignity the last moments of his life. I shall then mention the conditions to be created to achieve this purpose. Euthanasia, when understood as suitable clinical assistance to the patient, even during the process of his death, becomes something not only right, but meritorius as well, greatly praiseworthy for the medical profession.

My thesis could be worded as follows: the task of the physician is not, surely, to help death but life; however, he can and must help people to die as humanely as possible, namely, according to those qualities in keeping with respect. Such a way of dying may be described by the term "dignified." Death in itself cannot be dignified, but one should be able to live and must live his own death with dignity.

1) Great interest of the subject

I spoke of a threefold formulation of the euthanasia problem. Perhaps there is no other topic regarding which it is so necessary to begin discussion by showing the diversity of existing pre-suppositions and conceptions.

In the days of *Francis Bacon*, who is considered a pioneer in the introduction of the term " euthanasia " and a leading supporter of its practice, when diseases were incurable, or judged to be such, death arrived inexorably. This explains why he did not contrast euthanasia with the obstinate prolongation of life, as the case is today, but with the abandonment of the dying patient to the future triumph of death, when this seemed unavoidable. *Bacon* propounded only the duty of the physician to continue his treatment of the incurable patient for the purpose of seeing if he could still save him, or at least soften and alleviate the conclusion of his life. The term " euthanasia " applied only to the way of dying (not the time) and kept its etymological meaning. He called it " exterior euthanasia " to distinguish it - these are his words - " from euthanasia regarding the preparation of the soul, " which is the priest's concern, while the former is the task of the physician.[2]

The extraordinary progress of medicine in this last century has made it possible to intervene in various ways in the very process of death, sometimes stopping it, sometimes at least slowing it down or speeding it up: diseases thought to have a fatal issue up to a few years ago today can be cured, and with others, still mortal, their course can be slowed. Cardiac valves of plastic or taken from animals, pace-makers, artificial kidneys, etc. indefinitely prolong the life of many persons. Organs unable to function are replaced with organs of living or dead persons or animals, or with the application of suitable prostheses. Resuscitation techniques have made it possible for many men and women to survive after an apparent death which, up to a few years ago, would have been judged real and final.

But not every ensuing type or quality of life proves enviable, because of the invalidity, suffering, or disfigurement which follow, not to mention the cases where faculties suffer irreparable harm, or patients remain unconscious. It is understandable that many patients find such a type of existence undesirable and prefer to give up this way of living.

Several groups, which were previously in a minority but are every day growing more numerous, realize with horror that the increase in " successes " obtained by medicine as regards old age, incurable diseases, and accidents heretofore fatal, have been paid for with a prolongation of life in very disadvantageous conditions. So as not to be submitted to these conditions they grouped themselves into pro-euthanasia associations for the purpose of having their own members choose not only the way, but also the time of their death.

One of the most recent reasons for which the subject of euthanasia has become a welcome topic for the mass media is precisely the proselytism of these associations, which see in euthanasia the only means to protect their members from therapeutical obstinacy. But the term " euthanasia " in this second perspective undoubtedly keeps its original etymological meaning, centered on the manner of death: 'good', 'sweet'; but since the first half of this century what has prevailed is the clamorous insistence of these groups upon the right to choose the time and even the mode of their death.

Against this enlargement of meaning and with the express will to condemn what could not be accepted in the euthanasia claims, the Catholic Church reacted, giving euthanasia a very restricted definition. The term is kept only for actions and omissions (we must not forget that omission presupposes an undoubted duty of intervention) which, " owing to their nature or the intent with which they are performed, cause death in order to eliminate pain. "[3]

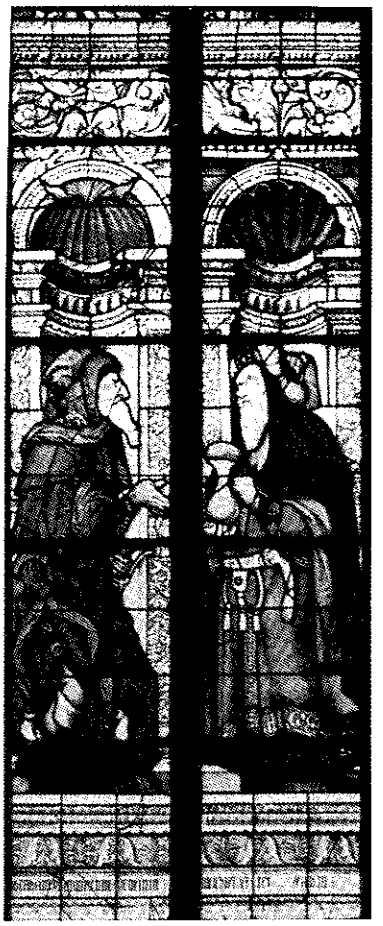
Such a precise definition of euthanasia has the advantage of avoiding all ambiguity. Apart from the intention, all actions and omissions which are the effective cause of death — and these only — are reproved by the Catholic Church and stigmatized as " euthanasia. " By giving to this term no other meaning, the Church may condemn euthanasia in all its manifestations, with no distinction whatsoever. But this same clarity becomes a source of confusion when the restricted meaning by which the Church's condemnation refers to euthanasia is not sufficiently understood, a meaning which, by the way, is in compliance with the traditional *ethos* of the medical profession, from the oath of

Hippocrates to the most recent wordings of its deontological codes.

Many times some of your colleagues pleasantly joking with me have said that they felt compelled by a sense of professionalism in given cases to practice euthanasia, going against what they supposed to be my religion-based ethical opinion. The amiable and joking tone would heighten when I pointed out that, in my modest opinion, they could have gone even farther without deserving any blame from the ethical point of view. All the more so because such behavior had for many years been approved by the Supreme Pontiff Pius XII. But this is not called euthanasia by the official Church Magisterium. I have been accused in religious spheres of creating confusion by using the same term, " euthanasia, " while referring to both acceptable and unacceptable ways of proceeding.[4] In the latter case — they say — I should use the terms " benemorthasia, " " orthothanasia, " " antidisthanasia, " etc. They may be right, but it is a confusion I had already found, and deeply rooted, in the common parlance of the physicians I know. I prefer to use the term in its vague common acceptation and then immediately make clear the presupposition I refer to, without paying too much attention to the distinction between active and passive euthanasia (also because not to practice it when it must be practiced is censurable) or insisting either on the distinction between direct and indirect euthanasia because this would prove incomprehensible for many a physician (may I be allowed to speak so frankly), and consequently, this distinction might strike someone as a form of pharisaism and hypocrisy.

Before going into further details, let me repeat that I am speaking and shall speak only from the ethical point of view. I forgot to underline this when I began lecturing on euthanasia in this cordial city of Milan. After a few days a famous jurist, in a brief article in the *Corriere Medico* (I keep the clipping in Barcelona), warned that, as regards euthanasia, if someone acted according to my advice, he might end up in jail. Perhaps the alarm would not be justified if the various shades of meaning had been grasped by the judge in his interpretation of Article 40 of the Code of Medical Deontology approved on January 7, 1978, now in force. But, in any case, I leave to the experts the juridical interpretation of criminal laws and deontological rules and limit myself to the ethical aspects.

When the old (and luckily now revised) Italian Code of Medical Deontology read, " The essential purpose of the physician when taking on the treatment of a patient should be, from the first moment, the preservation of his life: not even an action aimed at alleviating suffering may oppose this principle " (Article 47), Pius XII, when questioned by a group of anaesthetists, answered that it is legitimate to have recourse to analgesics and narcotics to relieve pain, provided that their administration does not prevent the performance of a more serious duty, even if the action of these drugs may indirectly accelerate the process of death.[5]



More generally, starting from the twofold reflection that all temporal activity is subordinated to the attainment of a supernatural purpose and that, apart from any religious creed, we all agree that the temporal is subordinated to personal realization and that this purpose (this realization) would be within reach of very few people if there were a pressing moral obligation for everybody to act heroically, he concluded that we are not obliged to maintain health if we cannot do so by ordinary means.[6]

Scientific and technical progress, together with the improvement of living standards, makes very uncertain even for a given place and time the distinction between ordinary and extraordinary means.

In morals there cannot be formulae or measures to be universally applied. To reach a correct opinion on the ordinary or extraordinary character of a means in a given case, different factors must be taken into consideration and contrasted. The final opinion depends on: I) a fair expectation of success; II) the level of the human quality of the preserved life (mainly of consciousness and the level of effective freedom); III) the foreseen type of survival; IV) the troubles (for the patients and their families) caused by the treatment; V) the cost of the intervention or therapy from an individual, family, national, and international viewpoint (here what is involved is the " economy of health "). Some of these factors can be pondered objectively. Others, on the contrary, depend on the patient's subjective evaluation and condition, his behavior when confronted with suffering, his own available funds in relation to the required cost, etc. On the other hand, it should not be forgotten that the " objectivity " of some elements of judgement has only a statistical value and that the estimated percentage of successes and survival time does not determine whether the patient in question will confirm the percentage judged to be positive or negative. On the other hand, though the recourse to extraordinary means is not an obligation, the right of the individual to have recourse to them, if he feels he has good reasons for doing so is not eliminated.

The above-mentioned decaration on euthanasia,[3] published in 1980 by the competent body of the Holy See, to the consideration of the quality — ordinary or extraordinary — of the means of treatment, adds and lays stress on the attention to be given to the proportion or disproportion existing between the difficulties involved in their application and the advantages of the reasonably hoped for results (the balance of cost/benefit analysis). And, in order to facilitate the application of this general principle, it is further specified that, failing other alternatives, it is legitimate, with the consent of the patient, to run the risk involved in recourse to a remedy still in its experimental stage. Should the results of the forecast not be reached, the therapy started may be discontinued without abandoning, for this reason, normal treatment. The recourse only to normal means can be justified and is in no way to be compared to suicide. It could not even be compared to homicide.

These last statements need to be justified because for the physician it is difficult to understand that to give up a remedy that might prolong life, in particular if this occurs in a rather indefinite way, is not tantamount to the euthanasia condemned by the Church.

No privilege is granted to the sin of omission. But omission presupposes the duty of making a given intervention. In agreement with the papal doctrine and with what reason tells us can be demanded from the common mortal, nobody is obliged to suffer disproportionate discomfort of any kind for the sake of a claimed possibility of obtaining results, when he does not feel inclined to do so. It is not the same to give up normal expectations of global realization (which would imply turning one's face away from the sovereignty of God and his designs of love, simply disobeying the ethical imperative) and to put an end to the slavery of a particularly troublesome treatment or refuse it owing to its consequences when the interested patient feels unable to give a meaning to the quality of life he could obtain. The suppression of a treatment in these conditions does not imply direct contempt of life, even if liberty is left to the triumph of death. Its approach is the indirect effect of honest behavior. In order to impute ethically an effect to one who refrains from doing something because he foresees the result, there must be an absolute obligation to avoid this consequence.

When the most precise

and up-to-date scientific information is not sufficient to assure an improvement the advantages of which would counterbalance the inconveniences of the treatment, with the permission of the patient or of the person who acts on his behalf, it is legitimate, from the moral point of view, not only to discontinue the application of the extraordinary means which are being carried out, but even to give up therapies which would uselessly prolong the distressing situation of an incurable patient and his family. It follows that there is no obligation to indefinitely prolong artificial respiration in a patient reduced to merely vegetative life or in still worse conditions and that it is not necessary to extirpate the metastasis in impending contact with a vital organ when the neoplastic process is at such a point of irreversibility that a surgical intervention would only prolong the suffering of the patient and the patient himself refuses it. Physicians are confronted with a still greater difficulty when it comes to giving up the practice of their profession notwithstanding the availability of the technical means needed to prolong indefinitely the patient's life. But we have to admit that when a patient with leukaemia or renal failure must periodically have recourse to blood tranfusions or dialysis, with a margin of autonomy increasingly reduced, and if his frame of mind makes him unable to give meaning to this type of existence and he deems unjustified the cost that the treatment would impose on his family or society, whose health funds are limited, he can conclude that it does not suit him to prolong a life full of suffering for him and his relatives.

We cannot deny the patient the right — which is a duty — of reasonably administering his own life. Usually deontological codes explicitly refuse the physician the right to impose treatment on a patient against his will. The patient alone can decide the continuance or discontinuance of therapy which should be of advantage to him.

It is worthy to recall that the suppression of an effective therapy presupposes a desire — expressed or reasonably assumed — of the patient. When he is not able to decide personally, his trustee, who legally or occasionally must give the consent on his behalf, must conform to what he has reason to suppose the patient, at the moment unconscious, would wish were he capable or, if his will cannot even be guessed, to what can be foreseen would give him the greatest advantage. The obligation of the trustee and of the patient's relatives, on the other hand, must be in line with that of the patient. Their only real obligation is to employ ordinary and proportionate means.

The opinion of *Francis Bacon*, as well as the original purpose of the pro-euthanasia associations (to defend their members from therapeutical obstinacy), presuppose the presence in the patient of a cause — illness or lesion — capable by itself of causing death. The term euthanasia should never be used without the imminence of the end. This is the specific feature of euthanasia which clearly distinguishes it from homicide and suicide. In these there is a will to take life and seek death, which, on the contrary, is in some way present in the cases of real euthanasia. To tell the truth, with euthanasia one does not flee from life, from death itself, i.e., the fact of dying; the patient wants to spare himself the painful process which will bring him to the unavoidable and foreseen end. This is the will clearly expressed by the members of the pro-euthanasia associations in so-called " biological treatment " and " vital treatment. " But in their eagerness to obtain from the public powers the acknowledgement of a sort of legitimacy for the document, they emphasized the motives of mercy toward themselves and others as a justification of their decision so much that they gave rise to a third feature of the euthanasia issue: its identification with mercy killing.

I don't want to go into the juridical and legal aspects of the problem. It suffices to ascertain what is aimed at with this third meaning of the term euthanasia, withdrawing it from the physician's proper competence. Undoubtedly a law on this matter involves enormous dangers. I think that their root and source may be discovered in the practical impossibility of typifying this supposed right to dispose of one's own life without causing doubts that the right to preserve it is protected. The presuppositions that the " moral minimum, " in the technical sense of this expression, should exclude do not contain anything essen-

tially different in the light of personal rights: legal permission to put an end to the life of an incurable patient near death seems to imply as well permission to act in the same way in the still more painful situation of the not yet dying patient; the irrevocably insane, the invalid who has no more interest in life, etc. " If the law, in perfect harmony with ethics, does not punish these cases of euthanasia ..., the general prohibition of killing would also be seriously affected in men's consciences. Besides, only a very short step would suffice to legalize the suppression of the subjects most seriously hit by malformations, the most dangerously insane, handicapped, incurable, elderly, etc. "[7]

A law aiming at regulating euthanasia would jeopardize as well necessary confidence in the relationship between the dying patient and the physician, inasmuch as the latter's intervention could no longer appear to the patient as unfailingly good for him; he would know that the means at the service of health and life (injections, drugs, etc.) could be used against him. And the physician himself, in the long run, would lose those inner checks that today restrain him from the temptation of shortening life, not to run the risk of prejudicing the real interests of the patient (*primum non nocere*) or of some relative or others. " Choices by the medical class are only apparently free and based on technical evaluations, even if ethically motivated. Actually, the pressure of public opinion, often supported by the intervention of the Bench, is remarkable. "[8] Little by little, the physician would find himself drawn away from his loyalty to the domain corresponding to him in accordance with the way in which his profession has been conceived since its beginning.

Attention should also be paid to the fact that death usually involves economical advantages or disadvantages which could upset the relative's judgement and condition that of the physician. The danger is made more serious today by the fact that, in an increasingly aging society, where the most appreciated values are efficiency and productivity, the old are marginalized and considered as useless. The step from euthanasia expressly requested by the patient to euthanasia only supposedly requested by unconscious patients, the insane, and others would be easy.

A Dignified Death

It was my intention to dwell more briefly on the first part of my exposition so as to better develop the positive aspects of a praiseworthy euthanasia which would enable the dying patient to exercise his unquestionable right to die with dignity.

We have seen that the term " euthanasia " involves manifold variations and nuances. Summing up, three different conceptions are reflected. First, the one set forth by *Bacon*, which appeals to the physician's duty to assist his dying patient in order to relieve his sufferings, if nothing else can be done; second, that of the modern " pro-euthanasia " associations, which claim an assumed right of every man to choose the way and time of dying; third, that preferred by jurists, tending to favor mercy killing.

As regards the second aspect, I have tried to make it clear that the strictest ethics offers the physician many possibilities not only of avoiding therapeutical obstinacy but also of sparing the incurable patient an undesired prolongation of his life. The physician, however, should not let himself be carried away by the negative and minimalistic conception, i.e., to see how and up to what point he may quicken the process of death without failing professionally and ethically. To shorten the time of life contradicts his professional calling and goes against the very purpose of the most important techniques in which he specialized. As to medical intervention, stress should be laid on the reduction of pain — except for a will to the contrary of the patient for reasons understandable only from the point of view of faith — and the strengthening of those qualites which give dignity to the human being and frequently diminish in the last phase of his life because of undue conditioning of the exercise of his freedom of conscience, lack of information, and difficulty in asserting his iniiative in matters of his own concern, and isolation which prevents social contacts.

Against these drawbacks, in favor of the dying patient we must claim: a) the right not to suffer uselessly; b) the right to freedom of conscience; c) the right to know the truth; d) the right to make his own decisions about himself and his own affairs; e) the right to maintain a confident dialogue with physicians, relatives, colleagues, and successors in his work.

a) *The right not to suffer uselessly*

Apart from possible religious imperatives, no other consideration, though noble and high, should be placed by the physician before what is proper to his profession and shapes his identity: to protect life with competent promotion of health and well-being inasmuch as the latter is dependent on the former. And, on the other hand, the physician must first of all therapeutically and preventively fight against disease and debility as well as the pain or discomfort which accompany them. Movements in favor of euthanasia are right in their effort to remind physicians of the second aspect of their task. They have too often forgotten it.

Pain as a symptom is useful as long as it helps us for the diagnosis and the suppression of the disorder which causes it. Maturity and other human values acquired by the individual who has learned to withstand suffering with dignity do not necessarily originate from suffering itself, and the ethical value of this experience presupposes a mature exercise of freedom and sufficiently noble motives in withstanding. The physician faced with pain has the unavoidable duty of eliminating its cause or at least relieving its effects. When he cannot do so without diminishing the patient's awareness, we have a certain dehumanization (which, however, is counterbalanced by the fact that it avoids the depression caused by pain itself).

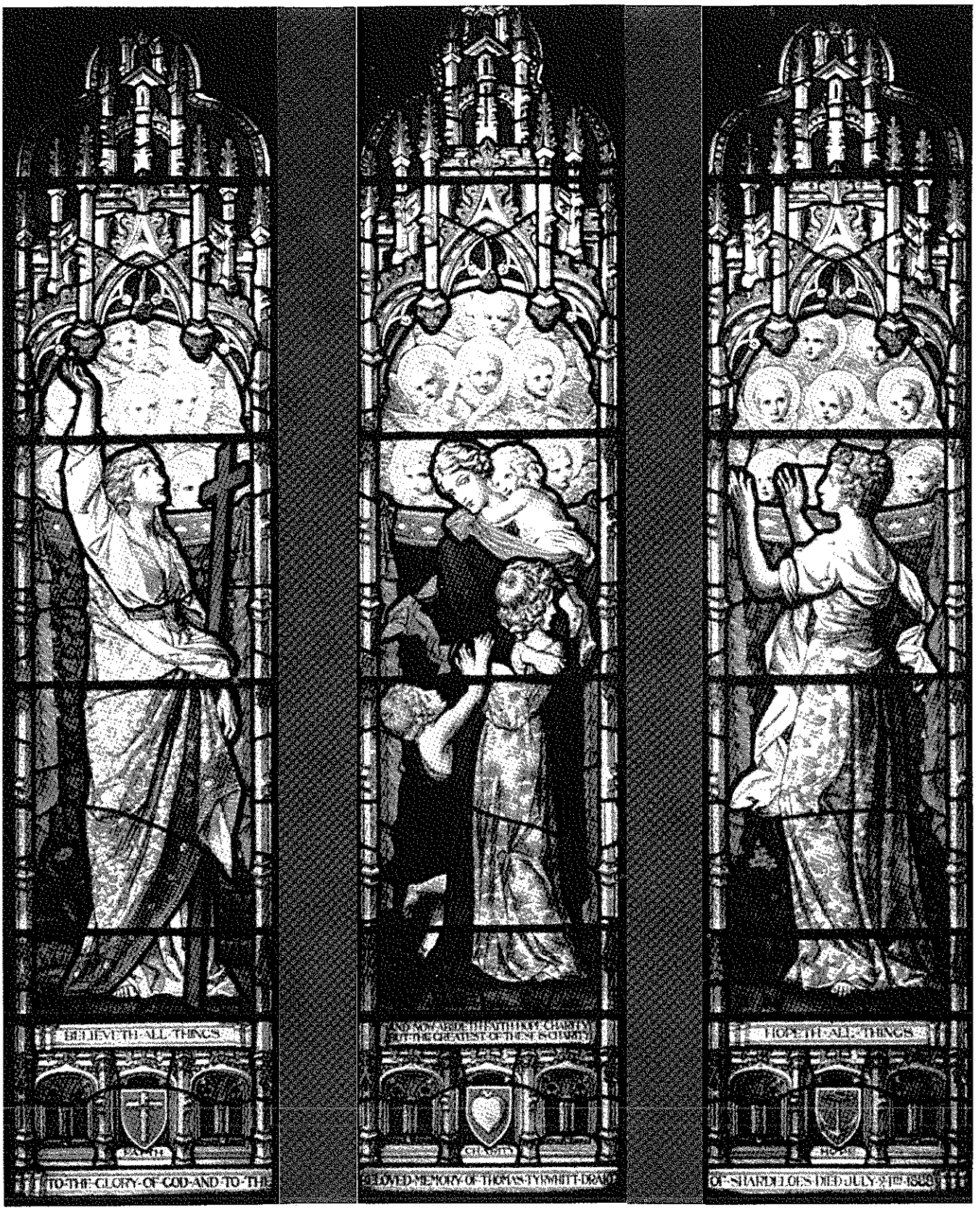
The ethically best dose of a substance producing narcosis should be that combining the minimum of pain with the maximum of responsible consciousness. The patient should not be deprived of the right to experience his own disease and his death as well, but there may be medical reasons prompting us to submit the patient to deep sleep before death puts an end to his life.

Finally, going into the sphere of faith and mystical theology, we must acknowledge that sufferings have a beneficial value at a personal level as well as an apostolic value for the person who undergoes them voluntarily and with this motivation, in union with the oblatory love of Jesus Christ. Without the presupposition of a supernatural vocation, the patient risks falling into the ethical-philosophical dangers which always threaten individuals in the throes of pain: moral egoism, physical regression, sterile self-concentration to the detriment of their neighbors.

Hence, these are the conclusions: I) there is the obligation to fight the cause of pain; II) fear of causing drug addiction, at least in the final stage of life, is irrelevant; III) the fight against pain would justify, should this be necessary or responsibly claimed by the patient, an indirect shortening of the time of life or free consciousness; IV) attention should be given to believers who sincerely want to moderate the use of analgesics and narcotics for true religious motives.

b) *The right to freedom of conscience*

Clearly formulated in Article 18 of the Universal Declaration of Human Rights and included in the Constitutions of most modern States, it is demanded by the ethical dimension of the human being and the self-understanding of his existence as a gift and a task to be carried out. One feels obliged to be what one must


BELIEVETH ALL THINGS
AND NOW ABIDETH FAITH HOPE CHARITY
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TO THE GLORY OF GOD AND TO THE
BELOVED MEMORY OF THOMAS TYSMITH DRAKE
OF SHARDELOES DIED JULY 21ST 1828

be, proceeding towards one's purpose, in agreement with one's conscience, in all the decisions of one's life. The Declaration *Dignitatis Humanae* of the Second Vatican Council lays the foundations for this right and develops its consequences. A disrespectful proselytism would increase the anguish of the patient at the terminal stage and could severely prejudice him. No moralist doubts that God will reward the man who dies sincerely reconciled with his own conscience, even if he is in error, objectively speaking. A leap to the objective truth against his own feeling and understanding could, on the contrary, ruin him. It follows that it must be made possible for the patient to be easily contacted by priests, religious, or other persons capable of helping him to reach peace with his conscience and give meaning to his illness, and even his death, whatever his sincere creed and ideology may be.

The medieval presentation of the moment of death as that on which one's destiny depends is repugnant to our modern sensitivity, but we cannot deprive the dying of the right to an option, in the last moments of life, to correct errors or crown their contributions to the ideals that gave meaning to their work. The ethical task of realizing and actually improving oneself during one's life implies the corresponding right to complete it by deciding, in agreement with one's own conscience, the process of one's death.

On the threshold of death we shall all recall life and death in the framework of our ideology and beliefs. The physician may not always be the most suitable person to help the dying patient facing the necessity of accepting the reality of the terminal stage from the viewpoint of his own conception of world and life. The physician, therefore, cannot deny the patient — on the ground of not absolutely necessary exigencies of medical treatment — the range of possibilities which may help him. He must, on the contary, make it easy for him to be approached by persons capable of giving him help, as we shall later state. The last service to a life is that of helping it to live its end, namely death, personally and responsibly, whether the patient thinks his existence is coming to an end or lives his death as an opening to transcendence. A meaning to death can be given only by one who succeeds in giving a meaning to life.

The individual benefited by medical intervention is always a person who has the right to continue his growth, even in the process of death, before himself, others, and God, when he believes in Him.

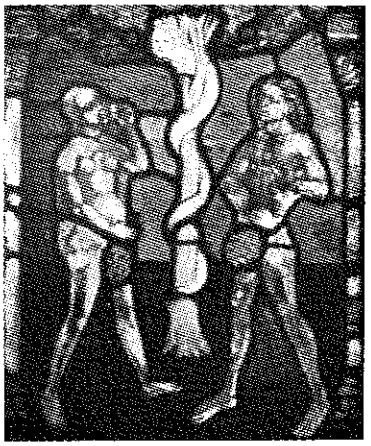
c) *The right to know the truth*

The awareness of matters concerning the patient and the corresponding obligation to inform him on them derives from the person's dignity and is at the base of human society as an absolutely necessary condition for the exercise of one's own responsibility in the full realization of oneself. Not only lies, but even a lack of sincerity would destroy the trust which is necessary in an interpersonal dialogue, and in particular in the patient's relationship with his physician. Hence the importance of the latter's credibility and, as a prerequisite of such credibility, his option for truth, even when this implies the need to reveal to the patient facts having a high psychological impact, such as a bad prognosis. Precisely in this case it is more urgent, in my modest opinion, to follow the rule deemed to be right in normal circumstances: the patient has the right to know the diagnosis, the therapy he is submitted to, and the prognosis, the risks he is running, the probability of recovery, the time it would foreseeably require.

Without truth it is impossible to perceive the needs of the hopeless patient. For a correct relationship with the patient, it is baneful to let oneself be taken into the so-called " infernal circle of lies, " the source of deception and injustice. The option of truth opens enormous possibilities for humanizing even the last stage of life.

The right to the truth of the terminal patient may, of course, come into conflict with the physician: relief from his pain. The solution is not the elimination of one of the two contrasting values, relief or truth, but in overcoming the tension between them through a progressive and pedagogical disclosure of the situation. Thus the physician can enable the patient to become each day more and more aware of the truth, up to its full disclosure when he realizes that the patient can positively accept it.

When there is ground for doubt, the right of the dying to know the truth must be given priority because their situation requires particularly important decisions. The primary criterion must be the good of the patient's person, in its integrality, which cannot be limited to the maximum possible of well-being here and now, without taking into account the transcendence proper to the



whole human being, however the patient may understand it in agreement with his own conception of the world and life (his own *Weltanschauung*).

Every experienced physician shows humility and discretion when formulating an opinion about the hopeless condition of the patient. It would be cruel to exaggerate the meaning of the prognosis and even more to set forth as a well grounded conclusion the not yet confirmed fear or suspicion. But the morally certain knowledge of an unavoidable and imminent death must be made known to the patient so that he may realize himself even in the last phase of his life. This duty presupposes the capability of the subject to enter into his role and play it well in his decisive moment. To leave him some hope (" a bit of open sky, " as it is called by some) would help, but we cannot forget that to take away false hope may open the way to hope of another type which enables the patient to accept truth with greater relief and thus fully realize himself as a man. This occurs also in the case of persons who do not believe in a future life, but have succeeded in giving meaning to their life and their relationships with other people. The ambiguous expression " right of the patient to die " has a true sense: no human being should be deprived of his right to live his own death, thus crowning with death his own realization. We shall, therefore, avoid telling this truth only when we realize that the other is not able to bear it. The right to the truth disappears when it would plunge the patient into a fatalistic despondency and annihilation of his personal being, when truth would be perceived only as a death sentence devoid of any reason or meaning. The obligation to tell the truth disappears when we know for certain that it will do only harm. It would never be honest simply to keep silent or to delegate someone else in order to escape one's own difficulty, which is originated by the dislike we all have of being faced by death because we know our death as future only through the other's when present.

This would perhaps explain why physicians tend to escape from confronting death and avoid speaking of it to the patient in impending danger, when they do not entrench themselves outright in exclusively technical assistance centered on the biological process, leaving aside the patient's personality and disappearing into the team impersonally attending to him.

d) *The right to decide personally*

Ever since modern culture became aware of the " coming of age " of humanity, the right to decide personally on what is of concern to each has been increasingly claimed in the various fields of social activity, and not without reason: what makes a procedure proper and humane is precisely its being decided upon by the free will of the interested party.

The recently issued Deontological Codes of the different associations of physicians and even more the catalogues summarizing the patient's rights correct the physician's tendency to impose his own will on the patient, for his good of course, but through a *paternalistic* style, already discredited in the field of work relationships. Particular care must be given to sensitizing physicians to the value of personal decision, because only thus can an interest for the person as such be easily felt.

I think we cannot justify the practice of some physicians who manage to keep the dying patient in ignorance and whose care is only that of informing relatives so as to know their opinion on what is or is not appropriate to do.

They have understood that the subject of the right to know and decide is the individual, at whose service medicine places itself.

The freedom of the pa-

tient — informed and ready to decide, particularly as regards his undelayable decision making with respect to important and definitive matters, as frequently happens in the case of terminal patients — is a must. To enable the patient to act as a protagonist, responsible for what is related to his illness, we must provide him with the data of diagnosis, prognosis, and all possible therapeutical alternatives. Only thus will he be able to choose and accept or refuse the treatment, starting from good knowledge.

It is the physician's task to objectively inform the patient of the above data, personally or through other more suitable persons.

It would be a breach of trust to make use of the power conferred by the condition of dependence of the patient to influence his decision and, even worse, to act in his place. The physician would deceive himself, notwithstanding his claim to be helping the patient and perhaps his relatives and legal representative as well, should his information lay stress on some facts rather than others, thus conditioning their decision in the direction he desires. He would be the only one responsible for the decision, with the aggravating circumstance of deceit.

To help to choose responsibly does not mean to determine the direction of the choice, but to offer the patient all the information and, if possible, all the needed time so that he can understand the elements which may have an influence on the result. When we speak of time, we are aware of the shortage of time often available to the physician; we only want to call his attention to

the slow pace of idea assimilation by the dying patient for both physiological and psychological reasons. Time is needed to overcome one's resistance and even to " listen, " through repetition, to what sometimes has more than once been said.

Leaving aside the problem of whether to discontinue or go on with the normal treatment, the condition of the patient at the terminal stage frequently warrants using a drug or technology still in its experimental period. Any change in the medical intervention, which cannot be held to be implicitly accepted by the patient because of its normality in similar circumstances, requires the latter's or his representatives permission. Should the patient decide by himself (refusing, for instance, the treatment), the physician ought to comply with his wishes, provided

that from the ethical point of view he is in agreement with this way of acting and there is no reason to suspect that the decision is due to someone else's constraint or to circumstances which might change. What matters in this case is to safeguard what cannot be set aside if the option is to favor the ethical perfection of the human being.
But to defend someone else's freedom should never mean to renounce one's responsibility. When the physician judges the patient's decision ethically unacceptable, he should find a colleague who might take his place in treating the patient, since respect for such a decision would not justify his formal cooperation in an action or omission which he regards as not honest. The value of the consent cannot be exaggerated. What justifies a surgical intervention or a treatment is not the patient's permission but the cause which motivates it and the appropriateness of the system employed. The patient's consent does not make homicide licit.

e) *Right to a confident dialogue*

The human being realizes himself in the social context. The patient at the terminal stage has the right — which is a duty as well — to complete his social contribution and not miss the help of his fellow men before his end. Special attention must be given to relationships with his physician, his relatives, his closest friends, and the world of his profession or work activity.

The *physician*, aware of the importance that the patient's trust in him has for the good result of therapeutic and sedative measures, behaves in such a way as to obtain it from the first con-

tacts, through an interpersonal relationship of understanding and welcoming which invite the patient to disclose his fears and suspicions. This attitude and the intercommunication with patients must be maintained, chiefly in the final stage.

Technical progress, with its interposition of gears, graphs, and cards between physician and patient, not to mention the distance imposed by the white overall, the sterilized rooms, the chief physician's being enthroned at the head of the team supplying him with data, make human syntony difficult and physical closeness impossible. The predicament of the patient, more marked towards the end of his life, makes him yearn for physical contact capable of soothing him. Medical interventions, and particularly the physician's person, must recover bodily closeness to the patient,once necessary and obvious and now withdrawn from him by an excess, not of scientific technology, but of cold academic technicalness. Nothing so tranquillizes the last difficult moments as a confident and open dialogue with the expert on the causes of the trouble. Nothing makes pain and anxiety more unbearable than the feeling of being abandoned by the physician. And this may take place without any express will, but only through the mere interposition of the usually zealous individuals who decide upon a separation or of equipment which makes dialogue impossible, or the creation of sterile areas to which access is forbidden.

We should submit to critical judgement the use of certain controls which, to protect the terminal patient from harmful germs, withdraw him from relatives and friends and leave him in the cold company of the machine. Compassion is aroused by the condition of abasement and foresakenness of some dying patients whose face and body are drilled by a quantity of tubes and probes, who are obliged to keep themselves bound to dead instruments to keep life going on, if we may decribe as life a condition of such degrading prostration. In this situation he cannot avoid feeling that his dignity is held in contempt, especially if he wishes to express his opinion, communicate with someone, and has no possibility of doing so.

Surmounting the natural repulsion for closeness to him, some physicians studied the course of the emotions, not always identical, which follow one another after the knowledge of a prognosis pointing, with more or less immediacy, to the fatal end.[9] The physician's knowledge of these reactions and their deep meaning would extraordinarily facilitate the interpersonal dialogue needed by the patient. It would even enable physicians to warn his closest relatives that the reactions of indifference and aggressiveness of which they are the victims are not intended to, and must not, offend them. It would be wrong to feel guilty because these are not caused by their behavior. They belong to a stage of the process, as a natural expression of the uneasiness of the dying patient, who shows it in this way. The victims become the most beloved ones. In their presence he lets himself go and loses any inhibitory restraint and self-control.

The physician must not jealously keep to himself personal communication with the patient, even as regards matters of health. Relief, which he must always offer, may be looked for, and better felt, by the patient from another person to whom he can more easily show his inmost wishes. By making it easy for this person to contact the patient and supplying him with data and appropriate advice, the physician would accomplish in the best possible way his duty towards the dying patient, assisting and helping him to accept death as something of his own, personal, which nobody can take away from him, which he has the right to live as a consummation of his own life, in communion with others.

In the panel summoned by the Pontifical Council *Cor Unum* with the aim of studying some ethical issues relevant to severely invalid and dying patients (November 12-14, 1976), the representatives of the Third World called the attention of their colleagues to " the importance for man to end his life as much as possible in the integrity of his personality and the relationships he has with his milieu, in particular with his family. "[10]

Up to the last century, the process of death and death itself took place, also in our world, *at home*, among members of the family.

The therapeutical means due to technical progress and greater facility in having recourse to them in the best equipped institutions have banished the presence of death from everybody's life and turned death into a real " taboo. " Society tends to ignore its presence and,

though a sound trend towards the reintegration of death, which is a sector of life, in life's complete span may be perceived in some minority groups, it is not easy for the physician to work in this direction. To see him in closeness to death does not favor his prestige as a supporter of health; furthermore, the hospitals and clinics where he works have made the concealment of death a sort of principle.

It would be unjust to place the blame on physicians only as a result of a cultural phenomenon which withdraws from human society the " death factor, " an everyday event as much as birth, but what is by no means undoubted is their influence on the arrangement of the medical structures where they work and even on the creation of the scale of values which characterizes the common way of feeling about all that touches upon illness and also death. Even the ministers of religion today less than in the past dare to speak of the termination of life and have almost completely ceased to promote acts of mercy aimed at preparing for a good death, notwithstanding its key function as regards the understanding of the truth and the transcendent dimensions of the human being to whose promotion they consecrate their lives. Once the meaning of life is lost, we also lose the meaning of its end. Direct active euthanasia is a " flight forward " from death itself and owes the great interest it excites nowadays to the fear we have of death. Even from the merely human point of view, a sort of familiarity with death makes it easier to meet it and, if we wish to fear it less and live it with greater simplicity, it is worthwhile not to conceal what is, after all, unavoidable.

To destroy the " taboo " of death, to put an end to self-deceit, will facilitate man's finding himself again, enabling him to give a new dimension to his own sense of responsibility in the face of death.

Usually, it will be a wrench for the dying to give up their *professional activities* and social responsibilities. To realize that their relatives are not and will not be neglected is for them a great relief. We cannot avoid thinking of the solicitude with which Jesus Christ, from the height of the cross, committed His mother to His dearest disciple, and at the same time entrusted to her motherly protection his disciples and all his work in the person of John.

The forecast of death on a middlé or short-term basis enables the patient to resign himself to being replaced in his social responsibilities. If the patient can contact the person who will replace him and knows that the latter will act according to his guidelines, he will feel greatly relieved. To solve, prior to his death, some of the problems that his absence will create for his family and others depending on his professional activity, enables him to get over the egoism which normally goes together with the instinct of self-preservation and facilitates his finding pleasure in his work as long as he will be able to manage it well. He even finds relief as regards dimly surfacing fears and anguishes. He may crown the task of his own realization in a social perspective. From the dirth of his possibilities he can shout, *" Consummatum est ". " It is finished " (Jn 19:70).*

I have abused your patience by dwelling too long on this subject. In the three concepts of euthanasia I have dealt with we may see the common denominator of the duty, a true must, to have mercy on the dying during their passing away, which is greatly different from mercy killing. But this is not enough. A positive view of euthanasia must allow the physician and whoever cooperates with him to give the dying the possibility of dying with dignity, i.e., relieved in their suffering and helped in the exercise of their own personal and social responsibility.

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Notes

[1] M. Cuyas, " Euthanasia from a Deontological Standpoint, " in *New Essays on Medicine and Human Sciences* (Milan: St. Raphael Scientific Institute, 1984), pp 437-447

[2] *Advancement of Learning*, Book II, and *De Dignitate et Augmentis Scientiarum*, Book IV, Ch. 2, in *The Works of Francis Bacon* (London, 1858-1859).

[3] Sacra Congregatio pro Doctrina Fidei, *Declaratario de Euthanasia*, 5 (May, 1980), AAS 72 (1980), 542-552.

[4] Cf. " Neither Euthanasia nor Therapeutical Obstinacy, " an editorial in *La Civiltà Cattolica*, 138/1 (1987), 313-326

[5] Pius XII, " Address on Certain Questions Regarding Anaesthesia, " February, 1957, AAS 49 (1957), 129-147

[6] Pius XII, " Address on Certain Questions Regarding New Resuscitation Techniques, " November 24, 1957, AAS 49 (1957), 1027-1033.

[7] Giacomo Perico, *Problems in Health Care Ethics* (Milan: Ancora, 1985), p 124.

[8] Angelo Fiori, " Medical-Legal Problems of Euthanasia, ", in *The Value of Life. Man Faced by the Problem of Pain, Old Age, and Euthanasia* (Milan: Vita e Pensiero, 1985), p.197.

[9] Elisabeth Kubler-Ross, *On Death and Dying* (New York: Macmillan, 1973).

[10] *Some Ethical Questions Concerning the Seriously Ill and Dying* (Vatican City: Cor Unum Pontifical Council, 1981), p. 5. Cf *Enchiridion Vaticanum*, vol. 7, nos. 1234-1281.

The " Not Yet Born ": A Life to be Saved

In the subject I intend to set forth, what interests me is to show the indissoluble link existing between the defense of the life of the not yet born and love for our fellow beings. This love, called also the recognition of man, is the essential content of the main ethical rule: this rule — termed " personalistic " — states that it is mandatory to recognize the person *for his own self*, in other words, that each has *in himself* the *sufficient reason* to be recognized. And it is precisely this rule which excludes the possibility of recognizing any person at the cost of another. What I have said represents the very foundation of ethical thought and action, the very core of ethics and morals.

Assuming that the issue is for us clear, we should consider as something simply superfluous and rhetorical the question " Why recognize man? " And if it is so, the demonstration of the necessity of the logical link between the assertion of the human person and the defense of the life of the not yet born should change the question " Why the defense of the life of the not yet born? " into something equally rhetorical.

I think that for us this is the sense of this question. Should it not be so for someone else, we must identify and eliminate the only reason which — following the personalism principle — may be imagined: that the recognition of man and the recognition of the not yet born has not been realized. This relationship, in fact, is not always felt by everybody, if not simply denied. And it is exactly this which makes clear the ethical weight and the moral importance of the query " Why defend the life of the not yet

born? " Fortunately the query need not be changed into something purely rhetorical, because what renders it a problem also expressly shows the way in which the difficulty arising from it may be successfully overcome.

And it is in this very point that I see my task as a scholar of ethics. The path to follow in order to fulfill it is therefore simple and implies two moments: first of all, the demonstration that to recognize man is impossible without recognizing his life, as well as — and this is the second moment — the demonstration that the not yet born man is a man.

However, before dealing with this matter, I should like to call attention to what is stated by the present-day declaration on the rights of man.

1) The personal dignity of man and the condition for its recognition in the declaration of the rights of man

Opinion, even if uniform in its views, is not a sufficient condition, or a necessary one, for truth. Let it suffice to think about Copernicus, who one day, all by himself and against the common opinion, " stopped the sun and moved the earth. " Opinion, however, is an index, and not a banal one, of truth, an index which we cannot ignore especially when every attempt is made to darken that truth.

From this point of view, particular attention is deserved by the present proclamation of the dignity of the human parson. It is expressed in a particularly eloquent way in the movement which is developing throughout the world for the defense of the inalienable rights of man.

The scholar of ethics sees in this movement above all an indication of the constant and generally sound moral sensitiveness of contemporary man, especially if we consider the enormous technicalization of life which conditions human conscience. The resistance offered by the conscience of man to the temptation of reducing the morality of acting only to its effectiveness is astonishing. Man, here, is always a person, a " for himself, " a " somebody " who must be affirmed in his selfhood.

Would this perhaps mean that for the sake of the morality of action no account is to be taken of its efficacy? Not at all! We wish only to emphasize the prevalence of the morality-of-the-action criterion above that of its effects, or, in other words the subordinate character of the action-efficacy criterion as compared with that of morality. The matter here is only to show the limit beyond which the criterion of efficacy turns against the person and, at the same time, the limit within which the effectiveness of acting is something demanded by the very inner logic of the recognition of the real person.

And this is precisely what inalienability — so often emphasized in the context of the defense of the rights of man — seeks to express. What does in fact the inalienability of these rights mean ? It means that it is impossible and simply illusory to recognize the real man without recognizing what the good of man is — so strictly linked to his " to be or not to be " — and that to injure it is tantamount to injuring the being of man in his very essence.

That is why moral rules, the object of which is to defend that essential good of man and assure what for him is so absolutely necessary, must possess exactly *the same binding force as the main rule* — the *personalistic rule* — and, therefore, the *absolute force of a rule that is binding, with no exceptions whatsoever*. Any attempt to admit an exception to the rule which *defends such a good* would mean — from a moral point of view — a quite absurd operation: the denial of man in the name of his affirmation. The declaration of the inalienable rights of man, therefore, is first of all the proclamation of the inviolability of everything on which dignity is based, his very existential structure; in other words, the proclamation of the absolute validity and sacredness of natural moral aw.

Thus, we should not be astonished if, on the list of the inalienable rights of man, we find in the foreground the right of man to freedom of conscience and religion, that is, the right to maintain faith in his own convictions, the right to secrecy, to which the absolute reprobation of tortures is linked, and, finally, the right to life, a right in which we are particularly interested here.

2) The right to life is an inalienable right of man

Biological life is not the highest good of man; however, it is a *fundamental* good. Life is not the highest of values. Already in ancient times we find that Socrates

reminded his contemporaries, " The point is not so much to live, but rather to live well. " Life is given to bear witness to values higher than life itself, values for which, as in the case of a tragic choice, one must be able to sacrifice it as one's own choice. And to faithfully serve the values superior to life is just what makes us realize that our life is worthy to be lived, a life worthy of what we are. *Man* is however, *what he is insofar as he is; he is, therefore* — at least in the dimensions of the earthly world — *insofar as he lives*. " Viventibus vivere est esse, " says St. Thomas Aquinas. For the human being, to live is to exist. For man, therefore, life proves to be the *fundamental* value. It is that good on the basis of which all the " remainder " finds support. Consequently, a sincere " yes " to man, to all the " rest " of the goods of man himself, *is possible* only by saying " yes " to his life. The recognition of life is, in other words, *the condition necessary for the recognition of man as man*. The acknowledgement of human life becomes, let us say, the test of the truth of the real ethical relationship of man with the " other, " that is, the verification of real morality, of true love for our fellow-creatures.

At this point, however, we must take another step forward: philosophical analysis of human existence in fact reveals to us *its unnecessariness, thus revealing, its radical gratuitousness*. Man begins to exist and continues inasmuch as he is a gift. Gift by whom? Not only by his parents, because there is always some parent who weeps disconsolately over the death of his or her children. A gift by whom, then? By him who, being the *Personal Absolute* of existence, is the Only One who can bestow a gift of personal existence on " another. " It is only thanks to the direct, creative intervention of the *Personal Donor* of life that man begins to exist, to be a man. Man begins to live — and lives — as the one whom God creatively calls by name. Owing to this call and this creative presence, man simply " is. " He lives as a theophany.

He lives by taking part in the *sacrum* and, at the same time, revealing it. For this reason, not only to the Jews, brethren in faith, but also to the Greeks St. Paul could say, " In Him we live, we move and are " (Acts of the Apostles, 17: 28).

He who deals with the life of man has to deal with God. The Creator is there where man is: that is why the " yes " of man is impossible if not through the " yes " to his Personal Creator. And this he cannot express except by a " yes " to human life as a " Gift from God, " the highest *gift in which the very Giver of life makes Himself present " in actu et in Persona*. " Hence it follows that the recognition of life at once becomes " the test of truth, " that is, the verification of the true relationship of man with every other man and with God: *verification of sincere love for God and his fellow-creatures*. The way we relate to human life becomes the *indissoluble " measure " of true morality and religiousness*. St John says, " Every one who believes that Jesus is the Christ is a child of God, and every one who loves the parents loves the child. " (St.

John, 5: 1). It is probably impossible to express this concept more deeply and concisely.

It is fitting to remark that the modern proclamation of the rights of man highlights — by virtue of an inner logic — this *fundamental position of life as compared with all the remaining values*; in this connection a great significance is to be ascribed to the request often put forward and accepted by the laws of many countries of the elimination of the death penalty by making reference precisely to " the logic of the good for man. " It is consequently impossible to defend the right of anyone — particularly that of ourselves — to anything whatsoever as a *right of man* if in reference to anyone we challenge the very foundation by which man has a right to anything whatsoever: his right to life.

And then, in this sphere, shall we not acknowledge as contradictory the action of those Members of Parliament who, while appealing to the inalienable right of man to life, declare themselves to be for the elimination of the death penalty for criminals whose crime was proved, but afterwards legalize the mass murder of completely innocent and defenseless persons: those not yet born? It is impossible to imagine a greater logical and ethical absurdity. An attempt was thus made to avoid such an accusation in the only possible way: by deciding that the suppression of the unborn does not amount to suppressing a man only because the former is not a man. But on what grounds? we ask ourselves. Perhaps only on the basis of the power of the " born " over the not yet born, a basis that does not take truth into consideration? A really fatal claim. As if the so-called referendum on the legalization of pregnancy interruption implies after all that the voters usurp the power to establish, through their own decision alone, who is or is not a man!

3) The not yet born man is a man.

And we have thus reached the central point of the not yet born issue: Is there some essential difference between the man who is still waiting to be born and the born? There is no essential difference; from the point of view of existence, this represents a problem, but whether or not he who is alive has the moment of his birth before or behind him is a question devoid of significance. From this point of view, the only essential meaning is to be seen in the moment when man begins to exist and to be a man, when, in other words, he is conceived. To this question there is only one reasonable answer, an answer which represents the data of both experience and logic: at the moment of his conception.

This seems to be the most concise expression of what is here obvious: in relation to the unitary process, characterized by continuity, the principle of reason which sufficiently explàins this process excludes the possibility of not contradictorily identifying such a process (as is precisely ours) without recognizing that it is the same at the point where it began and afterwards, during the whole time, unceasingly, from the moment of its beginning. It does not seem necessary to convince anyone that the life of man constitutes such a process: continuing and, at the same time, identical and homogeneous thanks to the identity of its subject: We must, therefore — in the name of the logic of the process — acribe the beginning of human life to the moment of conception. From the biological point of view it takes place when the father's spermatozoon meets the mother's ovule. Any other attempt to place in time the beginning of man's existence has against it the principle of sufficient reason and, together with it, the principles of noncontradiction and identity. Embryology as an empirical science supplies us with a more precise description of conception. It explains *how* human life starts and succeeds with fair precision in assigning it a point in time. Let us recall that the Chinese legislation, as well as that of other Far Eastern countries, would add to the newborn one year of life.

Philosophy, however, finds here a further problem to face; starting from the assertion of the spirituality of man (and here we arrive by another way) for its explanation *direct intervention* of a *cause* is required, a cause in keeping with the existence of such an effect as the *spiritual* existence of man is. And this intervention takes place precisely at the moment when the existence of man has its beginning, that is at the moment of conception. This intervention can be only a direct one by the *Personal Absolute of existence*. A preminently *creative* intervention. That is why from the conception of a new hu-

man life on, anyone who has something to do with this life has to do with man and his Creator.

A necessary conclusion of our reflections is, therefore, the following: from the strictly logical point of view, there is no need to build up an ethics of the not yet born as distinct from an ethics of life in itself. Because all that regards the recognition — or the defense — of the life of man as a *sine qua non* condition for the recognition of man and of God refers to the life of man *tout court* from the moment of his conception till his death. The moment of birth has here an essential role and, *on principle, only one single ethics exists, of the respect for man through respect for his life* as the fundamental value, *and respect for the only Bestower of the gift of life*: for the *Personal Creator*.

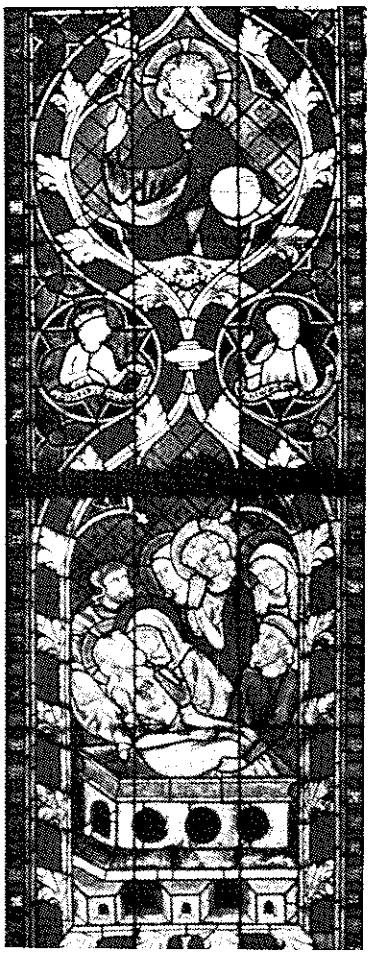
However, what does not need to be demonstrated from a logical point of view needs, on the contrary, to be particularly pointed out for psychological and pedagogical reasons, especially in connection with this concrete threat to the unborn by the born. To this threat another one is added — a threat which is less frequently remembered — the threat of man himself. Let us therefore dwell a little longer on this point, which constitutes a particularly meaningful verification of man's moral sensitiveness.

4) Who is threatened in particular?

Man in his pre-birth state is almost not taken into consideration and completely defenseless. He cannot defend himself with the means by which, in their own way, the born defend themselves, even if only by using sight and hearing, or, for instance, by crying. He is completely in the hands of the inventive power and will of those on whom he depends. It is also possible not to see in him what he is in reality: someone who must be acknowledged for himself. And it is possible to suppress him without realizing — sometimes — that by doing so it is murder that is committed and that it is a man who is eliminated from society. In the case of such ignorance — often terrifying — it is thus possible to kill him without even taking the blame upon oneself or feeling guilty, killing a man just the same. *Innocens sed nocens*. The voice of the moralist must thus resound particularly loudly in the name of the defenseless and of the Creator Who in them keeps silent.

Ethics must do all possible to lay bare and thus eliminate the paradox of people's lives in maximum peril from assailants who are quite dangerous because they are " armed " with the absence of sense of guilt. The ethics scholar must step forward and strenuously take the defense of those who pay with their lives for the ignorance, not considered culpable, of their killers. Otherwise, ethics would deny that which it would serve, the recognition of man.

However, when the killer is aware of what he is doing and, this notwithstanding, does what he does by relying on the privileges of anonymous murder in our case or on the lack of legal imputability of his action, then ethics must make known, according to Socrates, who has been principally



harmed. I quote the words of the great Athenian: " It is easier to be the victim of a crime than to commit it. "

It is not possible to physically kill a person without morally killing ourselves; without thereby obliging our milieu, first of all, those closest to us, to live together with a murderer. By silently eliminating from our bosom those not yet born, we become ourselves a society of morally dead persons.

For whom does the bell toll? Perhaps, as a matter of fact, it does not really toll for anyone. Murderers, in fact, are interested in silence and in eliminating whatever trace might recall the existence of so many victims.

But how can we not hear, in this deadly silence, the voice of alarm of warning? It is with precisely this voice that ethics speaks of the not yet born and for this voice ethics is absolutely necessary.

In the presence of the threatened life of the not yet born, the moral philosopher cries out, " Spare! " and adds, " *yourself above all!* Save the not yet born to save yourself! " While the moral theologian, for his part, cannot avoid recalling the words of Christ, words which may terrify and nevertheless fascinate (Matthew 25: 40): " In truth I tell you, insofar as you did this to one of the least of these brothers of mine, you did it to me. "

And precisely by them, the least, we shall be judged one day, in the name of Christ Himself.

At the beginning I said that I wanted to show the necessary link between love for our fellow-creature and the defense of not yet born life; the way to fulfill this task is linear and brief; it consists of two moments: first, to demonstrate that true love for our fellow-creatures — that is, the recognition of man as man — is possible through the recognition of life as a fundamental value for man; second, to demonstrate that the not yet born man is simply a man. From this it clearly follows that in reality the whole ethical problem only confirms, after all, the single preeminently anthropological problem: the not yet born person is a man, and this is the necessary *unum* of our subject, the only thing which is here necessary and sufficient to consider and at which it is necessary and sufficient to arrive.

That is why it is important to insist on this subject, however clear it may be.

Fr. TADEUSZ STYCZEŃ
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Technology and Questions Concerning Health Care and Education

The nuclear power plant explosion in the Soviet Union has aroused fear, concern, and uncertainty regarding environmental safety and the health of the populations involved to such a vast extent that it is comparable only to the most serious periods of epidemic and war experienced by mankind in the past.

It is precisely this fact which leads us to reflect on a work program for the ministry of health professionals in our time that must necessarily confront new data and new events, reformulating — though in new clothing — archetypes and very old situations.

The health care apostolate has always been central to the Christian world, a key experience, for it is the ministry of suffering.

Christianity, which, alongside Christ, has placed suffering at the very core of salvation, has represented such an exceptional novelty for man that it may be evaluated only in terms of religion.

Situating the salvific value of suffering at the heart of man's experience has exercised and continues to exercise a deep influence upon the Christian's behavior towards the sick, the weak, the marginalized, and the oppressed.

Behavior which was opposed to the dominant culture in Christ's time and to what, unfortunately, has very often been the dominant culture of the intervening centuries as well.

Two thousand years of Christian history have served to make this insight bear fruit in numberless diversified, but always meaningful episodes.

They have not, however, managed to eliminate a reality at the root of human nature: the ever-recurring temptation to place the weak on the fringe of society and culture, on the fringe of life itself, and to reward the strong, the powerful, the victors.

It is thus a problematic which is continually renewed, a challenge we Christians must accept and take up again in every age on the basis of the ancient roots, but with responses that are always new, adapted to different moments in history.

We must ask ourselves, then, how the health ministry may be formulated in these closing decades of the twentieth century leading to the threshold of the year 2000. And here the problems and questions abound; uncertainties and unresolved doubts start to multiply — in spite of the rationalistic, scientific culture which believed, on the contrary, it could provide reassuring answers in place of faith, *in place of salvation*.

Recent events have in fact reminded us that humanism, while arousing significant inherent energies for the rational governance of nature, has nonetheless unchained dangers as well which can lead us straight to destruction and render whole populations, whole continents impotent in the face of phenomena that are occurring, though it was thought they could be kept constantly under control. We cannot dwell at length here on the history of the health ministry over the course of past centuries.

The brief consideration we are attempting to offer has value only as a reflection on the past, and we must specify that, with respect to the ancient world, Christian faith and culture sought to influence not only with words, preaching, but with actions; for two thousand years it has thus invented and reinvented responses to the suffering unceasingly — we are referring exclusively to pastoral responses involving assistance, not to the religious ones, which have remained the same as they were twenty centuries ago and which, without a doubt, consist of the message of salvation.

Human responses have, however, been expressed in a thousand ways in every field — from the construction of centers to treat the sick to artistic manifestations, signs of solidarity with the poor, the creation of numerous orders and confraternities — a whole series of communities, groups, persons devoted to alleviating suffering, but also, in so doing, to giving it a meaning.

This commitment has created a structured organization branching out into all the traditional spheres of the Catholic world, particularly under the aspect of health care, to such a degree that there is a virtually unbreakable link between visible Christian presence and the medical attention offered to the sick, the elderly, and the dying.

At the beginning of this century that message was also repeated institutionally by modern societies, which established a set of organisms dedicated to health care; hence the initial appearance of health insurance for groups or categories of workers followed by the State's gradual intervention throughout society.

It is the period of the so-called " Welfare State, " which takes upon itself provision for the health of the infirm, the handicapped, and the marginalized, who were previously entrusted to volunteers, local efforts of an altruistic nature, and religious or lay confraternities, all of them, however, inspired by religious values.

In these years, the Catholic community has thus attained a new perspective — it observes that one of its ideals is about to enter the domain of civil rights, i.e., be accepted by the whole of society. Such acceptance can only be seen as a success, but, precisely because human history is the history of salvation, this fact, apparently positive in every respect, is, in turn, a mixture of light and shadow, posing new challenges and new problems for Christian culture, the Christian world, and the Christian ministry.

Concretely, there has practically been a syndrome of dispossession, as if Christians saw in public institutions dealing with health care a structure extraneous to them; as a result, for many decades two systems have co-existed: a private one frequently administered by religious institutions and a public one in a continuous process of growth. Today the focus is much more open, much more uncertain.

The social state exclusively involving institutional intervention is, in fact, starting to become extremely costly, with increasing outlays which do not provide proportional results in terms of economic effectiveness.

Hence the Christian too wonders how he should intervene, especially in the face of current tendencies to reprivatize these delicate sectors.

In the course of this programmatic note, we do not wish to deal with the subject in depth, but shall limit ourselves to stating that the specific problem of a Christian health care presence in public facilities should not be posed in terms of *competition*, but above all as contributing a different tonality, a different content to the functioning of such facilities.

The serious limitation of these vast health care megasystems today is really twofold, bureaucratic and technocratic.

On the one hand, the technocratic approach seeks only to solve health problems, the anguishing problems of disease, by upgrading instruments, equipment, computers; on the other, the uncontrollable cost explosion tends to multiply bureaucratic checks which do not, however, succeed in actually

holding back expenditures, but rather often attain the objective of complicating attention precisely to those most in need, thereby going against the original impulse to assist the weakest.

There is a risk that certain categories will once again be given priority and that the ill, the poor, the marginalized, and the elderly will be burdened with the not always humane methods of excessively elephantine systems.

In our view, therefore, the first point of a commitment to the health ministry at present involves reintroducing Christian humanism into public and private medical facilities.

Quantitative forms, procedures, techniques are useful; they may offer efficiency, serving to organize wards, work shifts, or balances — all of which are quite important. Yet if we do not bear a content within, a specific content charged with the energy of the will, the profound decision to regard the moment of illness as one of salvation, these bureaucratic machines threaten to go mad by themselves, ceasing to produce the benefits expected.

Hence an overwhelming initial task for the health ministry appears, one with at least two facets. The first entails training health personnel in values much deeper than those associated with mere professionalism — i.e., applied technical precision.

When health fails, technical intervention is, of course, indispensable; but it is also indispensable to create a favorable climate, a thrust, an enthusiasm which will overcome the maddening moments of bureaucracy and technologism.

The other aspect concerns health education. It is necessary to help the poor and the weak, those who do not understand, perhaps amounting to millions of people, those who do not know what to do in the face of obscure threats, like that of the toxic cloud or the Seveso disaster or the multiple attacks upon health by harmful agents or pollution — those who know not, who fearfully question, who ask science for light and do not always receive it.

Through an intensive effort in health education, we must, then, provide them at once with necessary concepts on physical well-being and disease prevention, but also a new and profound sense of solidarity.

We feel the health ministry in the immediate future should intially hinge upon these two points.

But we are faced with other demands as well.

A new and extraordinary field has been opened up by the biotechnologies.

In and of themselves, biotechnologies are not anti-human; on the contrary, as has been authoritatively recalled, man has been applying them for centuries, since initiating the fermentation of wine and beer with bacteria.

He employed biotechnologies to some degree in the past, but the latest actions in this field tending to influence the genetic patrimony are especially delicate and difficult, posing extremely serious questions.

The intellectual effort as well to create a sense of responsibility among those working in these areas is thus very important, for, as the recent catastrophes demonstrate, science is reaching confines beyond which the individual or a small group can suddenly do harm to all mankind, in an instant, like the ancient pestilences or disasters viewed as inevitable, wherein man was impotent in the face of the elements.

A situation is, then, reproduced requiring the maximum commitment of all of us — a cultural, pastoral commitment by each one in the place where he finds himself, including the most advanced frontier of science demanding reflection on man's use of instruments, maxi-instruments, so that they will not eventually destroy man himself. It is in this reflection that not formal limits, but the limits imposed by conscience, faith, the finality of any act — including research, which must always keep human experience at the center of all — can prove valid.

After professional training, health education, and the biotechnologies, we feel the fourth main battlefront involves the fight against famine and mortality rates in the Third World. Herein lies another central objective of the health ministry, one which, in our view, cannot be reached by the methods being employed today — i.e., simply exporting Western medicine to the Third World countries.

One of the consequences of this approach has indeed been to cure certain illnesses, but it has also created further imbalances of a most serious nature such as death from famine, expansion of deserts, and the flight to the cities of great Third World masses leading to even worse violence and disorder than had been initially feared on taking action.

We must, then, promote the development of a local culture linked to local historical values enabling the entire society to grow harmoniously, not only in attention to illnesses, but in overall attention to its own equilibrium as well. Otherwise the only goal attained will be to treat certain afflictions with Western techniques while horribly aggravating many others related to psychological, sanitary, and environmental factors. We must take into account tragedies like that of Bophal, India, which could be dangerously repeated in the coming years unless all our cultural energy is devoted to carrying out this exchange of experiences, techniques, and products — including Western science and technology — with other countries and social realities in the light of Christianly inspired humanism and not through mere trade relations, as is happening today.

We realize that we have traced out some vast fields of endeavor here for the immediate future, fields which may exceed the capacity of individuals and require a collective mobilization of the Catholic world for the year 2000 that must necessarily take on diverse forms.

Perhaps it will partially retain ancient, deeply rooted traditions and pastoral experiences concerning health, suffering, and care of the environment typically grounded in the close bond between nature and man already indicated by St. Francis.

But it will probably be necessary to invent new instruments, organisms, and movements as well to shape public opinion and take action not based on purely mechanicistic or rationalistic elements, but on a new and profound solidarity wherein the pathways of science, technology, and man are reunited, not divided, fragmented, and splintered, as is presently evident to all of us.

The Pontifical Commission for the Apostolate of Health Care Workers must respond to all of these demands and others, thereby sanctioning a renewed presence of the Church in the defense of man's health throughout creation.

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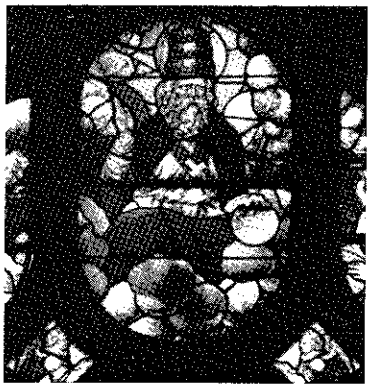
Clinical Experimentation, Laws, and Ethics Committees

It strikes me as opportune to focus upon the relations involving experiments conducted on man, laws, and the possible development of ethics committees in the Italian juridical-health care system.

A recent Meeting held in Milan (May 23-25, 1986) at the International Family Studies Center, with the participation of the St. John of God Foundation as well, " fixed our position " with respect to world developments in order to furnish comparisons, ideas, and valid proposals for the possible organization of Ethics Committees at Italian hospitals as elsewhere.



In some countries, there are centralized models of national ethics committees charged with supervising the research conducted on man through public financing (e.g., Australia; cf. *Report by the Medical Research Ethics Committee of the National Health and Medical Research Council*, November 6-7, 1985) or working out " guidelines " for clinical research (e.g., France).

In other countries, however, hospital committees of a multidisciplinary nature have been functioning for some time now, with the aim of protecting people from being used for research lacking in ethical prerequisites (Institutional Review Boards in the United States, for example, were made obligatory by the federal government's Department of Health, Education, and Welfare).

In Italy, there are at present only sporadic initiatives on a local level, particularly connected with clinical drug research of an innovative variety.

It is worth recalling, in addition, that some Italian researchers participate in the activity of the European Ethical Review Committee, which for nine years has been examining the protocols for clinical research which are spontaneously submitted by either individual scientists or the pharmaceutical industry.

Clinical Experimentation from an Ethical-Legal Standpoint

From a legal perspective, the problem presents itself under two aspects:

a) the ethical and legal position of someone subjecting himself to an experiment;

b) the ethical and legal position taken by the experimenter with respect to anyone subjecting himself to an experiment.

Four substantial legal principles are involved:

a) the right to " health care ";

b) the right to " physical integrity " and the correlated right to " control over one's own body ";

c) the right to conscious acceptance-refusal (informed consent);

d) the definition of the experimenter-subject relationship under its civil and penal aspects.

In a highly summarized manner, I aim to examine the nature of these rights and the consequences deriving from them for the problem which interests us.

1) The right to " health care "

The right to " health care " has developed in modern society in an increasingly extensive and legally binding fashion.

In our country as well, the concept of health — from which the foundations for

the first paragraph of Article 32 of the Constitution derive — as a " fundamental right of the individual and concern of the community " has been expanded to include not only the state of " physical integrity " and the related principle of law protecting the person under the aspect of an essential value, but also the state of " well-being " linked to the expression of harmony between individual factors (age, illness, sex, and so forth) and socioenvironmental ones. The characterization of health as a " subjective right " strictly inherent in the person has gained increasingly open and explicit

acceptance on a jurisprudential level as well.

In any event, it is asserted that this " protection " does not represent a right of the community, but one of its interests.

It should also be acknowledged that " individual health " is not strictly identified with " individual physical integrity ": for some time now there has been a hierarchy of values granting precedence to health with respect to integrity; for example, the sacrifice of a part to benefit the whole (provided that such a sacrifice is objectively necessary) is a principle which in the individual's domain has been applied from the outset in surgical practice.

The evolution of norms, in keeping with variations in common opinion, has emphasized that, on condition that the value of " health " is not disregarded, the principle of physical integrity is not inviolable, but may be significantly attenuated even when a direct, immediate good for the health of the subject is not involved, but rather a " figurative good " (psychological, emotional, moral, and so on), particularly if associated with the principle of social solidarity.

Yet the priority of the principle of solidarity over that of protecting physical integrity must not exceed the limits imposed by respect for the human person; his physical integrity should not be affected without his consent. In this connection, the activity of scientific " experimentation " may be included as well, which cannot be denied the goal of social solidarity either (if correctly formulated); rather, in entailing potential risks for the subject's physical integrity, it should, in turn, subject itself to his prior consent. If the argument is so stated, it is possible to examine some more specific aspects of the two " key points ": " control over one's own body " (as a principle mirroring the right to physical integrity) and the legal topic of " informed consent. "

2) Control over one's own body

In itself, the principle of " control " over one's own body for the purposes of scientific progress and usefulness to the community seems so evident that all the ethical and legal norms are concerned only with defining its limits; they greatly reinforce the general principle of control while establishing guarantees so that the indispensable rights of the person will not be infringed upon.

In Italian law, this is valid:

a) in accordance with Article 50 of the Penal Code on the " consent of the party entitled, " which sanctions control, not over life itself (the homicide of the consenting party is punished by Article 579 of the Penal Code), but over personal safety and health, attributing discriminative efficacy to the consent of the passive subject if the injury does not prejudice other equally important interests not subject to control;

b) in accordance with Article 5 of the Civil Code, where acts affecting one's own body are not all punished, but strictly regulated;

c) in accordance with Article 728 of the Penal Code on " proper treatment in suppressing the consciousness and will of others, " which clearly provides for the discriminative efficacy of the " scientific aim " (aside from " care ");

d) in the provisions on registering branded pharmaceuticals (Article 162 of the unified text on health laws, Article 14 of the royal decree of March 3, 1927, n. 478),

where the obligation that the request for registration be accompanied by proper documentation on the scientific research involved constitutes an admission that clinical experimentation on man is indispensable.

Finally, we recall that Article 32 of the Constitution, Paragraph 2 was formulated precisely to provide for needed experimentation on man, but with the intention of prohibiting scientific experiments on the human body not voluntarily accepted by the patient (thereby establishing the principle of the ethical-legal inadmissibility of the " human guinea pig, " with the exception of medical treatments made obligatory by law in the public interest, provided they do not violate the limits imposed by respect for the human person.

That being stated, it is nonetheless true that the " principle " of control over one's own body has different limits according to the circumstances.

It is necessary to define precisely the differences existing between the content of " biological, nontherapeutic experimentation " on man and that of " clinical-therapeutic experimentation. " In the former, there is no current or future personal interest on the part of the passive subject of the experiment; in the latter, we recognize the personal interest — usually direct and immediate, but occasionally on a remote basis as well — of the subject himself, though there obviously remains an implicit possibility that the results obtained may be generally applied to others.

It is clearly undeniable that the different ends which give rise to the classification are often correlated and interdependent; but it has seemed useful in theory and, above all, in medical-legal practice to insist upon the distinction, for the consequences vary considerably.

When the personal, direct interest of the passive subject is reduced, his control over his own body for experimental purposes is regulated by certain legislative norms which significantly limit the scope of Article 50 of the Penal Code on the consent of the party entitled.

In short, " scientific, " " biological, " or " nontherapeutic " experiments on man are legally judged to be illicit, and the professional involved may be subject to criminal charges (though possibly with the attenuating circumstance provided for in Article 62, no. 1, in the event he has acted out of " motives of particular moral and social value ") in the following cases:

a)when research is conducted without (or even contrary to) the consent of the passive subject or where such consent proves to be " invalid " as a result of natural or legal incapacity or because it has been extorted through violence, threats, suggestion, or deceit;

b) if, in spite of the subject's valid consent, it is contrary to " the law, " " public order, " or " morality ";

c) if it produces " permanent diminishment of physical integrity " (a phrase which, in our opinion, should be understood in a broad sense, also including " psychological integrity "), i.e., a lessening of personal integrity not only of a " permanent " nature, in the correct medical-legal acceptation of the term, but with harmful and appreciable functional repercussions as well;

d) where — if we prescind from all permanent harm and the foregoing remarks — there derives from the act a phenomenology of such a nature as to constitute, from a penal standpoint, a crime of personal injury punishable not through an action brought by the victim, but rather *ex officio*: therefore, in the case of fraud (very rare indeed in experimental practice), an illness exceeding ten days; in the case of culpability, an illness exceeding forty days; in both instances, an illness endangering life or an incapacity foreseeable for ordinary occupations for a period exceeding forty days, or, finally, if the victim is a pregnant woman, the acceleration of birth or an unwanted abortion.

On the other hand, where personal, direct interest obtains — i.e., the experiment is prompted by a tangible benefit for the life, health, or integrity of the passive subject — the regulation mentioned in Article 5 of the Civil Code and that concerning a crime of injury liable to prosecution *ex officio* are no longer binding; that is, when there is a medical justification (identifiable, though not always — we may recall, for instance, experimentation in the field of aesthetic surgery — with a " state of need "), it is permitted to exceed the limits previously discussed; indeed, the immediate danger of serious harm to the person, especially death, not otherwise avoidable, sometimes renders superfluous even the consent of the party entitled, if, in the correct sense, the " action is proportionate to the danger itself. "

In eventualities of this kind, then, the preminent and contingent " clinical " interest, whether or not it is " therapeutic, " permits broad possibilities for experimental action, above all if the " case " appears not to be treatable in any other way; however, professionals must in any event respect the fundamental premises of an ethical nature previously mentioned; violating them could easily involve professional conduct which is not only deontologically censurable, but also juridically illicit.

3) " Informed consent "

The right to conscious acceptance/refusal (informed consent) derives, in the subject under examination, from the same right to physical integrity which inherently takes precedence over any other private or collective interest and pertains to the general (and constitutional) principle of respect for the human person. " Consent " enables the right to control over one's own body to be applied, though only within the objective limits we have already cited, and, in the case of very worthy justifications prompted by social solidarity, also enables us to push the principle of control to the limit of permanent diminishment of physical integrity, as in the instance of transplants between the living.

The question as to whether informed consent is also needed for " therapeutic experimentation " should be responded to affirmatively in the pharmacodynamic phase (i.e., at the outset, with a large margin of unpredictability in the results), but the need for explicit informed consent undergoes numerous attenuations in the phase of " expanded experimentation " (or " generalized, " according to Polli), where the unpredictability or risk quotient is quite limited, precisely because the preceding experimental phases have been completed.

The possibility of " presumed consent " is valid only in case of need, when dramatic situations call for rapid action: where, as has already been stated, there is danger of serious harm to the person which cannot be avoided with the aforementioned therapies (because they are either nonexistent or ineffective) and when it is determined on the basis of solid evidence that the risks of experimentation are inferior to the potential direct benefits for the patient and there are also only indirect benefits for the progress of medical science.

The principle of " informed consent, " particularly as developed in Anglo-Saxon jurisprudence, involves a definition of the limits of its spontaneity (the prerequisite of freedom in

the face of coercion, investigation, pressure, or suggestion) and of consciousness of the content to which it has been given; there would otherwise be a " defective will " on the part of the subject, and the extent of the experimenter's responsibility could be indirectly determined if the information furnished were intentionally incomplete or false.

In short, we point out that " informed consent " in the fullest juridical sense may come into conflict with " experimental techniques " which under some aspects could become necessary in order for the test to attain a scientific status. This is especially valid for experiments conducted on the basis of randomization, with the administration of drugs or placebos and through access to a completely fortuitous protocol, according to the single blind or double blind methods.

These tests may become necessary when the margins of effectiveness in treatment are hard to define. Informed consent may objectively be an obstacle to employing such techniques, which should overcome subjectivism in evaluating results; it is unlikely that a " patient " would consent to an experiment in which he, in need of treatment, knows he might also re-enter the group of the " untreated " by chance.

A priori, many clinical researchers refuse this kind of comparison between " pharmaceutical " and " placebo, " structuring the experiment in terms of an " experimental drug " and a " known drug, " which is quite another thing both ethically and juridically as well, though the same problems of " informed consent " continue to appear.

4) Professional ethics in experiments on man

The ethical-deontological principles which apply to the experimenter provide

what could be termed a mirror image of the juridical principles thus far cited.

In recent decades precise documents have been drawn up, and at the same time there has been profound rethinking of the " ethicality " of experimental procedures applied to man; the Nuremberg medical code (1947), the Helsinki Declaration (approved at the Eighteenth World Medical Assembly in 1964), the Charter of Venice (1969) dealing with pharmacological experimentation on man, the Charter on the Hospitalized Patient (adopted by the Hospital Committee for the European Economic Community in 1979), and other documents as well bear witness to this fact.

In addition, the medical deontology codes of the national associations of almost all countries contain explicit norms protecting the rights of the person in the course of therapeutic or nontherapeutic experimentation.

From this group of documents it may be concluded that on an ethical-deontological level, the subject is well " codified. " Obviously, this does not eliminate the possibility that ethical and deontological norms will be violated, and it is exactly for this reason (and on account of some recurring, though rare, abuses) that measures have been proposed for stricter public control over clinical drug experimentation, along with all experiments affecting man in general.

Ethics committees, clinical experimentation, and protecting the patient's rights

It should be pointed out that in Italian society (and, consequently, in the Italian Parliament) there is also increasing reflection on *ethics committees* destined to represent one of the ways of protecting the person with respect to clinical experimentation.

This increased reflection may be discerned in proposed legislation concerning both pharmaceuticals and the broadened specification of the " rights of the patient. "

The appearance of certain procedural norms on clinical experimentation which are in force on a regional level is also worthy of mention (see the Tuscan law of August 25, 1978, no. 59).

I shall briefly dwell upon these topics.

Senate Bill no. 269 presented on October 26, 1973 and entitled " Norms on Clinical Experimentation with Pharmaceutical Products " (Senator Bompiani and others) for the first time in Italian law provides for obtaining the patient's " informed consent " in accordance with international norms.

Moreover, it contains the proposal to institute a local " Commission " to ascertain the concrete *feasibility* of projected experiments, in conformity with the approved research program. All responsibility is, however, left to the experimenter. It must, furthermore, be stressed that, according to Italian provisions, no product may be submitted to clinical testing unless it has first been screened by two ministerial commissions initially judging it to be " harmless. "

In the bill, still in a preparatory phase as regards the " protection of the patient's rights " (Senator Bompiani and others), there is, however, provision for instituting ethics committees at large hospitals with diverse specialties which could deal with clinical drug experimentation, along with all other health care problems offering significant ethical aspects.

The committee's specific task is to express nonbinding opinions on experiments and those medical acts seen to be charged with ethical overtones or religious implication and, therefore, rendering decisions especially problematic.

With respect to experimentation in particular, it is made obligatory for the experimenter as a first step to obtain the Ethics Committee's opinion through the Health Care Director at the hospital where the research is being conducted.

In the event this opinion proves negative, the experimenter may still begin his study, but must so advise the patient opportunely and also report the committee's position in both the experimental protocols and future scientific papers.

It is the patient's right not to accept or interrupt his participation in the experiment at any time.

In addition, it is the Committee's task to take direct note of indications made by patients and their relatives touching upon the protection of their rights and to stimulate the hospital administration in this direction through active collaboration, especially in the preliminary phase.

Committees may also function culturally as forums for study and debate.

These are the essential components of the proposal.

The Tuscan Region's law of August 25, 1978, no. 59,

dealing with pharmaceutical research on man, provides for formal administrative authorization of experiments.

Moreover, at the three University General Hospitals in the Tuscan Region (Florence, Siena, Pisa), advisory commissions were instituted to make known their *opinions* on requests for clinical-pharmacological authorization.

The Commission, made up of four " specialists " and one " layman, " was responsible for evaluating the following factors:

a) the appropriateness of the experiment and the adequacy of the methodological choices for research in relation to the requirements of the bodies cited in the first article of the law;

b) the competence of the personnel and the suitableness of the premises and equipment at the disposal of the experimenters;

c) the degree of risk for patients or others.

An affirmative opinion may be subordinated to particular conditions or precautions.

The opinion may also indicate other wards in which to conduct experiments and advance proposals addressed to the regional committee on expanding the tests to other facilities, within the limits provided for in Article 1, in order to obtain more complete verification of the success of the experiment.

In the course of experimentation, the Commission may request checks or information of the hospital or those conducting the test. In addition, it must provide the regional committee with data on the experiments being conducted within its jurisdiction and the instructions it has given in this regard. The committee may ask for reports or opinions connected in some way with these points. It should be possible to make public the experimental protocols, and the patient's authorization is judged to have been obtained by his consenting to tests.

In short, the Commission acts in part as an " Ethics Committee " as well, especially in ensuring that procedures receive " publicity. "

Conclusions

Juridical-legislative reflection on ethics committees is also beginning in Italy.

The " models " proposed are still quite varied, and there is no uniformity in criteria on the role such committees should play.

Aside from personal opinions on the topic, I feel it may be maintained that any research project, in order to be acceptable from an ethical standpoint, must, above all, be scientifically valid, though a medical definition of innovation is often delicate in borderline cases.

It must be acknowledged that procedures of no direct benefit to the subject but very possibly beneficial to others are sometimes employed without sufficiently considering all the implications for the freedom and health of the experimental subject. Finally, the appraisal of the risk/benefit criterion is frequently not made through a precise quantification of terms either.

These and other reasons as well provide the basis for the utility of ethics committees, which should calmly evaluate all the implications of an experiment.

According to the aforementioned *Report* of the Australian National Health and Medical Research Council, ethics committees on research can offer the following benefits:

a) for the patient: protection from physical harm, protection of confidentiality, assurance of free and informed consent, support in the face of possible legal implications;

b) for the researcher: a certification of experience and comptence, explicit permission to proceed with research, at least partial protection as regards his legal position;

c) for the institution: protection of its own reputation.

Furthermore, ethics committees have specific educational effects in

— reminding the researcher of his duty to respect human rights;
— recalling national and local research guidelines;
— promoting the adoption of valid research protocols;
— stimulating the members of the committees themselves to undertake in-depth study of the ethical problems in new fields of research;
— ensuring that research will not be inhibited, but stimulated.

On all sides the opportuneness of promoting, but not imposing the researcher's access to the ethics committee is recalled: this seems to be the responsible direction which has offered the best results until now.

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samuel propheta
david rex israel
iohannes evangelista

Giuseppe Moscati: A Holy Physician

When alive, Giuseppe Moscati was already being called " the doctor-saint " by the people of Naples. The Church solemnly confirmed this popular title by declaring him blessed in 1975 and a saint on October 25, 1987

A physician thus ascends, as they say, to the glory of the altars to accompany the great founders of hospital religious orders.

The peculiarity of Moscati — in the view of his biographers — lies not so much in his serene testimony of faith on every occasion and without any fear, or in his religious and devotional practices, as in having luminously demonstrated that the medical profession itself is an exercise of religious life. He thereby transformed this work of outstanding social value into a mission, characterized not only by " good words " and edifying borrowings from religious language, but by complete dedication to the men he encountered along his professional path That is why he had chosen the medical profession — to be close to the suffering But there is an additional factor here as well, a qualitative leap which only an exceptional love can produce — to succeed in bowing before the majesty of every single soul.

Everyone recognized his extraordinary capacity for making quick, balanced, and precise diagnoses. We believe that, unlike other doctors, who stopped at bodily symptoms, he had deeper insights placing him directly in touch with what he jokingly called " the mistress of the house " — i.e., the patient's soul.

Moscati's life was short — barely 47 years. Born in Benevento on July 25, 1880, he died suddenly in Naples on April 25, 1927, halfway through a busy, demanding work day like any other, beginning at dawn with Mass and Communion, continuing with visits at the Hospital for the Incurably Ill, where he had been chief physician since 1919, an hour of teaching at the University, and then, after a light meal, appointments at his office which, for the poor, were free of charge and, in cases of destitution, accompanied by a sum of money

As the excellent scientist he was, he could have paid more attention to his university career, but did not wish to abandon personal contact with the common people for this reason. He nonetheless authored 32 scientific studies, qualified twice for professorships, and participated in international congresses on physiology. His concern at the university was to train physicians who would practice their profession as a mission.

" Pain, " he once wrote, " should be treated not as a muscular contraction, but as the cry of a soul that a brother, the doctor, rushes to with the fire of love, charity, caring for the body and the spirit, without limiting himself to the cold prescriptions to be sent to the pharmacist. "

" Blessed are we physicians, " he further wrote, " so often incapable of overcoming a disease, blessed are we if we recall that, beyond the bodies, we are faced with immortal, divine souls, whom the precept urgently requires us to love as ourselves. "

The biographies narrate numerous episodes wherein this " beatitude " of the physician shines forth. He was perfectly familiar with all the back streets and alleys of the old part of Naples, where most of his poorest friends lived, and circulated there with a sureness which surprised whoever went in his company

And in the professional environment, in which attitudes of positivism and openly declared atheism prevailed in those years, his frank testimony of Christian faith always won the maximum respect.

When initiating an autopsy in the presence of students, he would make the sign of the cross before the corpse.

And in the anatomy theater he had a crucifix placed with the inscription:

" I will be your death, O death " He called his colleagues and the young students to inaugurate the theater, and a doctor later observed, " We had been invited to pay homage to Christ, to Life, who, after an excessively long absence, was returning to that place of death. "

A physician by vocation from youth onwards, Moscati thus demonstrates that sanctity can be in the world, in daily life, in work, in one's profession, without undergoing diminishment, but burning peacefully as a light in the darkness

DR. GIOVANNI FALLANI
Director of the S I S Agency

Testimony

Depression, a Problem of Our Time

Address at the World Health Assembly

Statement to Madagascar Bishops' Health Commission

Spain: University Institute for the Health Apostolate

Depression, a Problem of our Time, and the Christians in Psychiatry Association

Psychiatry and mental hygiene, a planetary problem

At the same time as basic problems in the fields of malnutrition, infectious dieases and general hygiene are gradually being overcome, it is becoming apparent that mental hygiene is an important factor in all societies. This need, which is medical in origin, also embraces many other fields: psychology, sociology and culture are all involved in the drama of mental disturbance.

A Christian reflection

In 1947, seven chaplains joined forces with Fr. Auguste Bernard and Doctor Suzy Rousset, chaplain and head physician at Rennes Psychiatric Hospital, to lay the foundations of an association for pyschiatric hospital chaplains. Pastoral care of the mentally ill presents delicate problems; one has to learn how to form worthwhile relationships with frequently changeable sick peole, how to recognise their various types of illness.

The need was soon felt to bring together in this association all health care personnel in psychiatric hospitals and to conduct a serious discussion from a Christian point of view on the many delicate problems posed by mental illness and the therapies and theories espoused by psychiatric and psychoanalytic doctors in the field of mental illness.

It is for this reason that priests, religious and health care workers (doctors, nurses, social workers, psychologists) working in psychiatry feel the need to study and discuss together. This is the scope of the Christians in Psychiatry Association founded in France in 1947 and connected organically to the Health Commission of the French hierarchy. At first, only psychiatric hospital chaplains were members. Later, religious sisters began organizing meetings and at length all health care personnel and many people interested in the Christian problems posed by mental illness came to swell the ranks. It is now open to all Christians from every confession, as can be seen from its organizing committee.[1]

This group of Christians has followed the evolution of psychiatry step by step, as well as the pastoral care which it involves. The themes discussed exemplify this: the sense of guilt, the humanization of hospitals, sexuality, suicide, psychotherapy and individual freedom, the ecclesiastical apostolate, etc. Christian anthropology and the ethical requirements that are its consequence have been the guiding light of these deliberations. The association has also obtained the means necessary for the attainment of its objectives. It organizes meetings every two years in order to discuss the matters submitted to its attention. It has founded a review: *Présences et perspectives en saluté mentale*; in October 1980 the 103rd number was produced. There are periodic formation sessions for new chaplains. Various regional pastoral days are organized.

Upon the initiative of one of its founders, Fr. A. Gebus, an international meeting is held regularly in the emblematic city of Strasbourg.[2] The 5th international congress took place in Strasbourg from September 15th to the 19th, 1986.

Representatives from nine European countries have taken part in these meetings, which have discussed the major themes of Psychiatry. Famous specialists gave very useful guidelines to the participants.

Among the major themes discussed, a principal one has been the faith life of the psychotic person, something which had never before been the object of discussion. A broad inquiry was launched; out of 7,000 questionnaires sent out, some 500 replies were returned, and these allowed a picture to be drawn up of the difficulties involved in the life of faith of the psychotically ill.

Psychoanalysis and faith were the subject of another session, a delicate matter which always arouses much interest. There are psychoanalysts who arrogate to themselves the right to make judgements about everything: for these, Psychoanalysis is a philosophy; there are others, closer to concrete reality, who prefer to confine Psychoanalysis to its own field, that of Psychology.

The last two congresses have attempted to give a Christian perspective to the major problems of today: " Man, a problem of our times, " and " Depression, a problem of contemporary man. " (The second part of this paper is a detailed report of the September 1986 meeting) The previous one was a most important congress which established the principles of Christian anthropology as the basis of judgement of the mentally ill and their treatment. The sick person considered as a human being, redeemed by Jesus Christ, and having an eternal destiny is someone who is evaluated and treated in a different manner.

These congresses have a participation rate of between 150 and 200 health care workers (chaplains, doctors, nurses, and psychologists), and they always enjoy great prestige.

A recent congress on depression

The problem of the growing importance of depression in our society was the reason behind the meeting of September 1986.

Depression, known from the origins of human history, is described at great length in psychiatric treatises. Under this general heading are grouped together various illnesses of varying intensity and etiology, from the great melancholic psychoses to neurotic depressions and those stemming from origins as distinct as old age and serious or painful illnesses (cancer, etc.).

Progress and limitations of medicine

In the past forty years, Medical Science has elaborated various medical and psychotherapeutical treatments, and these have known marked developments. The phenomenon of depression, however, is not a monopoly of medicine, indeed far from it; failures of therapies are by no means rare.

Are we not faced, at least in part, with an existential (spiritual if you will) puzzle?

Environmental materialism

It is an easy affirmation to make, but Professor Staehlin from Zurig, with his results at hand, proposes a real crusade since many depressed people are, in his opinion, victims of the wave of materialism that is swamping us. He has perfected a method of cure that

starts from Zen, relaxation as taught by Schultze, and the Spiritual Exercises of St. Ignatius, as well as physical training to strengthen the body, pious invocations, rhyming poetry and periods of listening to music.

On another level, Professor Lukas, following his master, Frankl, is trying to give new meaning to the lives of young depressed people, hosts of them victims of a too-easy materialistic way of life, undefended or fascinated by their surroundings; they want to have but do not know how to be. The entire art of the therapist consists in getting them to discover that life wants something from them.

Are there differences according to religion?

Another interesting line of research is the comparative study of depressions and suicides in relation to the predominant religion of a society or group.

The noble face to face of Protestants tends to be at the price of a higher risk of depression or suicide, to judge from careful sociological studies (Dr. Prinz). Pastoral direction, confession, the dynamic of forgiveness among Catholics would appear somewhat more reassuring. The experience of guilt, melancholic ramblings, are different in the various different Christian confessions. Further, differences can be noted in the case of Jews. Even the Talmud and the attitude of the Jewish community have their own special features (Dr. Jablon).

A wider interpretation is attempted by those who see the different forms of depression in relation to the main categories of social and religious systems: (1) animistic, polytheistic societies; (2) monotheistic and closely cohesive groups; (3) individualistic monotheistic groups; (4) individualistic technological societies (Dr. Moussaiou).

This sociological picture of depression goes hand in hand with the historical study of it, with its three components inherited from the past: the medical viewpoint, or organic, supported since the days of Hippocrates; the philosophical standpoint (see: Seneca and Cicero) which leads in the direction of conscience and, eventually, psychotherapy; the religious point of view, supported by Christianity: the " inaction " of the hermits, which possibly has modern reincarnations (Dr. Hubert).

The biological bases of depression

A general study of depression, however, cannot but make mention of the important contribution of neurophysiology, neurochemistry and genetics. At this meeting in Strasbourg, Fr. Kammerer recalled the contemporary hypothesis, well-known for its use of the synaptic neuromediators. He put us on our guard against various illusions which would not allow the administration of pharmaceutical compounds even in the classic, serious forms of depression, risking thereby leaving people to suffer intensely, waste away and perhaps even commit suicide in some cases.

Moral forces and faith endangered. Appropriate pastoral care

The weakening of moral and psychic forces in the depressed person can sometimes lead to the loss of the emotive and personal basis of his faith (Fr. Hohle). The primal basis of his devotion can be a break in this personal disaster but the force of depression can wipe everything out. From this derives the importance, for the pastor and the people around the sick person, of understanding this phenomenon and letting medical treatment take its course before attempting to restart a dialogue. Starting from these facts which the meeting brought to our notice, the role of the priest (and of those exercising pastoral care in general) appears much more specific. The contribution of a chaplain from France, and another from Italy, a Canon Law expert in the Roman Rota, Frs. Jardine and Paolo, plus that of a team of psychiatric nurses, showed us the outlines of pastoral care of the mentally ill. Here are the five most important points in this:

— What sort of meeting, what form of intelligent compassion should be adopted?

— Only use the Sacrament of Reconciliation in cases where awareness is present.

— Know how to analyze the patient's sense of guilt.

— The importance of the image of a Father-God - in reference to that written into the history of the depressed person.

— The sense of suffering of the patient

This meeting sought to invite all the participants, even the more skeptical, to have more optimism, less technical aridity, and, above all, to be more aware.

Dr. P. BROUSSOLLE,
Psychiatrist at C.H.S.P. Vinatier, Bron

CANON A. GEBUS,
Chaplain at C.H.S.P. Stepnasfeld, Brumath (France)

Address by Monsignor Justo Mullor, Head of the Delegation of the Holy See, at the Fortieth World Health Assembly, May 8, 1987

First of all, the Holy See Delegation offers its congratulations to the President of this Assembly on his appointment and to the W.H.O. Director General for the brilliant and constant activity that the Organization has carried out during the past year in order to improve health conditions in the various continents.

Among the themes proposed to this Assembly, my delegation, like many others — has chosen AIDS as the subject of its address to the Plenary Assembly Actually it is an epidemic which, beyond any superficial consideration and particular circumstances, raises fundamental problems — social problems — that require special attention

The effort made by the Executive Council and the Director General, in order to provide clearer information on this subject, provides evidence of it, as well as the inclusion of AIDS in the General Work Plan for the 1990/1995 period, which envisages the need to take social and psycho-social measures to curb a further spreading of this disease (see doc. A 40/6, 13 13 — 612)

My Delegation agrees on the idea that therapeutical measures are not sufficient to curb AIDS. The close relation between its diffusion and man's sexuality, between the latter and the control of interpersonal relations, requires the consideration of the physical, ethical and social aspects of the problem for the definition of the right measures to prevent and wipe it out.

If we consider medicine as " the art of treating and curing men, " and not only a physiological technique, man, in his wholeness, with his body and soul, his certainties and mysteries, his strength and his weakness, has to be the focus of all our thoughts, when we look for the most effective means to fight against AIDS.

On the basis of this consideration, scientifically proved data have shown that interpersonal relations require an atmosphere of confidence and mutual respect to be correct and to avoid psychic traumas. Otherwise physical or moral relations that become its social expression would be distorted and would lead to distrust, exploitation, oppression and to considering the partner as a mere object without human character.

This occurs especially in the field of sexuality owing to the close relation between its mechanisms of action and the sphere of affectivity and human fertility.

The lack of confidence — true intimacy — makes sexual intercourse artificial and deprives it of that " meaning " considered by Victor Frankl, the great Viennese master of modern psychiatry, as the foundation of any human action. Therefore, it is evident that politicians and experts responsible at the various levels for the health care service, in their efforts to find adequate measures to curb the spreading of HIV and vaccines and drugs necessary to treat AIDS patients, have to make all the people concerned aware of the obligations they are called to fulfill for the accomplishment of these fundamental choices Special care is needed for young people who have to make the important affective choice which would lead them to proper emancipation and to the constitution of their families What we have to accept is the idea of the absolute need for a complete formation of the human being in his wholeness.

Therefore it is necessary to restore the proper dignity of marriage, considered as a stable and legally recognized union between a man and a woman. This follows from common sense and especially from the elementary psychology according to which the precepts of the most important religions consider marriage as the normal condition for the correct satisfaction of human affectivity and fertility. Ignoring the psychological and social importance of marriage, or considering it a mere stable union on different bases, not only is contrary to what the history of mankind and the noblest cultural traditions teach us, but also represents an anthropological contradiction.

As John Paul II recently re-stated, sexual intercourse is necessarily related to marriage, which finds its fundamental expression in mutual giving; without this sexual relations lose their original and deep meaning.

One of the moral lessons of the *AIDS phenomenon* was underlined, a month ago, by *Monsignor Fiorenzo Angelini*, Pro-President of the Pontifical Commission for the Apostolate of Health Care Workers. He said: " *This new virus concerns not only science, but also the concience of men.* "

As a matter of fact, it is not possible to keep one's integrity by passing from a sometimes neurotic puritanism to suicidal permissiveness, which looks for anarchic pleasure, lacking any moral implication.

Fighting against the AIDS virus is right: WHO can be proud to be a pioneer in this fight. It is necessary to consider the victims of AIDS as sick people who need special care; that's why, besides the civil institutions directly involved, the various churches are also giving a good example of commitment in this field, which is the fruit of evangelic love and of the great ecclesial tradition of active charity ensuing from that love. The initiatives promoted by the Cardinal Archibishops of New York and Sao Paulo are noteworthy. To find efficacious vaccines and medicines is a pressing problem: all the most important laboratories in the world devote most of their work to this research But it is also right, necessary, and urgent to clarify some ideas and to give the proper orientations to men, who must be the masters, not the slaves, of their most sacred and lofty instincts.

Medicine and politics cannot but have concern for all the ideological aggressions which try to reduce sex to a mere mechanism of free and uncontrolled pleasure

Refusing to admit the dangerousness of these aggressions would amount to an attempt on the moral and physical integrity of a large part of the world population, and, in particular, young people. An objective and unbiased look at some literature, which presumes to inform, but, in actual fact, forms on sexual behavior, suffices for us to come to the conclusion that we need to promote " human ecology. " Flora and fauna are not the

only problems to be concerned with.

In trying to avoid meaningless or hypocritical moralisms, it is necessary to be concerned with the " moral deterioration " of men, who have to bear sometimes vile external pressures, which exploit fears, ignorance, violence, sexuality and egoism, and which, as a consequence, cause psychical and physical trauma that is very hard to control

AIDS is perhaps a providential challenge Far from being considered as an apocalyptic punishment, AIDS should be seen as an exhortation to a right revaluation of sound morality concerning the intimacy between a man and a woman, and should help to get over the phase of mere pleasure-seeking. Then, it will be possible to cross the threshold of a new era in harmony with the dignity of a generation which has reached the moon and looks at cosmic horizons The Director General's report is supported by the most recent statistics on the " geography of AIDS. " They show that, despite the increase in AIDS cases registered in Africa from March 1986 to March 1987, the insidious epidemic is widespread in the Americas and in Europe, where there are 41,514 cases of AIDS out of the 45,597 registered on the five continents. Therefore, AIDS could be defined as an endemic disease of rich areas. This statement has a deep meaning for those who, like my Delegation, must be concerned with the ethical aspects of human reality.

This problem has to be examined on objective and unbiased bases. The scientific method implies the impossibility of pre-establishing the relation of cause and effect between consumer society and AIDS. But the cold examination of figures shows the existence of a real and objective problem. This consideration allows us to advance a hypothesis: development ignoring the imperatives of the most elementary morality, and subjected to the law of consumption, affecting natural needs and the noblest human instincts, is fictitious, merely quantitative development. My Delegation thinks that in the interdisciplinary study of the " AIDS phenomenon " which is being carried out by WHO and other organizations, the developing countries should demand the consideration of this hypothesis. These countries have often supplied the raw materials — without being fairly paid — necessary to the present stage of development, which, in some ways, has proved to be useless and negative.

The third world has the right to be exhaustively informed on this development proposed from outside, and to choose other patterns that could offer to the populations of Africa, Latin America, and other countries a future free of any fear for the physical mental and moral integrity of their children. It also has the right to utilize the large funds that the industrialized countries must grant for the control and the prevention of the HIV epidemic. A further legitimization of this right is given by the consideration that, in the health care field, the developing countries have to bear other epidemics caused by malnutrition and by underdevelopment. Fighting against HIV and, at the same time, against onchocerciasis, the African sleeping sickness, malaria or gastroenteritis caused by polluted waters, means to oblige the third world to fight on two fronts. Obviously, all this will prevent it from reaching the public health standards which would give it access to the developed world. Following his usual impartial criterion, the WHO Director General observed in his report that the AIDS problem has to be considered from an overall point of view, including its logistic, epidemiological, economic, legal, political and ethical aspects. My Delegation perfectly agrees on this wise assertion: It is the only one which can guarantee the defeat of AIDS and can establish its deep etiology It corresponds to the most enlightened public opinion stated in a prestigious Genoan publication that cannot be considered either over-devout or moralizing. At the commencement of our sessions, it reported that AIDS raises an important ethical problem; it is the biggest challenge to liberal society in times of peace, and — as Paul Henri Spaak said — we have to want the consequences of what we want "

Mahler too, in his clear and frank introductory speech, in 1986, said, " Some Member States follow a political philosophy, others an economic one, others a cultural one and the rest a religious one. I think that our health care philosophy may involve all of them, not with the purpose of changing them, but trying to give them an additional dimension "

Therefore, as far as AIDS is concerned, it is necessary to find out the right measures to fight against it by considering all the consequences that the HIV virus has caused all around the world.

MADAGASCAR

Address of the Pro-Nuncio to the Episcopal Health Commission

I thank you, Monsignor Zevaco and Monsignor Vollaro, for your invitation to participate in this meeting of information and reflection seeking to lay solid foundations for the recently established Madagascar Episcopal Commission for the Apostolate of Health Services And many thanks to you all who attend this meeting for what you are and for what you do.

I am happy to be among you, not only because I thus see realized a wish of the Holy Father, i.e the establishment throughout the world of the Episcopal Commission for Health, but also because this initiative is in line with the particular attention and solicitude which, in different forms, the Nunciature has always shown for the world of health

In fact, if I myself and my collaborator almost every Sunday visit hospitals, we do nothing more than continue with joy a custom that my predecessor, perhaps after the experience of his hospitalization in Girad and Robic, inaugurated.

You have asked me to set forth some ideas on the organization and purposes of your Commission, which is starting its activity I find it useful, in this connection, to draw my inspiration, *mutatis mutandis*, from the Apostolic Letter in the form of a Motu Proprio, *Dolentium Hominum*, by which, on February 11, 1985, John Paul II established the Pontifical Commission for the Apostolate of Health Care Workers

This document recalls, at its beginning, the reasons for the permanent solicitude of the Church for the Apostolate of Health.

Let us, therefore, listen to the Pope so as to strengthen ourselves in the conviction of the value of our commitment.

" 1) The deep interest which the Church has always demonstrated for the world of suffering is well known. In this, for that matter, she has done nothing more than follow the very eloquent example of her Founder and Master. In the Apostolic Letter *Salvifici Doloris* of February 11, 1984, I emphasized that in his messianic activity in the midst of Israel, Christ drew increasingly closer *to the world of human suffering*. He went about doing good, and his actions concerned primarily those who were suffering and seeking help (no. 16).

" In fact, the Church, in the course of the centuries, has felt strongly that service to the sick and suffering is an integral part of her mission, and not only has she encouraged among Christians the blossoming of various works of mercy, but she has also established many religious institutions within her with the specific aim of fostering, organizing, improving, and increasing help to the sick. Missionaries, on their part, in carrying out the work of evangelization, have constantly combined the preaching of the Good News with help and care of the sick.

" 2) In her approach to the sick and to the mystery of suffering, the Church is guided by a precise concept of the human person and of his destiny in God's plan. She holds that medicine and therapeutic cures be directed not only to the good and health of the body, but to the person as such, who, in his body, is stricken by evil In fact, illness and suffering are not experiences which concern only man's physical substance, but man in his entirety and in his somatic-spiritual unity. For that matter, it is known how often the illness which is manifested in the body has its origins and its true cause in the recesses of the human psyche.

" Illness and suffering are phenomena which, if examined in depth, always pose questions which go beyond medicine itself to touch the essence of the human condition in this world (cf G.S., no. 10). Therefore it is easy to understand the importance, in the social-health care services, of the presence not only of pastors of souls, but also of workers who are led by an integrally human view of illness and who as a result are able to effect a fully human approach to the sick person who is suffering. For the Christian, Christ's redemption and His salvific grace reach the whole man in his human condition and therefore reach also illness, suffering, and death. "

This sector, therefore, poses delicate and unavoidable questions concerning not only the social and organization aspect, but the *ethical and religious one* as well, because in it fundamental " human " events, such as suffering, illness, and death are involved, with problems related to the function of medicine and the physician's mission towards the sick.

Consequently, the new frontiers for the progress of science and its possible technical and therapeutical applications touch the delicate area of life in its very beginning and deepest meaning. (Cf. the taking of a position on this matter by the Holy See through its *Instruction on Respect for Human Life in Its Origin and on the Dignity of Procreation*).

This requires a *coordinated answer* at both the international and national level (and this is why the Pontifical Commission and the Episcopal Commission, respectively, were established). In fact, the necessity of better coordinating the Catholic bodies at the service of the world of health had already been realized in 1983 by the Pope, who, in his address to Catholic physicians delivered on October 3, had preconized it.

" For this purpose, " His Holiness stated, " individual action is not sufficient. What is needed is intelligent, planned, constant, and generous work collectively carried out ... within every country ... and on an international scale. "

Such coordination should aim primarily to foster and spread *ever more adquate ethical-religious training of all Christian health workers* throughout the world, taking into account the situations and specific problems they must face in the practice of their profession. In the future these efforts must further *support, promote, and intensify* the *indispensable activities of study, research, and planning* related to the above-mentioned problems of health service, in the Christian vision of the true good for man. Serious and delicate ethical problems arise in this sector, wherein the Church and Christians must courageously and unequivocally intervene in order to protect the essential values and rights deeply rooted in the dignity and supreme destiny of the human person.

Spiritual assistance should hence be accompanied by an effort aimed at the *forming of an ethical conscience among health workers* and, I think, the commitment to help those Christians and believers who so wish to be true to the actual realization and not only the doctrinal enunciation of responsible parenthood in affirming real freedom and the defense of life.

Another problem attracting our attention today is the rehabilitation of drug addicts, while continuing with the huge task of helping the undernourished (wherein we provide help to the State's structures).

After having stated all the foregoing, allow me to express my conviction that the role of the Religious is essential.

In the light of these considerations, I feel that I can tell you that the tasks of your Commission could be the following:

— to stimulate and promote the work of study, training, and action in the world of health;

— to coordinate the activities concerning the services of health and their problems;

— to spread, explain, and defend the teachings of the Church about health care and favor their penetration into the country's health practice;

— to establish a dialogue with the Ministry of Health as well as contacts aiming at fruitful cooperation with our fellow Christians who are not yet in full communion with us but are nonetheless also aware that in the sector of morality some really important principles are not known;

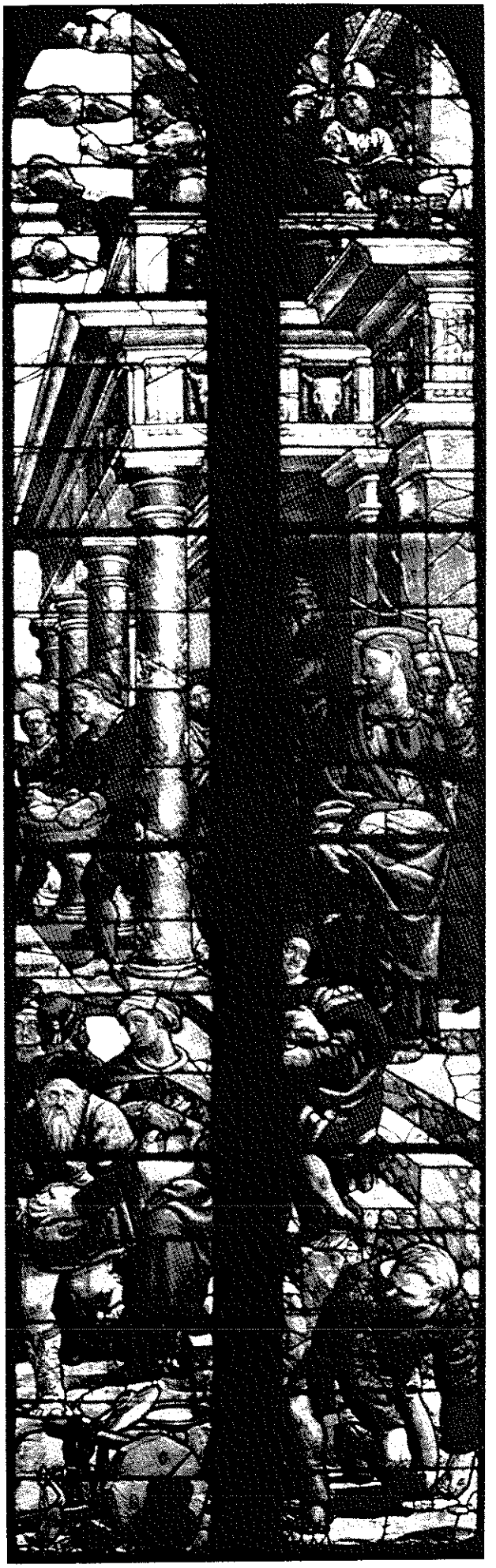
— to observe carefully and study the programmatic trends and actual initiatives of health policy in order to realize their importance and implications for the apostolate of the Church;

— to make the Church aware of new demands arising from new situations in those sectors where the State's bodies do not intervene or cannot work.

In fulfilling its mission, the Episcopal Commission might, of course, ask for the cooperation of experts, establish *ad hoc* panels for some particular questions and also seek the collaboration of other Episcopal Commissions and bodies of the Church.

With all my heart, I wish you every success!

✠ AGOSTINO MARCHETTO
Titular Archbishop of Boseta
Apostolic Delegate in Madagascar



SPAIN

University Institute for the Health Care Apostolate, Pontifical University of Salamanca (Spain)

The University Institute for the Health Care Apostolate (Iupasa) was founded by the Spanish Association of Health Care Religious Women (Fers)

Iupasa seeks:

— to be the gathering place for those persons who want to give a Christian answer to the great questions today affecting the world of Health Care;

— to give a different answer to the new ecclesial, social, health and cultural conditions, in order to guarantee proper formation and to go throughly into the motives of a good pastoral service;

— to consider men in their wholeness, with special regard to the real or potential sick

— to involve society in some pastoral problems that have to be supported by biblical, theological, anthropological and sociological sources and by the theological, moral human, and juridical aspects;

— to form the members of the Health Care Apostolate according to the needs of the Church and of society itself (see the Official Government Bulletin, 21 December 1985, Agreement on Catholic Assistance in Government Bodies, 24 July 1985);

— to establish an agenda of the pastoral plans which are being carried out in the field of health care and, for this purpose, research on new methods of doctrinal and anthropological examination based on the new discoveries is needed.

IUPASA is associated with the Pontifical University of Salamanca. It is governed by its own Statutes approved by the Commission of the University Rectorate on 24 June 1986.

Its purposes are the following:

a) training agents for the Health Care Apostolate capable of performing their evangelizing action in any sector of the health care field.

b) training persons responsible for evangelizing action in the health care field.

The Pontifical University of Salamanca will grant a Diploma to the official students who complete examination, seminars, and workshops included in their Syllabus.

DOCUMENTS FOR ADMISSION:

1. Certificate attesting that applicants have passed the selection exams, for all the students who have never attended university courses.

2. Any University degree received in public Universities or its equivalent. (The Nursing Diploma obtained in the Course of Official Recognition is included).

The Syllabus comprises three Academic Courses. The classes will be held at the Pontifical University of Salamanca, from Monday to Thursday, in the afternoon, from 5 to 7:30

Meetings

Preventive Medicine and High Technology in the First and Third Worlds

Activity of the Pontifical Commission

Visit to India
Japanese Trip
Jerusalem: International Congress on Epilepsy
France: Congress of Catholic Pharmacists
Spain: Meeting of Diocesan Health Delegates
Vatican City Conference
Activities in Italy
Bishops in Charge of the Health Apostolate

Preventive Medicine and High Technology as Applicable to the First and Third Worlds

Most Excellent Brothers in the Lord!

First of all, please permit me to express my profound gratitude to the organizers of this important meeting not only for having invited me to attend, but above all for having bestowed on me the honor of opening your deliberations.

The invitation you have given me and the theme you have chosen for these days of study demonstrate that the Episcopate of the United States has understood perfectly the importance and the tasks of the health care apostolate and therefore also the new Pontifical Commission, of which I am the representative here.

One of the objectives and duties of the Pontifical Commission for the Apostolate of Health Care Workers is to " follow carefully and to study organizational orientations and concrete initiatives of health care policies on both the international and the national levels, with the purpose of discerning their relevance and implications for the Church's apostolate. "[1]

The apostolate is such in the full meaning of the term when it takes upon itself that care for the suffering which is " an integral part of the mission of the Church. "[2]

The plea for health, and therefore for medical help, which rises up from the world today is a direct summons to the human and Christian duty of justice. A duty to which there corresponds a clear right on the part of our brothers. A most serious duty, one which Christ has indicated as the basic standard for measuring our faithfulness in following Him. A duty, both of justice and of that so-called " charity " which we often reduce to a sort of almsgiving that can be left to a discretional use of a feeling of compassion.[3]

The theme you have chosen for your deliberations, the imbalance between medical resources and social justice, is one of the most urgent and dramatic of our time.

It is an urgent and most serious problem, in terms of quality as well as quantity. Indeed, never as today have Science and Technology reached such awesome possibilities in the service of medicine. In spite of this, however, there are still great gaps, entire regions of the world that have not benefited yet, even in countries that have been overwhelmingly Christian for centuries.

I would like at this point to pay heed to the memory of the Scholastic axiom *distingue frequenter* in order to make some introductory definitions of the terms Preventive Medicine, High Tecnology, First and Third Worlds. We are all well aware that the wider the meaning we assign to a term, the more we risk ambiguity. These phrases have become stereotypes by now; they have been worn almost bare by constant use. For this reason, I consider it always helpful, when I want to be clear about the *status quaestionis*, to give at the beginning a clear *explicatio terminorum*.

Introductory definitions

Let me begin with the last two phrases: First and Third World. " Third World " has rightly taken the place of " underdeveloped countries, " which is restrictive and offensive towards peoples who, while living in the poverty that is a consequence of economic underdevelopment, are nevertheless the repositories of significant cultural and ethical values; peoples who, therefore, refuse to consider exemplary and desirable the notion of progress as currently understood in the First World. Moreover, while carrying connotations of deprivation, the concept of Third World is applicable not only to political or geographical areas of underdevelopment. The Third World can be found too inside the industrialized nations of the world, in the great waves of migrants of our age and as a consequence of economic systems which by their very nature are discriminatory. Even in your very rich country, it is possible to speak of the presence of the Third World.[4]

For those of us who regard this problem with a mainly Christian and ethical vision, the Third World is wherever anyone is left outside and deprived of basic human rights. It was in this sense too that the Second Vatican Council widened out the concept of the " missionary " Church, stating that the Church is everywhere in a state of mission, not just in the so-called mission territories.[5]

From the point of view of the apostolate of the Church, the terms First and Third World have to be understood as interacting realities, not conflictual ones. Here, too, I would just like to note — I shall return to it later — that there is now a spiritual underdevelopment which is becoming a really pathological phenomenon, on both the individual and the social level; this must also be taken into account when we speak of First and Third Worlds.

Likewise, the notion of High Technology is not be understood in just a univocal, almost mechanical, sense.

" If placed in a materialistic — Marxist or Capitalist — context, technology is supreme; the infrastructure prevails over the superstructure and conditions it. Identical technological processes are employed in both the North and the South of the world and eventually lead to identical social relationships. "[6]

But, if seen in a cultural context, the perspective alters. If the human genius is so diverse in its manifestations that we have a whole variety of different cultures, why should the same not hold good in the field of technology? The mere exporting of technologies to Third World countries, for example, does not fill the gaps, but rather exacerbates the imbalances. The introduction of technology — especially high technology — requires discernment, wisdom and gradualness. The drama of the lack of spare parts, for example, in countries where high technology systems have been imported in a wholesale manner, has resulted in the consignment of these systems to the museum of unrealized dreams.[7]

So the concept of high technology has to be placed in relation to the level of growth reached by a Third World country in social and economic terms. I would almost be inclined, without wishing to indulge in mere word play, to speak rather of technology able to meet the requirements of a country than of high technology as such. Finally, we come to the notion of Preventive Medicine. This is a reflex concept. Its extension is that of medicine itself. The time has come when Christians especially have to be promoters of an idea of health that does not just mean the absence of disease, or mere physical well-

being but instead something which extends to the whole human person Health which is the real opposite of every type of pathological condition physical, psychic, and spiritual.

After all the necessary distinctions have been made, even if in a summary manner, it must be recognized that all medicine, by its very nature, is preventive and is able to ensure the well-being, at least in the psychic and moral sense, of even the terminally ill.

The relationship between Preventive Medicine and High Technology can, and must, become the standard by which to measure to what extent scientific progress is truly progress of the human race and civilization itself.

The reflections that follow revolve around two themes: 1) Preventive Medicine and High Technology in the Third World; 2) Preventive Medicine and High Technology in the First World.

1) Preventive Medicine and High Technology in the Third World

The inversion of terms — First and Third World — with respect to what is usually assumed, is intentional.

An erroneous custom which has been encouraged by the criteria usually employed by the mass media induces us to consider medical conditions at large in Third World countries in terms of what I would call their most visible expressions: the persistence in wide strata of the population of endemic diseases long since defeated in the First World; the lack of medical and paramedical structures; the absence of social assistance.

Rjoul Follereau, who gave his whole life to the fight against leprosy, used to repeat over and over again that the real urgent need was to combat all forms of leprosy.

It is vain to talk of Preventive Medicine for the Third World and the introduction of High Technology to combat specific diseases and create conditions that prevent their outbreak if we do not get to the root of the objective injustice as well

Health education and technical progress imply the previous assumption of clear notions of the basic, inalienable rights of the human person: from the right to life to the right to education, nutrition, freedom, health and so on Values which do not eliminate each other but which are cumulative

No one person's health will be safeguarded if care is not taken that all peoples and their rights are protected. Preventive Medicine is not a concept that can be separated off on its own The proof of this comes precisely from its connection with high technology.

Endowing the Third World, perhaps even by means of forms of extraordinary assistance, with the achievements of High Technology so as to encourage the development there of Preventive Medicine would degenerate into a mere financial equation unless such a program formed part of a service rooted in the concrete recognition of the basic human rights of all people. In this regard, Preventive Medicine, in its technical sense, is something which comes later on; it could be considered as part only if understood in its relation to the general idea of health.

Moreover, this is the meaning of your recent statement on your country's economic system: technology must be at the service of all, precisely because technological achievement is not an end in itself, but a means for civilized progress. You referred to the Third World element in your country, the most advanced in the world, stating that having so many poor people in a nation as rich as yours is a social and moral scandal that cannot be ignored.[8]

The same judgement, if in opposite terms, needs to be made about countries that structurally and economically are part of the Third World. The importation of High Technology must be scaled to correspond to their cultural and social conditions. It must not be employed in a selective manner but in order to create the conditions of independent growth on a general scale without force.

John Paul II has stated, in his recent Message for the World Day of Peace, that, with reference to Science and Technology, new and marked divisions are emerging between those who have the support of technology and those who do not. Such inequalities do not make for peace or harmonious development but instead aggravate already existing situations of inequality. The Pope goes on to add, however, that if people are subjects of development and its objective, a wider sharing of the progress achieved by technological processes with the less advanced nations becomes an ethical imperative of solidarity, as is also the refusal to make such nations the proving grounds for very dubious experiments or the dumping ground for questionable products.[9]

We are aware that it is precisely Preventive Medicine that can prolong life expectancy which, in Third World countries with rare exceptions is at a low level. But, from the Christian point of view, it is absurd and contradictory, according to the Natural Law, that a program designed to raise life expectancy should be based on demographic campaigns which involve the sacrifice of human lives. It is incredible to think that we have arrived, in more than one instance, at presuming the improvement of medical conditions in Third World countries if human beings that might be subjects of disease, starvation or abandonment in later life could be suppressed at birth.

I have visited very many Catholic medical organizations in Third World countries In some, they are the only, or at least the major, existing medical structures. The urgent need to introduce technology, especially to aid Preventive Medicine, is something noted everywhere among them. The priority problem, however, is not that of introducing high technology, but rather technology which assists and supports gradual and homogenous development of present and possible medical care. This brings me to a consideration of something which I do not think has been sufficiently studied as yet

In Third World countries, the population is generally young. According to the annual statistics published by UNESCO for 1981, only 39% of the population in Latin America was over 25 years of age, as against 60% in Europe. It is true that youth " can be reduced to a mere word " — it can represent just a biological fact that can and is subject to sociological manipulation. The importance of the presence of many young people in the Third World cannot be equated with their importance in the First. But the fact that the majority of people are young can be an important factor in bridging the gap between the need for Preventive Medicine and the introduction of technology. It would be sufficient to ensure that technology does not enter the Third World in the form of preassembled products, but rather as an apprenticeship for the young, so that they can themselves become the principal agents in the application of large-scale Preventive Medicine in their own countries.

In order to achieve progress along these lines, we need to create a mentality that is lacking still, even in our own midst I have always been of the opinion that medical help and pastoral care are not two separate entities; they are two convergent facets of the care of the sick. Furthermore, here we are dealing with two aspects of the same reality: evangelization and human development — never one without the other, but always the two together, because it is one individual that has to be saved.

Two concepts, therefore, should guide us in examining the relationship between Preventive Medicine and High Technology with refer-

ence to the Third World.

First, the development, spread, and effectiveness of Preventive Medicine cannot exist if there is not a foundation of commitment to the recognition and defense of the basic human rights of the person. As regards sharing in the advantages offered by High Technology, this must be understood as something which is gradual, in proportion and scaled to meet the real needs of those to whom it is offered and aiming at producing lasting results in the medium and long terms.

2) Preventive Medicine and High Technology in the First World

I should like to start from a disconcerting consideration in sharing some reflections on this point.

When we think of the situation of Third World countries in Preventive Medicine, there come to mind the great endemic diseases. If we turn our gaze to the First World, a startling observation must be made: the big social disease of the rich and industrialized nations, drug abuse, originates in the Third World.

This sort of mysterious nemesis or vendetta on the part of the Third World countries leads to the creation of exactly the same kind of Preventive Medicine challenges that are seen in those Third World countries with regard to other diseases. And this is without mentioning the menace of the spread of AIDS and the many varied forms of hypertension and neuroses to be found in the First World.

High Technology, which has led to fascinating advances in Medicine in the First World, appears impotent in the face of the drug problem.

Without wanting to force the parallel, it can be truly said that to the pathological condition of the Third World there corresponds a psychic and spiritual pathological condition in the First World. This observation should make us prudent in speaking about High Technology, in regard to Preventive Medicine, as an exclusive privilege of the First World.

Thus we come back to the fundamental problem: the recovery or safeguarding of ethical and moral values as the basic condition for the realization of Preventive Medicine in the real service of the whole person and the entirety of the human race.

In your last statement, to which I have already made reference, you rightly maintain that economic questions are part of a wider vision of the human person and family. I do believe, however, that besides this evaluation in general terms, it is necessary to take into account another aspect of the question.

Preventive Medicine and High Technology have extraordinary — inexhaustible — possibilities in the First World. But it is precisely these possibilities that, while opening roads to ever new technological achievements, often involve considerable risks. Scientific experimentation has led to the well-known temptations of genetic manipulation, demographic planning and the practice of euthanasia.

At the same time, there are growing areas of outcasts in the First World countries, entire sectors of the population that are unable to enjoy the achievements of High Technology, and not even the most elementary forms of technological assistance now available. It is sad, not to say tragic, that in the heart of a First World city that has the broad problems that are typical of a Third World city public opinion is urged to rejoice because of the succesful predetermination of the sex of one baby.

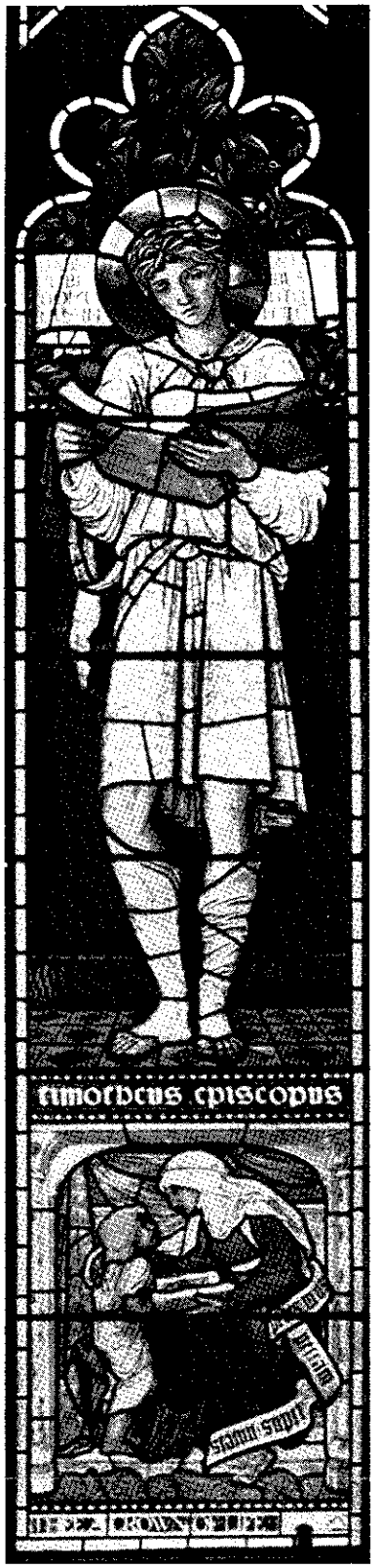
Leaving aside for the moment the ethical and scientific implications of such an event, its social evaluation is sufficient to give us a measure of the extent to which High Technology can trample underfoot every order of priority in the field of medicine and health care.

This paradox, not the least cause of social unease and moral disorder on both the individual and the collective levels, is a direct challenge to the pastoral concern of the Church.

I think we have to be very clear on this point.

The Church is called upon, in First World countries especially, to be an exponent of Preventive Medicine, that is, of the defense and promotion of the basic human rights of every person. We should be grateful to John Paul II for having given us some basic ideas stemming from the unrelinquishable principle of the integrity of the person. From *Redemptor Hominis* to *Dives in Misericordia*, from *Laborem Exercens* to *Salvifici Doloris*, there is a pressing plea to look at the whole person and at the redeeming and healing action of God as the priority in the apostolate, something that must reach each and every person.

An erroneous vision, even — to my way of thinking — inside the Church, often forces us to magnify the importance of individual ethical questions. We have always been aware of the wise distinction between a doctrine of faith and a disciplinary directive; while the former is unchangeable, at least as regards its object if not the terms used to formulate it, the latter is



based on criteria of pastoral opportuneness and therefore can be subject to progressive refinement. I consider certain polemical debates about particular disciplinary directives superfluous and even devious, in that they can call into question basic truths of the faith that cannot be challenged. An illuminated morality is not Illuminism, nor must rationality be confused with Rationalism.

It has always been difficult to obtain the needful harmony between Science and Faith and to respect it in practice. But it is nevertheless a necessary, and a fruitful, harmony. Sometimes it may seem that faith and respect for the Church's directives are a brake on Science and Technology. But this is not so and cannot be so, since the vision of mankind afforded us by Christian Revelation broadens out the horizons of Science; it does not restrict or narrow them.

If the connection between Science and Faith — and by Science I mean Technology as well — had been, perhaps also through our dutiful concern, more close and constant, then today we would perhaps not have had the threat of nuclear disasters, environmental contamination and all the other cosmic tragedies that are now possible.

One thing in the directives of the Church is often forgotten, especially in First World countries: the constant effort of the Magisterium of the Church to respect, in the light of the Revelation of Christ, the basic laws of nature. Cautious waiting and the suspension of judgement have often been found to be providential.

But, to return to our specific theme, Preventive Medicine, it is a primary duty for us Christians — and particularly for us Pastors — to insist that assistance, even in the strictly medical sense, be inspired by the principles of the dignity of the human person.

Christ, who showed himself in his preaching and ministry to be " a doctor for both bodies and souls " — in the felicitous phrase used by the Fathers of the Church — asserted that he had come to give life, life in all its fullness. The Preventive Medicine which we must support, promote, and defend is Medicine for Life.

Nothing would be more dangerous in the way of acting of the First World than to pretend that the great achievements of technology have already given man more that he dared hope. The downward imbalance between Preventive Medicine and High Technology in Third World countries must not be transformed into an upward one in First World Nations.

The Pastoral Theology of medical care is called upon to promote a constant balance between Medicine and Technology. The working criteria of this balance — as speakers will have the opportunity of describing shortly — can only be based upon an integral vision of the dignity of the human person.

John Paul II has written in his Apostolic Letter *Salvifici Doloris*: Medicine, as the science and also the art of healing, discovers in the vast field of human suffering the best known area, the one identified with greatest precision and relatively more counterbalanced by the methods of ' reaction ' (that is, the methods of therapy). The field of human suffering is much wider, more varied, and multi-dimensional. Man suffers in different ways, ways not always considered by medicine, not even in its most advanced specializations. Suffering is something which is still wider than sickness, more complex and at the same time still more deeply rooted in humanity itself. "

This profound statement converges with the concept of Preventive Medicine and, I would say, marks a constructive meeting-point between medicine and the pastoral care of the sick.

It is starting from this idea that the Pope goes on in the same document to speak of the medical profession as a vocation. Vocation implies a pastoral commitment towards those who suffer. There are different vocations according to the differences between illnesses, but they are united in the objective of healing, precisely because the object is always the same, the unique and entire human person.

Conclusion

The theme you have chosen for your deliberations is evidence enough of the effort the Church in the United States is making in the field of concrete pastoral action directed towards contemporary problems.

Let me end with an invitation. I have often said that the present Pope, intervening for the first time in the history of the Church with a solemn and wide-ranging letter on the theme of human suffering, and with the establishment of a Pontifical Commission for the Apostolate of Health Care Workers, has accomplished something of historic import. The apostolate is such only when it is also concerned with the field of medicine and health. A glance at the problems of the First and Third Worlds shows the seriousness and the scale of the plea for health that rises up from mankind. So a new field opens up for the Church, a field in which She is called upon to work with new spirit and with creative initiatives. All this, however, will be possible and effective only if carried out in a spirit of complete co-operation. In Christian terms, co-operation is called communion. An action inspired by fraternal co-operation is in itself a credible witness. We Pastors should be the first to be convinced that the maximum we can achieve alone is less than the minimum possible working together.

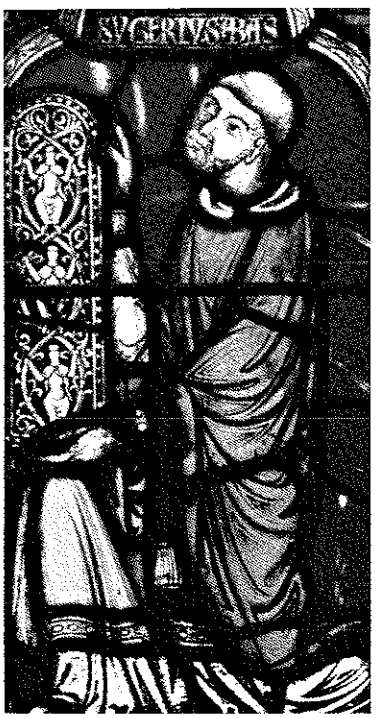
The first, partial survey conducted by the Pontifical Commission for the Apostolate of Health Care Workers has shown how widespread is the Church's presence in this priority area of the apostolate.

In brief, every void that still exists in the area of medical assistance, above all in the area of Preventive Medicine, is a black mark for us. I refer especially to Preventive Medicine because the Church is present in this field of health care on a vast scale in Third World countries, and often too in the most neglected and abandoned areas of the First World.

In asking ourselves what we should do, it is imperative that we examine the areas we have neglected and continue to neglect.

Contact with suffering is a primary and immediate form of contact and communication with the person. We draw near to persons who are suffering not in order to discuss their pain, but to love, and in loving we become receptive to their plea for help.

Technology in all its forms is a tool of incalculable value and effectiveness, but it always remains



an instrument. The starting point is the vocation to serve the human person, the most perfect image of the Creator. The Son of God, taking flesh, chose to assume the condition of the " least. " Jesus, if I may be allowed to put it thus, made himself " Third World " in order to be completely human and to remind us today that our categories have to be seen in a broader light. Third World is every place where someone is suffering, everywhere in the Person of Jesus Christ, who wished to be so personified, we meet our brother.

✠ FIORENZO ANGELINI

Footnotes

[1] Motu Proprio *Dolentium Hominum*, (11 February 1985), 6

[2] *Ibidem*, 1

[3] *Mt.*, XXV; cf. 2 *Cor* 5:10

[4] Cf. FELICIAN A. FOY OFM - ROSE M. AMATO, 1985, *Catholic Almanac*, Huntington, Indiana, 278

[5] Council Decree " *Ad gentes* ", 2

[6] *Il Terzo Mondo può nutrirsi*, Rapporto al Club di Roma, Vita e Pensiero, Milano 1984, p. 108.

[7] *Ibidem*, p. 111.

[8] Final Document of the General Assembly of the National Conference of Catholic Bishops, USA, (10-14 November 1986). Cf. *Origins*, 30 November 1986, 4.

[10] PIERRE BURDIEU, *La Jeunesse n'est qu'un mot*. In " Questions de Sociologie, " Paris, Editions de Minuit, 1980, pp. 143-154.

[11] Apostolic Letter *Salvifici Doloris*, 5.

Activity of the Pontifical Commission

KERALA - INDIA

For a more effective presence of the Church in the world of health

Vatican Radio's newscast of July 31, 1987 included the following report on our trip to the State of Kerala, India:

" The Pro-President of the Pontifical Commission for the Apostolate of Health Care Workers, Archbishop Fiorenzo Angelini, accompanied by the Commission's Secretary, Fr Redrado, is making a 10-day visit, from the 2nd to the 12th of August, to the Indian State of Kerala, where he will meet with local bishops and government officials in the field of health, stopping at hospitals and leprosariums and participating in a Congress of Catholic Health Professionals at Cochin, from the 7th to the 9th of August. The main points of this long itinerary covered by Msgr Angelini and Fr Redrado are Bombay, Trivandrum, Quilon, Ernakulum, Cochin, Trichur, Calcutta, Kottayam, and Kanjirappally. As was previously stated, in Cochin Msgr Angelini will preside over an important convention of Catholic health professionals devoted to the topic 'Towards Better Health' and will speak on 'The Effectiveness of the Church's Presence in the World of Health, Especially in Mission Countries' "

These days were certainly work-filled, but also marked by growing enthusiasm and hope on the way to realization.

We visited twenty-four medical centers, ten bishops in their respective sees, and nine religious communities

The medical centers visited belong to the Catholic Hospital Association of India in the State of Kerala These facilities range from the simplest, most concrete level to the full technological development characteristic of Europe. There is no great complication, only basic activity, preventive medicine, hygiene, pressing social problems.

At each facility we encountered a religious community, sometimes quite numerous We noted the bishops' keen interest in the subject of health, in terms of development, the intensity of the Church's presence, and the good being done Contacts with religious communities outside the realm of health care were only sporadic, but we were able to observe the Church's vocational strength in the State of Kerala and furnish a list of existing communities.

We are duty-bound to thank Fr Ferdinand Kayavil and Fr George S Pereira, Presidents of the Catholic Hospital Associations of India and of Kerala, respectively, for their preparation, coordination, and presence during our trip. They accompanied us in depth and provided us with precise explanations clarifying situations, reasons, and environments.

In an effort to summarize what caught our attention most forcefully, we may mention
— the generous, quiet dedication on the part of religious which is so widely apparent;
— a great many sacrifices by those who believe in what they are doing;
— a task which is never finished;
— clear signs of evangelization in the midst of health care activities;
— fresh, youthful faith; a seedbed of vocations, an immense forest of young plants in need of orientation, growth, transplanting, and communion with the universal Church.

We take this opportunity to thank the members of the hierarchy we have encountered for their kind hospitality and generous welcome. We are most grateful to the numerous religious, priests, and chaplains or bishops' representatives at the hospitals.

VISITS

1. Diocesan Health Center, Palayam Dispensary-clinic under construction.

2. Missionary Sisters of Charity of Mother Theresa of Calcutta, Sishu Bhavam, Kunnukuzhi Center for the children of unwed mothers and school for adolescents.

3. Sisters of the Divine Savior, Deepa Sadam, Pulluvila, Karumkulam, P O Trivandrum. Fishermen's quarter. Dispensary, preventive medicine, home care.

4. Missionary Sisters of Charity of Mother Theresa of Calcutta. Kochuthura, Reivandrum. Center for the elderly and underweight children.

5 Carmelite Sisters. Kochuveli Dispensary and home care.

6. Sisters of the Holy Cross. St Anne's Nursing Home. Pettah, Trivandrum Maternity (12 beds), dispensary, and home care.

7. Sisters of the Holy Cross Bernarda Nursing Home Sankumughom, Trivandrum Dispensary, 12 home care teams, parish with several elderly priests.

8. Canossian Sisters. Poonthura, Trivandrum. St Philomena Dispensary. Fifty persons a day. 375 families receive weekly check-ups for the children. Elementary school.

9 Canossian Sisters. Fatima Hospital Maternity Home. Thumba, St. Xavier's College, P O. Trivandrum. Orphanage (87 girls), maternity (20 beds), home visits, and dispensary

10. Sisters of Bethany. St John's Hospital (belonging to the Malabar Oriental Rite) Leprosarium (40 beds), home care, 2, 790 leprosy victims in the area under treatment. Pirappencode, P.O. Trivandrum.

11. Benzinger Hospital (belonging to the Diocese of Quilon). General hospital with 350 beds, clinic, nursing school, religious community.

12. Holy Cross (Sisters of the Holy Cross). Kottayam. General hospital (400 beds) owned by the Sisters, dispensary.

13. Sisters of the Holy Cross St Joseph's Hospital, Thanky Jn, Shertallai, Alleppey. Maternity-children's hospital with 80 beds.

14. Sisters of Mary Immaculate. Greengardens, Shertallai. General hospital with 200 beds, leprosarium with 200 beds.

15. St. Joseph's Poor Home. Punnapra, P.O. Alleppey. General hospital, elderly women

16. Lisie Hospital Ernakulam, Cochin. General hospital with 650 beds owned by the Diocese of Ernakaum of the Syro-Malabar Catholic Rite 100 sisters.

17. Sisters of Charity (the Child Mary) Lourdes Hospital, owned by the Archdiocese of Verapoly, Cochin. A general hospital with 350 beds, nursing school, 42 sisters of the Child Mary and 10 Carmelite nuns

18. Little Flower Hospital. P. B. 23, Angamalli. General hospital with 600 beds owned by the Syro-Malabar Rite Diocese of Ernakulam, nursing school.

19. Caritas Hospital. Thellakon, Kottayam General hospital with 200 beds owned by the diocese. School of Pharmacy Secular institute with 70 members

20. Little Lourdes Mission Hospital. Kidangoor, Kottayam. General hospital with 100 beds owned by the diocese. School for nurse's aides.

21. Mercy Hospital Chengalam, Kottayam. 125 beds, owned by the Hospital Sisters of Mercy.

22. High Range Medical Centre Pallikunnu, P.O. Peermade, Idukki. A small hospital for tea-growers in the region. Religious community.

23. St. John of God Hospital. Kattappana 250 beds, general hospital, dispensary. property of the St. John of God Hospital Order. 11 Religious. Women's community and novitiate

24. Assisi Hospital. Mukkoottuthara, Kottayam. General hospital with 100 beds, owned by the Franciscan Sisters of All Saints.

Bishops

1. The Most Reverend Simon Ignatius Pimenta, Archbishop of Bombay

2. The Most Reverend Jacob Acharuparambil, Latin Rite Bishop of Trivandrum

3. The Most Reverend Benedict Thangalathil, Syro-Malankar Bishop of Trivandrum

4. The Most Reverend José Fernandez, Latin Rite Bishop of Quilon

5. The Most Reverend Peter M. Chenaparampil, Latin Rite Bishop of Alleppey

6. The Most Reverend Cornelius Elanjikal, Latin Rite Archbishop of Verapoly

7. The Most Reverend Josè Kureethara, Latin Rite Bishop of Cochin

8. The Most Reverend Francis Kallarackal, Latin Rite Bishop elect of Kottapuram

9. The Most Reverend Kuriakose Kunnasserry, Syro-Malabar Rite Bishop of Kottayam

10. The Most Reverend Mathew Vattacuzhy, Syro-Malabar Rite Bishop of Kanjirapally

Religious Communities

At all the hospitals we encountered women religious, generally in large communities. We also visited other residences and novitiates, including the following:

1. St. Bridget's Convent, Vellayambalam, Trivandrum 695003.

2. Franciscan Sisters of the Immaculate Heart of Mary, Pattathanam, Quilon 691001.

3. Missionary Sisters of St Therese, Cherupushpa Nivas Convent, Umayanalloor, Industrial Estate P.O. 691571, Kottayam

4. Mount Carmel Generalate, Alwaye 683106.

5. St. Joseph's Generalate, S.H. Mount P.O. 686006.

6. Visitation Congregation, Generalate House, Nattasserry, S.H. Mount P.O., Kottayam 686006.

7. Caritas Secular Institute, Thellakom P.O. 686016.

8. The Christ Child School, Quilon.

9. Canossian Convent Nirmalashram, Nahakali Caves Road, Andheri (East), Bombay.

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

JAPAN

As we indicated in the last issue, the Pontifical Commission's presence in Japan this past June was especially significant. The country has only a small Catholic minority, representing 0.35% of the total population of 120 million. " Made in Japan " is a phrase which consumer society constantly places before our eyes, reflecting a land where work, technology, industry, and social progress are well-established facts of life

This situation might strike one as an obstacle for our trip, but the truth is quite the opposite. It served as a barometer to measure — precisely in this environment — the space available for the Church's evangelization and the type of language which proves appropriate We have seen and felt that our visit was effected with complete normality; the words " health, " " illness, " " hospital, " " death, " and " patient " pertain to the universal dictionary of mankind and equally affect the Catholic, the Protestant, the Moslem, the Buddhist, the believer, and the nonbeliever. We might say, " We got through to everyone. " Accordingly, it is through such language and common signs that the Church may penetrate with its values, go beyond, evangelize, be present — that is, we stress the importance of this Health Office in the Church as a universal means of outreach, dialogue, and evangelization.

In spite of the Church's being a small minority, the Japanese people highly esteem the spiritual and intellectual activities of the Catholics, particularly in the fields of education, medicine, and nursing.

The general public greatly appreciates the expert attention in social service and medical care provided by personnel at the Catholic facilities.

Most of the long-established Catholic hospitals were created for the victims of leprosy or tuberculosis They successfully met social and medical needs in the periods before and after the first and second world wars.

They have now been transformed mostly into general hospitals serving local residents, with special emphasis on respect for the human person, with all his spiritual, physical, psychological, and social needs; respect for life in our

maternity clinics is well known and highly regarded.

Our Japanese visit focused on two cities, Tokyo and Nagoya.

In Tokyo, we were guests of Archbishop Peter Seiichi Shirayanagi, local Ordinary and President of the Japanese Bishops' Conference. We visited three facilities: St. John's Home Hospital, Bethany Hospital, and Seibo Home Hospital. At all of them we were greeted by signs of respect and fraternity, in a spirit of closeness. We asked about their health, organization, and available means, and visited individually many of the patients and elderly, along with some of the Missionaries at Seibo Hospital.

A short stop at the Jesuits' Sophia University enabled us to contact the infirmary and greet several elderly religious and patients there.

We also paid a courtesy call to the Nuncio of His Holiness, the Most Reverend William Apuin Carew, with whom we conversed at length on the meaning and content of our visit.

Our final act in Tokyo was to attend a reception and colloquium with several leading representatives of Japan's Catholic physicians at the Edmont Hotel. The following ideas stood out in the discussion: the importance of our presence, the significance of the Catholic Medical Association, the favorable evaluation of Catholic hospitals in Japan, and the need to work with non-Catholics.

In Nagoya, we were also guests of the local Ordinary, the Most Reverend Aloysius Nobuo Soma. We visited a center for the physically handicapped and Holy Spirit Hospital, run by the Sisters of the same name.

But our presence in Nagoya was principally motivated by attendance at the National Convention of Catholic Health Care Institutions, in which we actively participated at both the inaugural and closing sessions. Msgr. Angelini at the end of the Convention stressed the nobility of the mission of serving the sick, the need for training to assist human life, and the universality of health and illness, expressing his special thanks to the Pope — so close to the world of medical care — for having instituted this Pontifical Commission, called to animate, coordinate, and spread such noble ideals.

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

JERUSALEM

International Congress on Epilepsy

From the 6th to the 11th of September, 1987 the Seventeenth International Congress on Epilepsy was held in Jerusalem. The Pontifical Commission for the Apostolate of Health Care Workers was invited to participate in the session devoted to " Epilepsy and Religion " by the Congress organizers and asked Dr. Gian Luigi Gigli, neurologist at Rome University II, to represent the Catholic viewpoint in interconfessional dialogue.

Dr. Gigli addressed the topic by bringing out, first of all, the image of the epilepsy patient deriving from the Gospels. He stated that, according to the Gospel account, the epileptic does not appear so much in the guise of the diabolically possessed, but rather as a privileged witness to the passion, death, and resurrection of Christ prefigured in the different stages of his crisis, as is seen particularly in the episode following the Transfiguration. Dr. Gigli went on to deal with the historical evolution of the Church's attitude towards candidates for the priesthood afflicted with epilepsy, especially in the light of the Code of Canon Law. Dr. Gigli concluded by mentioning the contribution the Church can make to break the barrier of prejudice and discrimination still surrounding the epileptic patient in our day.

The other papers presented at the session, moderated by our representative together with a leading Israeli magistrate, dealt with Protestant attitudes towards epileptics; epilepsy in ancient Hebrew sources, in Arab literature of the Middle Ages, and in Buddhism and the Far Eastern religions; and, finally, the influence on human history of manifestations of epilepsy associated with religion (presented by an atheist neurologist from Australia).

The session on " Epilepsy and Religion " opened the Congress and was attended by most of the 1500 participants. On the afternoon of the same day there was another session with free communications devoted to this subject. The Congress Proceedings will be published in volume 17 of *Advances in Epileptology* (Raven Press).

AVIGNON - FRANCE

The Nineteenth International Congress of the Federation of Catholic Pharmacists

Nearly four hundred members of the Federation of Catholic Pharmacists participated in a Congress in Avignon, September 5-8, 1987.

Archbishop Fiorenzo Angelini, Pro-President of the Pontifical Commission for the Apostolate of Health Care Workers, and Fr. Redrado, Secretary of the Commission, were special guests of the Congress.

The theme — " Mass Media, Communication, and Health " — was truly suggestive, bringing out these key terms which the Federation wished to recall in establishing the following principle: " Good communications practice on the part of the pharmacist makes the patient more responsible in the proper use of medicines and improvement of his own health. "

In the context of these ideas papers and reports were read, and Msgr. Angelini delivered the inaugural lecture on " The Catholic Pharmacist: A Living Presence in the World of Suffering. "

The atmosphere was genuinely fraternal, and there was a visible dynamic of growth within the Federation, along with enthusiasm and the search by these professionals for a specifically Christian role.

In the course of the Congress, Dr. Jean Dréano relinquished his post as Federation President. For the past six years he has encouraged the members with enormous dedication. He is succeeded in the office of president by Dr. Edwin Scheer. We wish him every success in his work.

MADRID - SPAIN

Twelfth National Meeting of Diocesan Delegates for the Health Apostolate

From the 27th to the 29th of September, the Twelfth National Meeting of Diocesan Delegates for the Health Apostolate was held in Madrid. Msgr. Osés, the Bishop re-

sponsible for the health ministry in Spain, opened the sessions. He was accompanied in the presidency by Fr. José Luis Redrado, Secretary of the Pontifical Commission, the two presidents of FERS, Fr. Adriano Yugueros and Sr. Antonia Azpilicueta, and the national delegate, Mr. Rude Delgado.

The main topic for reflection was " The Most Needy and Neglected Patients. " The contributions concerning these patients — chronic, elderly, terminal, psychiatric, addicted, severely retarded, and AIDS victims — provided exceptional clarification and gave rise to work groups and a perspective on the challenges these patients offer to society and the Church in Spain Eight experiences involving such people were commented on which indicated continued concern and the implementation of solutions, though on a small scale. An excellent paper by Professor Juan Antonio Pagola supplied and shed light on the major guidelines for assisting these patients

The Diocesan Delegates then presented a proposal for " Patients' Day, 1988 " and also informed on the projects of the various Commissions which have now begun to work within the National Delegation — those devoted to Pastoral Care in Hospitals, the Parish Health Ministry, Mental Health, Education, and Christian Health Professionals. The entire national team had prepared this activity at an earlier meeting.

After closely observing these sessions, we may state that a great deal of progress is being made in Spain in the health apostolate. There is a clear awareness of the problems, and the national organization is becoming increasingly consolidated, along with the responsibility of the Diocesan Delegates; there are many difficulties, but also a healthy dose of experience. The book *Religious Assistance in the Hospital. Pastoral Orientations*, the fruit of the efforts and reflections of many, was also presented at the meeting — a genuine instrument, not only for hospital chaplains, but for all working in this area, especially administrators and heads of hospital departments. The conclusion which might well be reached is that in Spain the health apostolate is enjoying good health

VATICAN CITY

Second International Conference: " The Humanization of Medicine "

For the second time, the Pontifical Commission for the Apostolate of Health Care Workers took the initiative of organizing an international conference, held at the Vatican City Synod Hall This year's topic was " The Humanization of Medicine. " The Synod Hall attracted attention in October as the meeting place of the Synod Fathers where many voices were heard on the role of the laity in the Church. A few days later, November 10-12, it was the scene for world-renowned authorities to deal with subjects like " life and the right to life, " " man and health, " and " man and medicine. " Three Nobel Prize winners were invited to chair these sessions:

Professor K. Sune Bergstrom, Nobel Prize winner in Physiology and Pontifical Academician (Sweden);

Professor Carleton Gajdusek, Nobel Prize winner in Medicine (USA);

Professor Rita Levi Montalcini, Nobel Prize winner in Medicine and Pontifical Academician (Italy).

The highlight of the meeting was the Pope's presence and words stressing the centrality of man and calling for the fullest humanization of medicine today.

The Conference was characterized by an atmosphere of search, study, and genuine contact among professionals who had come from all over the world and represented diverse responsibilities in the health field.

The *Proceedings* of this Second Conference will be published in the first 1988 issue of our journal, *Dolentium Hominum*.

ITALY

Other Activities

Our work " at home " over the past summer and in early fall has been quite intensive: responding to requests for commemorative celebrations at hospitals, blessing the first stone of a new hospital in Pietralata, Archbishop Angelini's and Fr Redrado's attendance at the centennial of Padre Pio's birth, participating in Suffering Day at the Garbatella Center, a meeting at the French Embassy to Italy with officers of the Bioethics Section to deal with the subject of Ethics Committees, exchanges with the members of the Pastoral and Laity Secretariats of the St. John of God Brothers' General Curia, contacts at our headquarters with Spain's National Health Apostolate Team and several diocesan delegates, and, finally, our presence on November 7th at the official inauguration of the CAMILLIANUM Institute for the Pastoral Theology of Health Care, which will train future professionals through master's and doctoral programs in this field.

Organizing and holding the Pontifical Commission's second International Conference, devoted to " The Humanization of Medicine, " also involved numerous contacts by guests with our Secretariat and Committees.

The canonization of the physician Joseph Moscati on October 25th required our active collaboration on a number of levels, but most especially the untiring efforts of our Pro-President, Msgr Angelini.

With the Synod of Bishops, in the month of October our work certainly " peaked " in intensity. Archbishop Angelini was named by the Pope to participate in the Synod, and this fact undeniably entailed an appreciable but " healthy " and gratifying increase in the workload. The sick and the world of the laity associated with health care clearly had a spokesman in the Synod Hall, not only on the occasion of his address and in giving the Synod Fathers copies of the book on *The Laity in the World of Suffering and Health*, but also in daily encounters and dialogue with those in attendance. Many Synod Fathers invited by Msgr. Angelini visited our offices individually or in groups. This was a truly joyful occasion for us, marked by fraternal exchanges centering upon the objectives and activities of our Commission, the importance the Pope attaches to this area, the need to broaden pastoral vision of the world of health, the training of future ministers of the health apostolate, and the new questions being posed today by medicine and biology for the conscience of health professionals These encounters and commentaries were genuinely constructive.

Bishops in Charge of the Health Apostolate

Shortly after the establishment of the Pontifical Commission for the Apostolate of Health Care Workers, we contacted all the Conferences of Bishops, one hundred in all. Among other things, we requested that they name a bishop who, on behalf of the Episcopal Conference, would be responsible for the health ministry in each nation. On several occasions, we further pressed this point, particularly during our visits to various countries. At this time, a little over two years after the Pontifical Commission's coming into existence, more than half the Conferences of Bishops have responded, and fifty-eight bishops have now been named: Africa, 18; America, 16; Europe, 15; Asia, 6; Oceania, 3. We hope to complete this list gradually with appointments to the posts which remain to be filled

The aim of these designations in relation to our work is to provide knowledge of the Health Apostolate by way of a specific interlocutor in each Episcopal Conference and encourage the bishops in organizing and coordinating the Church's presence in this sector. In many countries, not only has a bishop been named to take charge of the health ministry, but a national director has been appointed as well or a small Commission or Secretariat has been created to program and coordinate all the pastoral activity being carried out in this area.

These steps deserve our praise and congratulations and will certainly entail new action, a new style, and an increasingly abundant, rich presence in the world of the sick, health professionals, and all the values associated with health and illness.

We have now had a number of contacts with the bishops appointed, either in writing, or during our trips, or in their visits to Rome, especially for *Ad Limina* visits

It is our hope that these relationships may be solidly structured, and as the list is being completed, we are considering different formulas likely to contribute to a better knowledge of reality, more effective service, and a fruitful exchange of experiences.

We include below the name and address of these bishops

Africa

Most Rev. Mathias Isuja, Bishop of Dodoma, P.O. Box 922 - Dodoma - Tanzania.

S.E.R. Mgr. Jacques de Bernon, Evêque de Maroua-Mokolo, Evêché, B.P. 49 - Maroua - Cameroun.

S.E.R. Mgr. Charles Vandame, Archevêque de N'Djamena, Archevechè, B.P. 456 - N'Djamena - Chad.

S.E.R. Mgr Hubert Michon, Archêveque de Rabat, 1 rue Abou Inane, B.P. 258 - Rabat - Marocco.

S.E.R. Mgr. Chretien Matawo Bakpessi, Evêque de Sokodè, B.P. 55 - Sokodè - Togo.

Most Rev. Dr. Boniface Dalih, Bishop of Cape Palmas, Catholic Mission, P.O. Box 11 - Harper - Cape Palmas - Liberia.

Most Rev. Jams Owusu, Bishop of Sunyani, P.O. Box 9712 - Accra - Ghana.

Most Rev. Felix Alaba Job, Bishop of Ibadan, P.M.B. 5057 - Ibadan - Nigeria

S.E.R. Mgr. Lucien Monsi-Agboka, Evêque d'Abomey, Evêché, B.P. 18 - Abomey - Benin.

S.E.R. Mgr. Anselme Titianna Sanon, Evêque de Bobo-Dioulasso, Evêché, B.P. 312 - Bobo-Dioulasso - Burkina Faso.

S.E.R. Mgr. Pierre Zévaco, C.M., Evêque de Fort-Dauphin, B.P. 47 - 614 Tolagnaro - Madagascar.

Most Rev. Bishop Allan Chamgwera, Zomba Diocese, P.O. Box 115 - Zomba - Malawi.

Most Rev. John Njenga, Bishop of Eldoret, P.O. Box 842 - Eldoret - Kenya.

Most Rev. Mansuet D. Biyase, P.O. Box 941 - 0002 Pretoria - South Africa.

Most Rev. Helmut Recketer, S.J., P.O. Box 680 - Chinhoyi - Zimbabwe.

Most Rev. Bishop Adolph Furstenberg, Bishop of Mbala, Bishop's House, P.O. Box 55 - Mbala - Zambia.

S.E. Mgr Bakole Za Ilunga, Archêveque de Kananga, B.P. 70 - Kananga, Kasai Occ. - Zaire.

S.E.R. Mgr. Evariste Ngoyagoye, B.P. 1390 - D.S. 213 Bujumbura - Burundi.

America

S.E.R. Mons. Hector M. Rivera, Obispo Aux. de San Juan, Arzobisapdo, Apartado S-1967 - San Juan, 00903 - Puerto Rico.

S.E.R. Mons. Priamo Tejeda Rosario, Obispo Aux. de Santo Domingo, Arzobispado, Apartado 186 - Santo Domingo - Rep Dominicana.

S.E.R. Mons. Carlos M. Ariz, Apartado 343 - Colon - Panama.

S.E.R. Mgr. Rodrigo O. Cabrera, Obispo de Santiago de Maria, Obispado, Santiago De Maria Usulutan - Salvador

Rev. Mgr Carlos M. De Cespedes, Apartado 105, Camaguey - Cuba.

S.E.R. Mons. Carlos Talaver Ramirez, Apartado 118-055 - 07050 Mexico - Mexico.

His Eminence Card. John O'Connor, Archibishop of New York, 1011 First Avenue - New York, N Y. 10022 - USA.

Most Rev. Mgr. John A. O'Mara, Bishop of Thunder Bay, 1306 Ridgeway Street, P.O. Box 756 - Ont. P7C 4V5 Thunder Bay - Canada

S.E.R. Mons. Rodrigo Escobar, Obispo de Girardot, Calle 19, n. 11-65 - Girardot, Cundinamarca - Colombia.

S.E.R. Mons. Augustin R. Alvarez, Obispo tit. de Nasbinca, Plaza Bolivar, Machiques 4021 - Est Zulia - Venezuela.

S.E.R. Mons. Javier Prado Aranguiz, SS.CC., Obispo de Iquique, Casilla 18D, Bolivar 588 - Iquique - Chile.

S.E. Mons. Carlos Parteli, Avda. Millan 3279 - Montevideo - Uruguay.

S.E.R. Mors. Oscar Paez Garcete, Alberdi 782, Cas Correo 1436, Asuncion - Paraguay.

Emo Rmo. Card. Pablo Munoz Vega, Av. America 1866 y La Gasca, Ap. 1081, Quito - Ecuador.

S.E.R. Mgr. Jesus A. De Lama, Ceb-Casilla 2309, La Paz - Bolivia.

S.E.R. Mgr. Alfonso Felipe Gregory, Rua Benjamin Constant, 23, 20241 Rio De Janeiro - Brazil

Asia

Most Rev. Diosdado A. Talamayan, Archibischop of Tuguegarao, Archibishop's Residence - Tuguegarao - Cagayan - Philippines.

Most Rev. P.S. Hardjosoemarto, Bishop of Malang, Jl. Cut Mutiah 10 - 1002 Jakarta - Indonesia

Most Rev. Joseph Cordeiro, Archibishop of Karachi, St. Patrick's Cathedral - Karachi 3 - Pakistan

His Eminence Card. Michael Michai Kitbunchu, Archibishop of Bangkok, Assumption Cathedral, 51, Oriental Ave. - Bangkok 10500 - Thailand.

Most Rev. Gabriel Kap-Sou Lee, Bishop of Pusan, 4-81 Dae Cheong Dong - 600 Busan - Korea.

Rev. Fr. Giuseppe Dalla Ricca, MI, Medical Affairs Committee - Chinese Bishops Confr., P O. Box 36603 - Taipei Taiwan.

Europe

S.E.R. Mgr. Guy Herbulot, Evêque de Corbeil, Cours Mgr Roméro - B.P. 170 - 91006 Evry Cedex - France.

His Excellency Msgr. Joseph Mercieca, Archibishop of Malta, P O. Box 29 - Valletta - Malta.

Most Rev. Czeslaw Domin, Bishop of Katowice, ul. Jordana 39 - skr. Pocztowa 331 - 40-043 Katowice - Poland.

S.E.R. Mgr. Theodor Hubrich, H.H. Weinbischof, Max-Tosef-Metzeger-Str. 1 - 3010 Magdeburg - German Democratic Republic.

S.E.R. Mgr. Elamar Kredel, Erzbischof von Bamberg, Obere Karolinenstr. 5 - 8600 Bamberg - Fed Rep. of Germany.

Most Rev. Philip Harvey, Aux. Bishop of Westminster, 4 Egerton Gardens - NW4 4BA Hendon - England.

Most Rev Donald Brendan Murray, Bishop aux. of Dublin, St. Kevin's, St. Agnes'Road - Crumlin - Dublin 12 - Ireland

S.E.R. Mons. Ugo Donato Bianchi, Piazza Pascoli 2 - 61029 Urbino Pesaro - Italy.

S.E.R. Mgr Ante Bogetic, Prilaz Jurja Dobril 3, 51440 Porec - Yugoslavia.

S.E.R. Mons. Antonio Baltasar Marcelino, Apartado 441 - 3808, Aveiro COdex, Portugal.

S.E.R. Mons. Javier Osés, Apdo. de Correos 2, 22080 Huesca - Spain.

S.E.R. Mgr. Jean Tcholakian, Sakizagaci cad. 31, B.P. 183, Beyoglu-Istanbul - Turkey.

S.E. Mgr Henri Schwery, Eveque de Sion, Avenue Moleson, 30 - 1700 Fribourg - Switzerland.

S.E.R. Mgr. Roger Bourrat, Eveque de Rodez, 1, rue Frayssinons, 09000 Rodez - France.

S.E.R. Mgr Maximilian Aichem, Herrenstr. 19, Postfach 251, 4010 Linz - Austria.

Oceania

Most Rev. Peter James Cullinane, Bishop of Palmerston North, P.O. Box 8003, 36 Ihaka Street - Palmerston North - New Zealand.

Most Rev. Petero Mataca, Archbishop of Suva, Box 393 - Suva - Fiji.

Most Rev. Eric G. Perkins, Auxiliary Bishop of Melbourne, 383 Albert Street - East Melbourne Victoria 3002 - Australia.

News from Around the World

THE UNITED STATES

Physicians' Training in Clinical Medical Ethics

The Center for Clinical Medical Ethics at the University of Chicago has announced the creation of a *National Leadership Training Program for Physicians in Clinical Medical Ethics*. Beginning in July, 1988 and continuing for three years, this innovative program will offer three training positions each year to prepare mid-career physicians as leaders of clinical medical ethics programs at their institutions. The program is supported by The Pew Charitable Trusts and The Henry J. Kaiser Family Foundation.

Physician-scholars will receive a stipend of $45,000 plus $7,000 in support allowances during their first year of training at the Center. For the following three years, when physician-scholars have returned to their sponsoring institutions, training will continue through an outreach network coordinated by the Center for Clinical Medical Ethics. The sponsoring institution will receive $45,000 ($15,000 per year for three years) to help support the physician and to develop an institutional clinical ethics program.

The Center has recently been seeking nominations for the first year's program (July 1988-June 1989) from the deans of United States medical schools and from the directors of major health organizations and ethics institutions. Inquiries should be addressed to:

DR. MARK SIEGLER
Professor of Medicine
Director, Center for
Clinical Medical Ethics
University of Chicago Hospitals
5841 S. Maryland Avenue, Box 72
Chicago, Illinois 60637
(Tel : 312-702-1453)
U.S.A.

INDIA

Catholic Hospital Association

Introductory Notes

The Association was founded in 1943 by the Australian doctor Mary Glowrey, who was the first religious to practice medicine in India. Today its active members number nearly 2000. Several government bodies are involved in the Association's activities, but an Executive Director is in charge of its management. The Association is concerned with many important activities such as distributing the medical supplies coming from the Catholic Medical Mission Board (New York), acting as intermediary between its members and government bodies, issuing publications, helping people to find a job, promoting family reconciliation (this is one of India's greatest problems), distributing funds granted to the basic welfare structures, examining and supporting the various projects submitted to its attention, getting high quality supplies with the collaboration of the national government. In the near future the Association will devote all its efforts to the field of health care services and basic welfare structures.

Health Care Department of the Association

Among the Association's main activities there is the organization of courses, seminars, and round-table discussions connected with the health care workers' training in the field of public services; support for plans having the same purposes and therapeutic means in keeping with local needs and resources (for instance: medicinal herbs). The Association acts as a meeting point for the various national and international organizations working in the field of public health in order to successfully perform its activities, especially in South Asia.

Three Issues of the Association's journal Medical Service

The issue worked out by the team for Public Health and Development and entitled " Health and People's Power " outlines the theory and practice of local health activities carried out especially in poor and rural areas. The main target is pointing out suitable methods for all those concerned with the process of making people responsible and capable of making the proper decisions for their welfare. In pursuing this goal, specialists'assistance should be envisaged, in order to help people acquire analytic awareness of the factors affecting their health and of the remedies at their disposal. The involvement of workers coming from the poorest classes and the democratic experience of people's participation in public activities are fundamental in this perspective. Another issue of the journal deals with the development of people-oriented policies

CHILE

Assistance to the Sick

Assistance to the sick is a constant concern of the Chilean Church, which has indeed instituted Ordinary Pastoral Action with this aim. Its task is to evangelize and prepare the sick to receive the Sacraments. It acts in hospitals and other similar facilities under the responsibility of the Episcopal Delegate of the Department of the Ministry to Hospital Workers and the Sick or directly at home through parish priests. The Crusade of Chilean Caritas' Volunteer Service organized Assistance to the Sick in collaboration with the above-mentioned Department, for the purpose of promoting and spreading this apostolate among lay volunteers through their participation in hospital groups and in the parish team of Assistance to the Sick. These volunteers previously attend a National School which periodically organizes specialization courses. Their work is the fruit of their love for God and for their brothers and promotes the sick person's encounter with God

ITALY

Catholic Association of Health Care Workers (ACOS)

The Study Congress and the Thirtieth ACOS National Day, which took place in Rapallo on March 22nd, 23rd, and 24th, 1987, gathered more than 300 participants from all over Italy to discuss the theme " Environment and Health. " In accordance with the trend emerging from the Third ACOS National Congress, " Proposals for a Different Health Culture, " in October, 1986, the participants thoroughly examined the themes connected with the health care workers' commitment to serving man in his wholeness and supporting a more human and Christian life.

ACOS is aware of and receptive to the most recent guidelines resulting from the work of world and community organizations. It points out the need for a world commitment to an " environmental policy considered as a main element of economic, industrial, farm, and social policies " and to " the awareness of one of the greatest challenges of our time, aimed at mobilizing citizens and all the people responsible for seeking suitable solutions. "

ACOS follows the precepts of the Church expressed in the Council documents and in John Paul II's addresses concerning the risks threatening all mankind because of deviations in understanding and exploiting technological progress, which, on the contrary, should aim at the improvement of men's life and actions.

ACOS seeks to avoid the risk of a limited and unilateral outlook that could lead to simple utopian exaltation of a return to nature or to an unreserved condemnation of technological progress, seen as a threat to nature and mankind.

ACOS pursues the following goals: to make its own contribution, on the local, regional, and national level to the elimination of the causes of environmental pollution; to call for changes in the production processes by means of safe and " clean " tecnologies; to suggest the proper steps in the development of a health culture based on prevention and on instilling a sense of personal, family, and community responsibility for well-balanced and sound attitudes and a more sober way of life, respectful to natural goods. Taking into account the specific responsability of the groups belonging to the Association, ACOS thinks that the training of health care workers of any kind and on any level is still centered today on the treatment and relief of the sick.

It calls for a change in teaching programs for the purpose of training workers who think and act in terms of health rather than disease, preventing diseases and promoting health as well as treating and rehabilitating the sick; not only to the advantage of the individual sick person, but also of the family and of the community; as members of a health care team, contributing to and trying to find the most effective ways of utilizing the available financial resources and supplies, in view of the condition of the country's health care situation and of the order of priorities it imposes.

Permanent training of all health care workers is held to be fundamental, in order to inform them and make them capable of informing and acting in the field of preventive medicine and of environmental and personal hygiene, in health care organizations, families, schools, work places, and in the community in general.

In this perspective, ACOS calls on its regional centers and local groups to promote and actively participate in initiatives (such as courses, meetings, debates, campaigns, and radio and TV programs) aimed at developing health care education. ACOS seeks to act on the trade union, political, and parliamentary level, in order to pass the National Public Health Plan, not yet in force, and to promote the goals that, in accordance with those of European WHO, the health care structures pursue for the achievement of the target of " Health for All. "

Considering the basic structures and the prevention services as an essential instrument for the accomplishment of health defense and education, ACOS promotes and supports every local initiative aimed at pointing out flaws and deficiencies and at reinforcing health care workers' freedom of action in the planning and management of services.

ACOS is convinced that the improvement of health, lifestyles, environmental conditions, and services requires the intervention of other sectors of the public administration and of intermediate groups and large-scale information for the active participation of every citizen as well as of the community. ACOS thus confirms its availability for active collaboration with public and private professional associations, unions, volunteers, Church groups, and movements interested in the problem of environment and health.

Educating and promoting health means evangelizing, as stated at the Congress, and ACOS asks all its members to take on this responsibiliy in the most coherent way.

ENGLAND

AIDS: Meeting the Community Challenge

This is the title of a book which deals with ministry among AIDS victims. The book contains many testimonies and specialists' opinions and tries to fill the gaps existing in this field.

ARGENTINA

Bienvenido, Juan Pablo II

These were the words on one of the placards posted in Buenos Aires for the Pope's visit on June 6th, 1987.

With this greeting many professors, doctors, and consultants at the Medicine Faculty of Buenos Aires University expressed their agreement with the following principles of medical ethics:

1) Yes to life from the moment of conception;

2) Yes to the human being, with equal dignity for both sexes;

3) Yes to family responsibility in the upbringing of children;

4) Yes to natural family planning;

5) Yes to the natural insemination of women;

6) Yes to the chastity and purity of life and morals;

7) Yes to the dignity and safety of work;

8) Yes to research within the limits of morals;

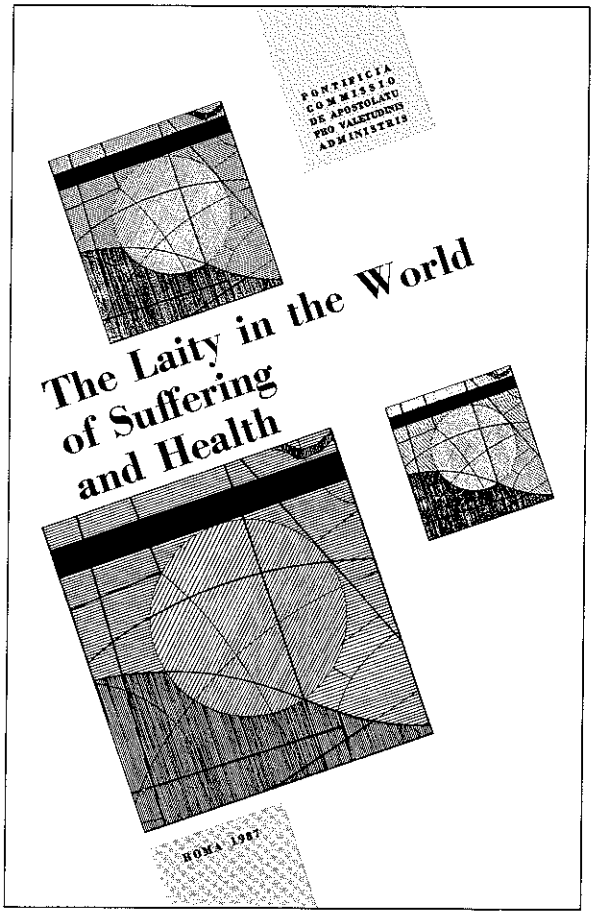
9) Yes to the dignity of natural death;

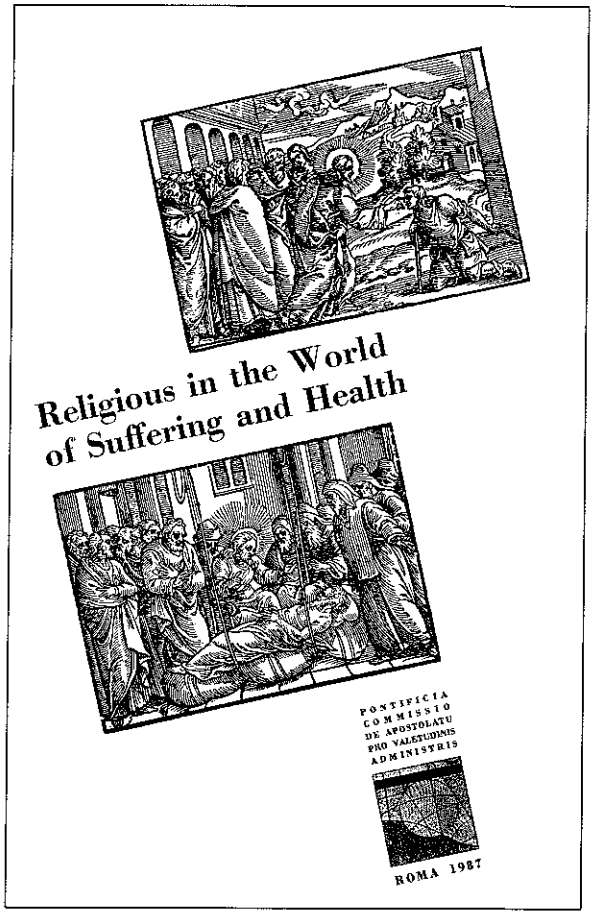
10) Yes to God's own image in every man and woman.

SPAIN

No to the Extension of Legal Abortion

The Spanish Supreme Court rejected the Socialist government's proposal to apply the abortion law for economic reasons as well. The law passed in 1985 remains in force according to which abortion is legal in case of danger of the mother's death, of the fetus' malformation, or of pregnancy due to rape or incest.





Two Recent Documents Prepared by the Pontifical Commission

The Laity in the World of Suffering and Health

Summary of the Main Topics

1. Health and salvation

Life as a gift of God.

To save man is to place oneself at the service of life.

An integrated vision of health and illness.

Being healthy involves balance.

2. The ministry or diaconate of health care

Specific, qualified attention by the Church in her concern for the sick reflecting her vocation.

Whereas professionalism simply involves doing a job, vocation leads to performing a service — i.e., a ministry, which the Christian tradition also terms a " diaconate " — which is becoming increasingly specialized in view of technological progress.

3. Vocation and mission of the laity

The laity's mission derives from Baptism.

Lay witness is most commonly and meaningfully associated with the areas of work, technical expertise, and specific professions.

The vocation and mission of the lay health professional approximate the ministry of Christ Himself, who concentrates on bringing about the conversion of man's heart while prodigiously curing his physical illnesses. His apostolate may thus be regarded as a particularly distinguished ministry.

4. The laity and concern for the sick

Concern for the sick is an obligation of every Christian.

The individual level (witness).

The collective level (coordination, cooperation, technical means).

The ecclesial level (integration into the Church's organic pastoral practice in harmony with the different charisms and ministries).

Openness, dialogue, communion with all groups.

5. The professional function of the laity

Advances in science and technology demand ongoing professional training for the laity.

Honesty and professional competence are indispensable conditions for the apostolate.

The laity's role in caring for the sick includes:

scientific research
health education
practical assistance for the ill

6. Profession and mission of the laity

The lay health worker fulfills a true diaconate of charity in practicing his or her profession.

Health professions are at the service of life (the problems of euthanasia, abortion, experimentation, conscientious objection, and others).

Awareness of health problems (new illnesses, nutrition, etc.).
The humanization of medicine and the need for collaboration.
Accompanying the patient in the final stages (service in a spirit of faith).

7 The hopes of the Church

Research, prevention, rehabilitation.
Lay health professionals will find an indispensable resource for providing care in prayer and the Eucharist, inspired by Christ's own concern for those who suffer.
The lay health worker should imitate Mary in dedication and generosity; She is hailed by the Church as *Salus infirmorum*.

Religious in the World of Suffering and Health

Summary of the Main Topics

1. Contacts with Religious

A vast army of consecrated men and women throughout history at the service of the sick.
They ask about their mission and how to fulfill it today by creating new forms of presence.

2. New situations

Complexity of the world of health: contradictions, experiences.
The world of health involves the whole person and his or her values.

3. Profound transformations

Greater scope of health care.
A new vision of health.
The secularization of society.
The hospital as a crossroads.

4. Problems and challenges for Religious

Questions: How should man be helped today?
A loss of leadership roles.
Challenges in professional activity:
professional qualifications
renewal
adaptations, relationships, responsibility, availability
The cry of the poor and charism
Specific gifts:
confronting the Gospel
revision
identity
credibility
relativity
broad horizons

5. Light along the way

Christ's way of dealing with the sick.
Religious called to be present like Jesus in the world of health: announcing the Good News to the poor
" I have come that they may have life ".
" Whatever you did to these . . . you did to me. "
" Go and do likewise. "

6 The sign of religious life

Bearing witness to God: Converted to God, transformed into new men and women, Religious have undertaken this mission alongside the sick.
Bearing witness to communion: the experience of God, communion, service.

7. The world of health as a place of consecration

Consecrated to God in the service of man.
Health care involves more than treatment.
Man is the center of life (sensitivity, concrete commitments):
to promote life
to fight for justice
to educate for health
to catechize the healthy
to humanize care
to opt for " the least "

8. Service to the sick is evangelization

The testimony of charity
Announcing the Word
Celebrating the Faith
Building the Community

9. Prime concerns

To provide adequate theological, pastoral, and technical training.
To render service to the sick more ecclesial:
collaboration of the laity
involvement of the Church community
To review activities.