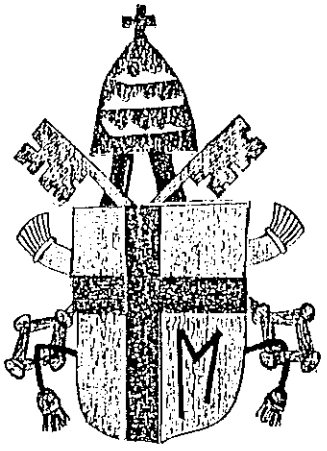

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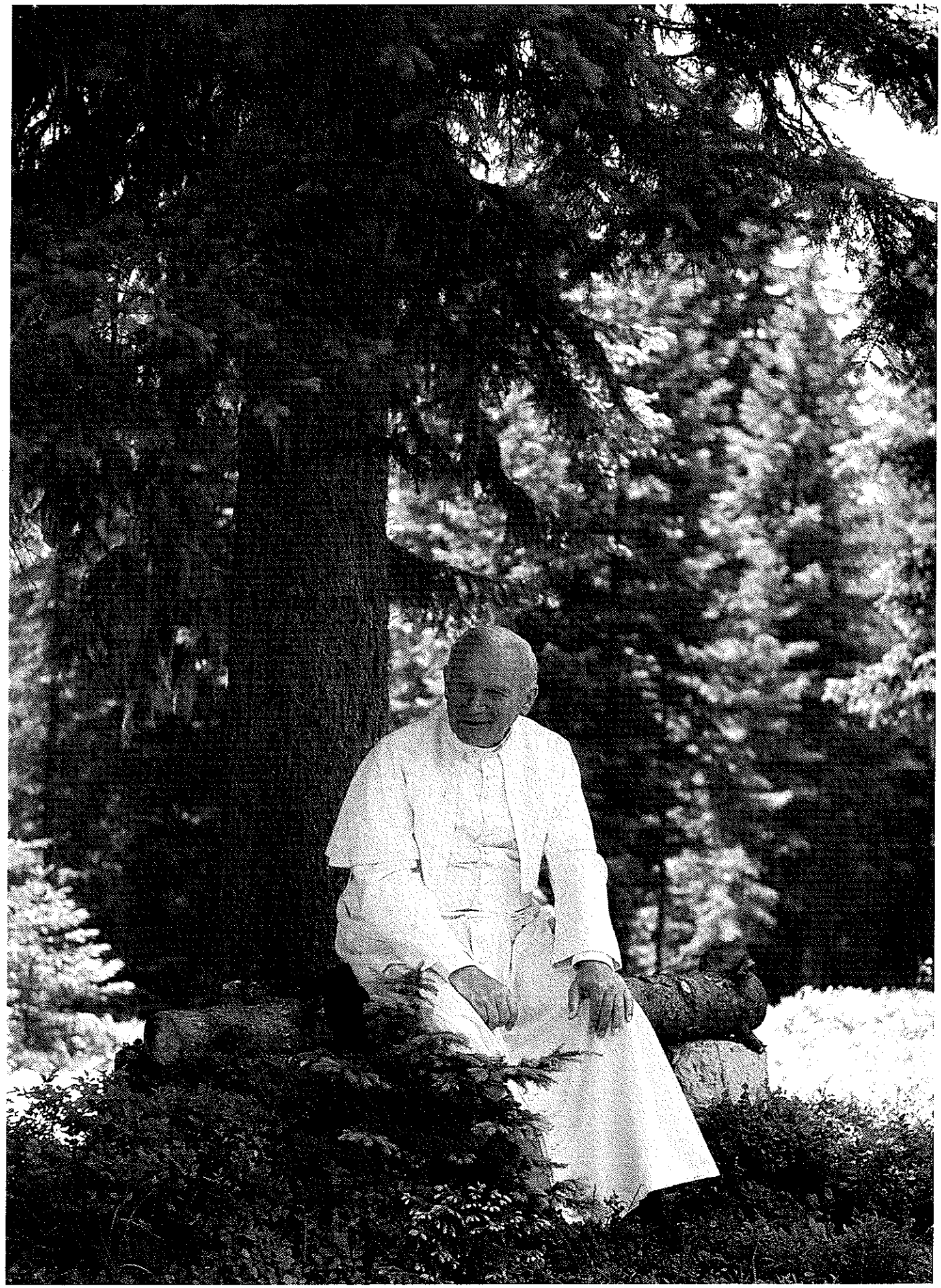
Contents

The illustrations in this issue have been taken from **The Atlas of Medicinal Plants** ***(Osaka, Japan: Doshomachi Higashi-Ku, 1971), with texts by Tatsmo Kariyone, professor at Kyoto University's School of Pharmacy, and illustrations by Ryohei Koiso of the same University. The book contains 150 watercolors of as many different medicinal plants.***



The Care of the Sick According to Canonical Legislation

My title may seem provocative or have the flavor of a superficial approach or one based on convenience. But, if we observe the profound nexus linking canonical regulation to the Church and manage to grasp the bond — neither fortuitous nor marginal — between the infirm human person and the Church as an institution willed by Jesus Christ, who " has taken up our infirmities and shouldered our illnesses, "[1] the approach will immediately prove logical and theologically, normatively, and pastorally relevant. If canonical regulation is to help the *communitas fidelium* to grow in the Gospel dimension and thus be an instrument of salvation for humanity, it cannot fail to reflect Christ's care and concern for men who are sick and in need of attention.

Charity: The Fundamental Norm of Canonical Regulation

Until a few years before Vatican II this assertion nearly made some canonists cry shame, and not just the civil jurists. Within the Church there were some who accused canonical regulation of being the tomb of Gospel charity and the grave of the authentic Christian message — they saw no link between charity, which is love, and the law, which is obligation. The Holy Office dealt with the problem by intervening with a decree condemning the theses of J. Klein dated February 2, 1950.[2] But the in-depth ecclesiological vision which would issue from Vatican II was then lacking, and canonical regulation was still seen more as the prescription of rights and duties than as a concrete expression of the reality of communion proper to the Church willed by Jesus Christ. Church communion is the constitutive, constitutional norm which, in keeping with the Founder's will, must animate the entire structure of the People of God and must thus be a source of juridical production as well for canonical regulation. Communion between the local Churches and that of Rome and among the local Churches manifests the one single Catholic Church (cf. *LG*, no. 21; can. 368), determining rights and duties which are permeated with it as an expression of pastoral charity proper to the ministers of the Church and to the entire Church. It has rightly been observed that the bond of communion in the life of the Church does not remain exclusively within the limits of the invisible, spiritual sphere, but demands a juridical form which is, nevertheless, at the same time animated by charity, as was specified at the Council in the explanatory note prior to the third chapter of *Lumen Gentium*. The juridical form and the animation of charity, then, must not and cannot be understood as opposites, but as two aspects of a single ecclesiastical reality in which the juridical form exists animated by charity. Indeed, Professor Ghirlanda clearly explains the juridical relations among the different persons in the Church and among the different particular Churches; rooted in the gift of the Holy Spirit and constitutively grounded in the Eucharist, by their very nature they must be animated by charity. From *Lumen Gentium* (no. 11), *Presbytorum Ordinis* (no. 5), and canon 897 it is deduced that the Eucharist is source, center, and summit of the Christian community's entire life[3]; it follows that all the ecclesiastical ministries exercised by the different persons in the Church must have the Eucharist as a reference point and be ordered towards it. With *Lumen Gentium* (no. 3), moreover, and other Council texts,[4] we must consider that the Eucharist, as the sacrament of unity and charity among all the members of the Church and among all the Churches, produces and manifests both hierarchical and ecclesiastical communion. For this reason, both the hierarchical juridical

form and the other social relations in the Church have charity as their fundamental constitutive principle. Universal and local communion, expressed in corresponding juridical forms, receives life from union in charity.[5]

Accordingly, not only is there no recognizable opposition between charity and canon law, but there subsists such a profound bond between them that regulation in the Church not possessing its foundation and defining element in the first of the precepts established by the Lord, which thus makes it regulation of the Church and of the Church alone,[6] is unthinkable.

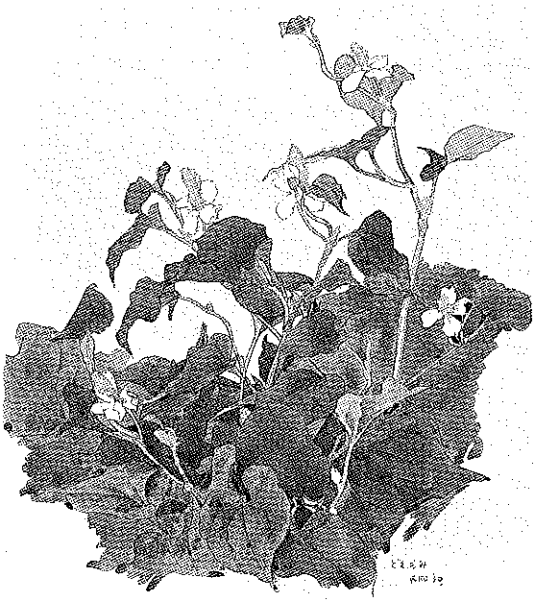
The Pastoral Charity Willed by the Code of Canon Law for the Sick

From this conception we infer, first of all, the intimate, essential nature of canonical regulation, at the center of which is man as a person possessing goods and values with a dimension which is not purely earthly and temporal, but supernatural and eternal. This regulation's attention for the human person primarily derives from the truth of the eternal vocation of man, whose origin, history, specific nature, and potentiality with respect to a life in God[7] are explained to us by Vatican II in numerous texts; canonical regulation makes it the ground of its whole structure. The Church, even in the face of every other authority, through the mandate received from Christ, feels duty-bound to be "the sign and safeguard of the transcendent character of the human person," since she knows that man is not limited to the temporal horizon alone, but, while living in human history, integrally conserves his eternal vocation, "for which reason the mission of the Church herself, 'founded on the Redeemer's love', contributes to extending the radius of action of justice and love within each nation and among nations"; and this is to protect and promote "the fundamental rights of the human person and for the salvation of souls," as *Gaudium et Spes* (no. 76) states. Certain principles derive therefrom for the regulation of the Church which are laws constituting all canonical legislation, like the obligation, for instance, mentioned in Paragraph 2 of Canon 222, arising from natural law and thus pertaining to every norm (*ex iustitia*) and acquiring peculiar significance for the baptized on a supernatural plane as well as a result of the Gospel commandment of charity (*ex caritate*), involving the faithful through the force of both natural and positive divine law and, therefore, from an ethical standpoint, both internally and externally.[8]

In reflecting on the essentiality of the varied structural expressions of Vatican II's ecclesiology, the new Code sees the human person in his existential-historical concreteness and in the perspective of eternal life, the end of every creative effort by her juridical system and consequent norms, to such a point that it concludes them with a principle clearly mirroring the specificity of canon law, which as the most illustrious medieval canonists openly maintained — validly recalled by equally illustrious canonists of the most recent canonical school functioning in Italy before Vatican II, among whom Pio Fedele had already distinguished himself with his general speech on canon law — could and can be found in no other principle except *salus animarum*, which always and everywhere in the Church *lex suprema habenda est* (canon 1752).

From this attention to the concrete person — or, rather, the individual, as preferred by Giuseppe Capograsso, solicitous about losing nothing that is existential and real in the person standing before us, willed and loved by God for an eternal destiny — derive the multiple norms on the dignity of man (cf. canon 96), who should be respected and protected in his fundamental rights (canon 747 §2; canons 795 and 807) and seen with a Gospel spirit even when he falls into error and commits offences so that he will be corrected

— though punished — not by executioners, but by *pastors*, and brought back into full ecclesiastical communion as a son.[9] Among the canonists' maxims is one which, when applied to the care of the sick, clearly indicates the spirit in which those who for the Church's social body are not healthy must be treated: *remedia levia* should be used first, and only when the seriousness of the illness so requires, should we resort to *acriora et graviora remedia*. And the inclusion in penal canon law of norms protecting human life, the person's physical integrity, is significant; not only abortion (canon 1398) and homicide (canon 1397) are punished, but also serious wounding and mutilation of members of the individual (canons 1397 and 1336).



And it does not strike me as out of place to see in this norm a call by the Church for integral protection of the individual from the moment of conception, against all genetic manipulation altering the hereditary biological patrimony. I assert this in the conviction that the legislator of the post Council code has not disregarded the fear expressed by Vatican II concerning the dangers of scientific research reaching the point of directly influencing human life by means of technical instruments.[10] The fear that resorting heedlessly to dangerous powers may irreparably prejudice the future of humanity is conveyed by the Church, which, as we see in the reference to canon 1397, is intensifying her pastoral action, especially through statements by the Holy See — regularly documented by this journal — in defense of the individual from the first instant of life.[11]

The Church encourages all research and every initiative undertaken to defeat illness, but cannot tolerate science and technology's going against human life. Her action is aimed, first of all, at educating the faithful in the Christian meaning of illness so they will surround the sick with the utmost solicitude; they are exhorted to perform works of mercy for every patient, without exceptions or discrimination. And she rather often addresses all men of good will, going beyond all boundaries so that man will always be regarded by all as a person, particularly if in need or ill.[12] At the root of all action by the Church is a doctrine which is not purely human; that is, there is a theology declaring that "life is one of the greatest values because it descends directly from God, the origin of all life."[13] And the Church, John Paul II recalls, from its beginnings "has always regarded medicine as an important support for her redeeming mission to man. From the ancient xenodochia to the first hospital complexes and down to the present day, the ministry of Christian witness has proceeded in step with that of solicitude for the sick."[14]

And she has done so with her legislation as well, all of which is not in the Code of Canon Law. The Code, it should be added, does not exhaust the norms of the Church, which often legislates through decisions and decrees, too, with the force of universal law, not to mention the resolutions of diocesan synods, which have a specific value but are not always binding for the faithful of the Churches which have enacted such regulations — if taken up by nearly all dioceses, they virtually acquire universality. Accordingly, by way of example, on the occasion of the Twentieth National Eucharistic Congress held in Milan in 1983, in a Congress document on "The Eucharist and the Pastoral Care of Suffering," certain instructions by the 1972 Diocesan Synod regarding the sick were recalled, and it was specified that "by its very nature, the Synod has a juridical and disciplinary concern" and is thus binding.[15]

As for current canonical legislation contained in the new Code, we have canons 566 § 2 and 976 on special authorizations for hospital chaplains to benefit the sick and for every priest in regard to those in danger of death.

Canon 529 § 1 decrees it a particular duty of the parish priest to assist the sick, especially if dying, obliging him to be particularly solicitous in this service and to

show a special, effusive charity towards them (*effusa caritatae*). Here the Church's love involves the ministry of humanity and Gospel charity. The parish priest continues the work of Christ and renders the Church present. Like her Founder, "the physician of the flesh and the spirit,"[16] with maternal solicitude she announces the Good News to the poor and heals distressed hearts.[17]

In addition, in regard to the elderly and "those who are affected by an illness, as well as those who assist them" canonical legislation mitigates the prescriptions which it requires healthy people to comply with, as expressly stated in canons 919 § 3, 167 § 2, 930 § 1 and 2, 539, 555 § 3. These and other prescriptions (cf., for instance, canons 530, no. 3, and 922) offer concrete witness to the Church's love for the sick and should be considered within her broader service to the human person, as seen in his historical condition and integral vocation, which goes beyond the limits of the temporal to participate in the eternity and beatitude wherein man will pass from mortality to immortality and from sickness to glory, in his body as well, according to the Pauline expression, which is the revelation of God's love for the human creature (cf. 1 Co 15:53-54).

In *Salvifici Doloris*, John Paul II calls this commitment by the Church the "Gospel of salvation"; she regards the care of the sick, expressed with the "sensibility of the heart," the only or main expression of our love and solidarity with suffering man."[18] And the Pope also recalls in his Apostolic Letter *Dolentium Hominum*, "Indeed, over the course of the centuries, the Church has been deeply aware of service to the sick and suffering as an integral part of her mission," and has acted in this connection with a precise conception of the human person and of his destiny in God's plan,"[19] employing all her energies, involving her institutions, and using her structures, including her legislation and canonical regulation.

✠ VINCENZO FAGIOLO

Secretary of the Congregation for Institutes of Consecrated Life and Societies of Apostolic Life

[1] Mt 8:17. Cf. Is 53:4; Jn 1:29; Mt 9:2-8, 18-26, 27-31, 33, 12:9-13, 14:34-36, 15:29-31; Mk 1:23-27, 29-34, 40-41, 2:9-12, 3:1-5, 5:25-34, 41-42, 6:53-56, 7:31-37, 14:1-4, 17:11-14; Jn 9:1-41, 11:1-44. These texts contain numerous accounts of healings worked by Jesus, who in the parable of the Good Samaritan decreed the principle or law of charity which should be particularly practiced to benefit the weak, poor, and sick (Lk 10:25-37). It is the parable of the great commandment of love.

[2] I dealt with it at the Seventh National Week for Pastoral Updating held in Florence, May 16-20, 1957. See "Carità nella comunità cristiana," *Atti* (Milan: Didascaleion, 1958), pp. 113-141. I then maintained that canonical regulation translates into juridical terms the exigencies of the Church, which are those of the Gospel, for the sole purpose of helping the Church herself to set aflame the charity of Christ in the hearts of the faithful. This topic is dealt with on the basis of the canons concerning the bishops and parish priests, whose defining note is pastoral charity, which leads them to be *forma faiti gregis ex animo* (1 P 5:3), fathers and pastors towards their subjects, and thus to love them *tanquam filios et fratres* (canon 2214 § 2 of the 1917 *Codex*).

[3] The Council constitution on the liturgy affirms that "the renewal of the alliance of God with men in the Eucharist situates and ignites the faithful in the urgent charity of Christ. From the liturgy, then, and particularly from the Eucharist grace comes to us as from a spring, and we obtain with maximum efficacy, that sanctification of men and glorification of God in Christ towards which all the other activities of the Church converge as their end" (no. 10).

[4] Cf. *SC*, no. 47; *UR* no. 2; *PO* nos. 7 and 8, canons 899 § 1 and § 2, 900, 897.

[5] Cf. G. Ghirlanda, "Chiesa universale, particolare locale," in *Vaticano II* (1987), p. 866 seq.

[6] JOHN PAUL II, when presenting the new Code of Canon Law with the Constitution *Sacrae Disciplinae* of January 25, 1983, stated that "the instrument, which is the Code, fully corresponds to the nature of the Church, especially as it is proposed by the Magisterium of the Second Vatican Council in general and by its ecclesiological doctrine in particular."

[7] Among the numerous texts see those on God as the principle of man, on the integral vocation of the human person, on the end of man, on man as redeemed by Christ, on the value of the human person created in the image of God and sanctified by Christ, on the ministry of the Church to defend and promote the values and goods of each man (*LG*, nos. 17, 48; *GS*, nos. 12, 24, 29, 34, 41, 51, 76, *et passim*).

[8] G. DALLA TORRE, in *Commento al C.D.L.* (Urbaniana, 1985), p. 127.

[9] Cf. Council of Trent, Session XIII, de ref. c. 1; canon 2214 § 2 of the 1917 *CIC*. These are the sources for canon 1339 and the following ones on penal remedies and penances.

[10] Cf. *GS*, nos. 5, 33, 43. M. Cuvàs, "Il progresso biomedico interpella la teologia morale," in *Vaticano II*, vol. 2, p. 62 seq.

[11] Cf. Congregation for the Doctrine of the Faith, *Instruction on Respect for Human Life in Its Origins*, February 22, 1987.

[12] JOHN PAUL II, "Address to the Fifteenth World Congress of Catholic Physicians" (October 5, 1982).

[13] *Ibid*, no. 2. Cf. Gn 2:7, Ezk *37:8-10*.

[14] *Ibid*, no. 3.

[15] Milan, 1983, p. 50.

[16] St. Ignatius of Antioch, *Ad Ephesios*, 7,2.

[17] *SC*, *no. 5*.

[18] *In Enchiridion Vaticanum 1983-1985*, vol. 9 (1988), p. 653, no. 677.

[19] In *Enchiridion Vaticanum*, l.c., p. 1371, no. 1411.

Integral Care of the Sick: The Role of Spiritual Help

Today we are witnessing noteworthy progress in medicine and surgery, in diagnostic and therapeutic methods, and other areas. However, in spite of so many technical means available to all using health services, we paradoxically observe that more humane treatment of the ill is being repeatedly called for, and increasing numbers speak out in favor of what has come to be termed "humanity in medicine" (1,2). This seems to indicate that the human dimension of the medical task is being lost or is at least deteriorating, perhaps because a global view is lacking which encompasses the fullness of the ill person (3).

This essay seeks to analyze the question, pointing out one concrete aspect: what the role of spiritual help is and how this help — not only from the priest, but also from health personnel sharing in a transcendent sense of life — can contribute effectively to such hoped-for humanization of medicine.

I. In illness the totality of man is altered

Man, when becoming ill, remains a human person. His admission to a health facility does not turn him into a mere number on a case history (an ulcer, heart, or cancer patient, for example). The fact of getting sick does not cause him to lose his personal identity or capacity to respond to life — he does not cease to be "someone" and turn into "something."

It is clear that, since man is a psychophysical unity, when he grows ill, his whole self suffers. Illness affects not just the body, but the person in his totality — in a certain sense, the whole man becomes sick (though it should be pointed out that the soul does not get sick, but rather the state of mind or attitude, as López-Ibor observes). Pope John Paul II reminds us that illness and pain "are not experiences affecting exclusively man's corporal condition, but the whole man in his integrity and somatic-spiritual unity. Aside from this, it is evident that illness manifesting itself in the body sometimes has its origin and real cause in the depths of the human soul" (4).

In caring for the ill, this perspective should never be lost from sight. It is not enough to try to heal the organ or damaged function, but man as such must be treated.

"The sick person is a being supremely in need of very diverse types of aid on account of the diversity of his requirements — biological, psychological, social, and spiritual (ethical and religious). His situation calls for what is today termed *integral* care in order for him to recover or take on his illness in a positive way, to fight against death or accept it and live it out with dignity when it comes" (5).

What does "integral care" mean?

To explain the phrase, we shall avail ourselves of a recent document of the Magisterium of the Church, the Encyclical *Sollicitudo Rei Socialis* (December 30, 1987), which refers to another subject, but whose formulation is of use to us. In dealing with man's development, Pope John Paul II states that this development must be integral, i.e., of the *whole* man. Development involves varied aspects — economic, social, concerning cultural identity and openness to the transcendent. If such diverse (moral, cultural, spiritual, etc.) human exigencies are not taken into account, development proves unsatisfactory and, in the long run, contemptible (no. 33).

Accordingly, the sick person must be offered *integral care*; that is, he must be

cared for in his totality, in his being as a human person, for he suffers in his body and his spirit and must be assisted in both. What Alexia, a fourteen-year-old girl who died in the University Clinic of a Ewing sarcoma, said is significant: " I am not a patient — I'm a person who has a problem, " and she would forcefully stress the word " person "

What does it mean to treat a patient as a *person* or *humanely*? Simply to treat him as what he is, a human being who does not cease to be such on account of becoming ill.

This leads us to recall some anthropological presuppositions, for in accordance with different conceptions of what man *is*, very different consequences follow for treating, curing, accompanying him, helping him to die.

10 Our point of departure, then, is the following: man is an intelligent, free being, corporal and spiritual, not just a biological mechanism composed of tissues, organs, and systems. More briefly: a being composed of a body and a soul that is spiritual and immortal (6).

Humane care, though so important, cannot, therefore, be reduced just to certain achievements which some might regard as a *summum*: seeking to provide the patient with kind, cordial treatment, corporal and psychological well-being, the absence of pain, a high quality of life, and so forth. All of this constitutes only one aspect of humanity in treating the patient. But this *humanity* also includes the spiritual dimension of the person, to which spiritual help thus corresponds.

For a health professional sharing in a Christian sense of life, every man, especially the patient, is a creature of God deserving all respect. In referring to the task of Catholic hospitals, Pope John Paul II pointed out that " they should do everything possible so that the sick will be cared for as their dignity as persons 'made in the image and likeness of God' (Gn 1:26) requires " (2). Moreover, man is a child of God (cf. 1 Jn 3:1-2). This revealed truth constitutes the unrenounceable basis for all Christian anthropology, as the Pope recently recalled in his Apostolic Letter on the dignity of women (August 15, 1988, no. 6).

Let us now analyze the content of what we understand to be integral help. We shall do so by means of a " structure " which may be readily assimilated and could also assist each of us to reach a *personal* assessment of how deeply we go in caring for the sick.

II. Integral care of the sick

The following aspects may be considered.

A) Biological Doctors' and nurses' attention is minute in regard to all the biological aspects: circadian rhythms (sleep, nutrition), excretions (urine, evacuation, etc.), hygiene, signs and symptoms of illness (pain, vomiting, cough, hiccups, etc.).

There is no question that " biological mastery " has brought with it progress in the treatment and comfort of the sick. The most highly reputed facilities and schools are certainly scrupulous about " biological aspects, " and any defect in such care is synonymous with poor quality. In any event, these aspects represent the primary task of health personnel.

B) " Human ": Considering the *person* beyond the biological organism has been interpreted as courteous, affective treatment involving relationship (conversation, attentions, etc.). This offers a second level: " humanitarian medicine " Lamentably, this treatment is sometimes not provided, though *it is now recognized* universally as an index of quality. We shall analyze this aspect more broadly at once in dealing with what we regard as the spiritual needs of the sick.

C) The spiritual needs of the sick

We may distinguish up to *three levels* herein

1) At the first level the person is respected in the understanding of what is

happening to him. He is given *every explanation* needed on minor details or large programs so that he will have sufficient knowledge of treatments, explorations, etc. to be effected. The nurse plays an important role in this by explaining tests, symptoms, side effects, repercussions on daily life, the meaning of the illness, opening up perspectives in areas wherein the patient may "realize himself," orienting him as regards the new "role" he will have in the family, society, etc., speaking of fears, anxieties, and concerns, and seeking to listen so that the patient himself (and his family) will learn to:

a) face up to stress in human terms, by:

— identifying its cause,

— enumerating possible options to overcome it gradually,

— establishing the easiest options,

— giving them priority,

— choosing and deciding;

b) look for solutions (sometimes rather unsatisfactory) and remain calm in the face of problems "with no way out" which occasionally appear;

c) put them into practice

2) After understanding, which provides humaneness and facilitates the patient's being taken into account at a hospital because it makes him feel respected, the second level is *help in decision-making*. Although the medical team advises concerning decisions, they are often virtually mandatory, for there is no alternative; in such cases, the medical team should seek to foster decision-making in both minor affairs of daily life and making plans, choosing restful activities, and family or social relations. This helps the patient maintain self-esteem: he thus comprehends and decides in freedom; he knows the medical team respects his "human and spiritual" rights and feels like "himself."

A reflection of this approach is found in the words of the Spanish Bishops: "One who is sick needs to be loved and recognized, listened to and understood, accompanied and not abandoned, helped but never humiliated, feeling useful, respected and protected; he needs to find a meaning in what is happening to him" (Message of the Bishops of the Pastoral Commission, Patient's Day, 1987).

This "humane treatment" obviously involves all the members of the health team: doctors, nurses, auxiliaries, etc. All should collaborate in treating the patient in this way. This goes from knowing his name or some details of his life story, tastes, hobbies, etc. to helping him to die when the time comes.

This treatment might be expressed in the following words: *to be* with the patient is more important than *acting* for the patient. But to truly be with him one must first know him, hear him out, share his problems, hopes, difficulties, history, and humanity. Then and only then will we have a response, and it will be a response capable of qualifying our professionalness because it will give meaning to the word "care" and, above all, will manage to give value to the personhood of the patient in his totality (7).

III. Spiritual care in a specific sense

The third level — on which we shall elaborate in greater detail — is the transcendent, starting from the conception of man as a spiritual being open to God.

This conception enables the patient to:

— give meaning to his illness;

— gain greater self-knowledge;

— advance in the sense of the transcendent, find the reason for living, dying, struggling;

— reach God (through the *sacraments*, above all).

At this level the health team is not excluded, as we shall see further on, even though those engaged in the health ministry (chaplains and others) can best provide attention.

In connection with this spiritual care of the sick, let us consider some prior questions:

1) *It is a right of the patient.*

The patient, whether or not he is hospitalized, as a person has the right to have all his possibilities for exercising religious liberty recognized and facilitated.

This right is recognized in the Declaration on Religious Liberty of the Second Vatican Council (cf. *Dignitatis Humanae*, no. 2). It also appears in the Universal Declaration of Human Rights of December 10, 1948 (articles 18 and 19) and in the Spanish Constitution (article 15).

In Spain, the Church-State Agreement on Religious Assistance at Public Hospitals (July 24, 1985), in recognizing the right of Catholic hospital patients to such aid, regulates this right through the creation of a religious assistance service (*BOE*, December 21, 1985) (8).

By virtue of this agreement, in each public hospital there must be a religious assistance service and pastoral attention to Catholic patients from which other patients who so desire, family members, and health personnel at the facility may also benefit.

The service is to be financed by the State and endowed with a chapel, an office, and a place of residence for the chaplains, who will act in coordination with the other hospital services.

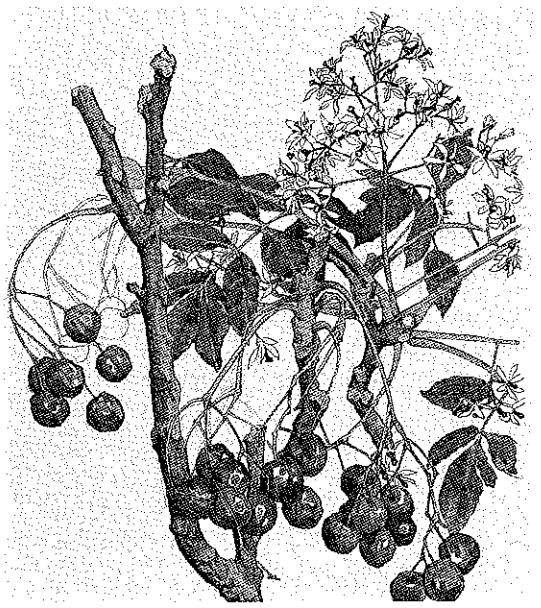
In this way, in ensuring religious assistance at public hospitals, the spiritual dimension of the sick person is recognized and even the therapeutic value attending it may have.

2) *It is a duty of those attending and accompanying the patient.* A daily duty which from the moment of the patient's admission should be performed with tact and sensitivity. It may prove necessary to prepare for a fatal outcome well in advance, working day by day, changing direction as needs appear. The medical and nursing team, together with the chaplain, should point out the road to be followed, arranging for everything related to the patient, including his family, so that all will fall into a true and peaceful context full of human warmth.

In this regard, what a well-known oncologist writes in a classic manual of internal medicine is significant; in referring to attention for terminal cancer patients (but applicable as well to other kinds of patients), he says the "physician must seek support from nurses, *priests*, and social workers for the care and assistance of these patients" (9). Something similar may be gleaned from certain works devoted to nursing activities, where it is recalled that the nurse should take an interest in the patient as a *whole*, and since there are cases in which these spiritual needs emerge in the patient, this aspect should be attended as well (10,11).

Moreover, ordinarily the patient realizes his state, even if he does not expressly say so: for this reason, without hiding the truth from him (12,13), but measuring his potential for acceptance, one must manage to lead him — if need be — to the definitive end. And this is the task of all caring for him.

3) *It is a necessity* in response to the condition of the sick person, when the spiritual dimension of the human being usually becomes more manifest.



Every man needs spiritual help, but it might be asked what the specific spiritual and religious help for the patient involves.

Illness produces an alteration in the psychophysical self in such a way that man encounters something he cannot dominate and which the doctors cannot fully dominate either. Sickness, on "laying bare the essence of things," provokes a convulsion in the inner world of one suffering it. It has been said that illness, particularly if serious, "offers us some of the scarce ways our contemporary culture permits for a return to our interior" (14). The patient experiences his own limitation and fragility (*in-firmitas*) and almost inevitably asks himself a series of questions (on the meaning of pain, life, death, etc.) to which he seeks

a solution. This necessarily makes him open himself to *others* (doctors, nurses, patients, etc.) and the *other*.

"Illness," says Victor Frankl, "makes man feel more forcefully his lack of centeredness and marginalization, with the consequent longing for fullness and rootedness in the Being who is Love" (15). Or, as Cardinal Suquia has written, "In sickness walls which in times of health seemed indestructible collapse by themselves. In sickness man, still and in silence, awaits the salvation of Yahweh" (*YA*, September 27, 1987).

4) Spiritual help *is not a task exclusive to priests* or those who are now said to be working in the health care ministry, but in differing degrees corresponds to all health personnel. The Christian nurse, for instance, plays a primordial role

here: to succeed in remaining close to the sick person, consoling, comprehending, encouraging, helping to find meaning in pain, etc. Virginia Henderson has written, "Respect for the patient's spiritual needs and help so that he may satisfy them form part of basic nursing care in every sort of circumstance. If religious practices are essential for man's well-being in a healthy state, they are even more indispensable in the case of illness. This concept of doing everything possible so that the patient can practice his religion involves a series of specific activities which cannot be enumerated at this time. We shall nevertheless cite some of the most evident ones: helping the patient go to the oratory, having the minister of his religion visit him, giving him facilities so he can speak to the minister and allowing him to receive the sacraments forming part of his religious life" (16). And the same may be said concerning doctors. Both should know how to arrive at the end in their action. For, even when the medical treatments available have been exhausted and the patient reaches the level of irreversibility, their function is not for this reason over. Concretely, in the terminal phase, in addition to maintaining the physical and psychic care needed (avoiding pain, suffering, insecurity), an attempt should be made, above all, to accompany the patient, pray with him, help him to give supernatural meaning to pain, etc. (17).

One might reach the point of thinking that there is nothing left to be done. What is the use of the doctor's presence or the nurse's care? But this formulation is due to a health model which provides for action only when illness is under control. If this is not achieved, profes-

sional identity itself may be threatened. But health professionals as well should be at the side of the patient and the family so they will feel comforted and to help them at that time to encounter the meaning of illness and pain. And not only this. They can collaborate in authentic spiritual assistance to the sick person. The Founder of the University of Navarra once told a professor at the School of Nursing: "Think that ...the patient is Christ. He said so.... Treat them with affection, care, sensitiveness. Let them lack nothing. Above all, spiritual aid. Prepare them well" (*En memoria de Monseñor José María Escrivá de Balaguer*, Eunsa, Pamplona, 1976, p. 161). This preparation not only involves *facilitating* the priest's presence, but should offer specific assistance so that the patient may live out the Christian dimension better.

IV. The Mode of Spiritual Attention

We have stated that spiritual attention is not the exclusive task of the priest. The doctor and nurse, if Christian, can and should collaborate. In reality, in the integral care of the patient, the whole health team should collaborate, each in his own way, in complementary fashion, without suspicion, helping one another. In this regard, I can also point out the interest being shown in Voluntary Help Committees (18), concerning which we already have quite a rich experience at the University Clinic, though the indispensable role of the priest must be acknowledged, especially with respect to sacramental action.

Schematically, we shall allude to the specific task of the chaplain, for which he may nevertheless need the help of health personnel. We shall focus entirely on the sick, omitting from our study attention to the family and health workers and other aspects (liturgical, doctrinal, advisory, etc.) which also form part of the chaplains' task.

1. The *pastoral visit* (5,19,20,21) is the privileged moment to make the patient feel the presence of Christ and of His Church — undoubtedly one of the most gratifying moments in the chaplain's work. When it is a first contact with the patient, the priest must possess a great deal of common sense, prudence, patience, and knowledge of psychology; he must know how to listen and, if possible, gain access to some information on the patient he is going to visit.

It should not be forgotten that the first thing patients generally wish for is the recovery of bodily health; for this reason, the visit they await most is that of the doctor. There are, however, always some patients for whom the most important thing is spiritual care; and those attending the sick must be alert so as not to neglect this aspect. I recall a concrete case at the University Clinic. Alexia, whom I mentioned previously, as a result of an error was left without Holy Communion one day. To excuse herself a nurse tried to minimize the event. Alexia's mother said, "Look, young lady, for my daughter the most important thing is to be able to receive Communion every day. I beg you not to let this happen again."

It is the priest's job to offer spiritual services, adapting them to each concrete situation; a prior catechesis will often be necessary.

The first contact facilitates and prepares the way for later encounters, and from these the chaplain's different offers will gradually emerge: presence, company, small services, helping someone pray, catechesis, until arriving at a specific sacramental ministry: Confession, Communion, Anointing of the Sick (exceptionally, in cases where life is imperiled, Baptism and/or Confirmation may be administered to sick children).

2. *Sacraments*

This is not the place to set forth extensively the role of each of these sacraments in the integral care of the ill Christian. Let it suffice to indicate a few points of interest to us.

If the sacramental celebration should normally constitute the culmination of a significant relation with the patient and the result of a faith process lived out by him (5), it seems logical that, while respecting the level of each patient, the chaplain should facilitate these "signs testifying to God's love for the patient" in every way.

This requires complete availability so that patients can turn to him with confidence and without fear.

Penance

Since illness is usually a propitious occasion to hear God's call to conversion (cf. *Ritual de la Uncion y de la pastoral de los enfermos*, Praenotanda, nos. 1-41), the priest must be attentive so as not to lose this opportunity, which, moreover, ought

not to conclude with the act of confession. An attempt should be made to accompany the patient along the entire road of his conversion, and this is not utopian. He may even be encouraged, on leaving the hospital, to get in touch with the parish, apostolic groups, etc. to help him to maintain his decision.

Holy Communion

From the beginnings of Christianity the Church has seen to taking the Body of Christ to the sick. " Let it not be forgotten that the primary and principal end of the Eucharistic reserve involves the possibility of taking Communion to the sick unable to participate in the Mass " (*Ritual de la Uncion*, no. 64 b). For this reason, every facility should be provided so that sick hospitalized Christians may — if they so request reasonably and are prepared — receive Holy Communion in their rooms.

The best time for the patient must be sought by avoiding clashes with other services: medical visits, nursing, cleaning, other visits, etc. At the University Clinic we have two moments: the early morning for those going to the operating room, and the early afternoon (between 3:30 and

4:30) for the remaining patients who have requested it. The priest is usually accompanied by a nurse, auxiliary, or student assigned to the ward who facilitates the task by straightening up the room, opening or closing the windows, offering a glass of water to a patient needing it to be able to swallow the host, etc. This work, which at first sight appears foreign to the job of nursing staff, falls, we believe, perfectly within what we term *integral care* of the sick and in this sense should not prove strange to those caring for them. For a patient with religious convictions, this service is just as important — or even more so — as taking his blood pressure or administering medicine.

Anointing of the Sick

Anointing is the sacrament specific to illness (not death) to help the Christian to live through this situation in conformity with the sense of his faith (cf. *Ritual de la Uncion*, nos. 47,65,68).

On becoming ill, the Christian needs special help from God reaching him through this sacrament, which " grants the patient the grace of the Holy Spirit, and the entire man is thereby helped in his health, comforted by confidence in God, and fortified against the temptations of the Enemy and the anguish of death, in such a way that he can not only bear his misfortunes with fortitude, but also fight against them and even obtain health if appropriate for his spiritual salvation " (*Ritual*, 6).

The pair Extreme Unction-death is still very much alive in the popular mind and in that of many pastors. It is necessary to recall forcefully, as the Second Vatican Council stated, that " the Sacrament of the Anointing of the Sick is not just the Sacrament of life's final moments, but should be administered in the case of serious illnesses" (*Sacrosanctum Concilium*, 73)

In any event, it is highly advisable not to delay the administration of this sacrament, and efforts should be made for the sick to receive it when fully lucid, with an attempt to overcome the resistance some patients — and, above all, relatives — display. Anointing can certainly be received by someone over seventy or before certain operations (tumors, cardiopulmonary, heart or liver transplants, etc.) or when a long and complicated post-operative period is anticipated (21). " To judge the seriousness of the illness, a prudent or probable opinion is sufficient, without troubling one's conscience and taking the doctor's view into account, if thought necessary " (*Ritual de la Uncion*, no. 8).

The sacrament may — and, we believe, should — be administered to the seriously ill who are unconscious, provided we know they are Christians and have not expressly rejected it. The *Ritual de la Uncion* (no. 14) specifies that this may be done when " it is assumed that, if they were lu-

cid, they would, as the believers they are, request this sacrament" (cf. Code of Canon Law, c. 943).

As regards the administration of Anointing, we shall set forth our experience at the University Clinic.

Anointing is received in the unconscious state in situations such as cardiac arrests, accidents, sudden death, etc. and also in terminal cases where, for whatever reason, it has not been possible to administer it previously.

Perhaps the term "semi-conscious" does not prove to be so precise, but everyone with health care experience is familiar with this situation in patients who are seriously ill, have a very high fever, are regarded as terminal, etc.

Table 1

Degree of Consciousness on Receiving Anointing

YEAR	No OF ANOINTINGS	CONSCIOUS SUBJECT	SEMI-CONSCIOUS	UNCONSCIOUS	UNKNOWN
		%	%	%	
1984	370	168 - 45%	52 - 14%	118 - 32%	38
1985	364	161 - 44,2%	42 - 11,5%	138 - 38%	23
1986	422	182 - 43,1%	56 - 13,3%	155 - 36,6%	29

The conscious subject is the person receiving the sacrament while fully lucid; he may have requested it previously and be able to participate in the liturgical rite, for example.

The data indicating the time elapsing from the day the sacrament is administered to the time of death, if occurring, are also relevant. Very schematically, we shall inform on our experience during 1984, 1985, and 1986. It is unnecessary to point out the resistance with which the reception of Anointing meets rather frequently (almost never among patients, nearly always from families). There are always some who still intimately associate Anointing with the nearness of death. A generation will have to pass, and extensive catechesis will be needed (in families, schools, parishes, etc.) in order for this sacrament to be incorporated with normality into the health ministry.

Voluntary discharge refers to patients in a terminal state who, for whatever reason, are taken out of the hospital; they usually die within a few days. *Discharges* are patients who recover (after surgery, for example, having surmounted a critical phase prior to being discharged).

In commenting on Table 2, we may observe that between 40% and 50% of the Anointings are received in the two or three days immediately preceding death and that the day of death is when the sacrament is most frequent, for the reasons indicated earlier. In any event, this fact should not be associated with unconscious reception. It certainly occurs in cases of cardiac arrest, sudden death, voluntary delay of the family, and so on, but there are many instances of reception of Anointing on the very day of death in a good state of consciousness.

In connection with the Anointing of the Sick, it would also be interesting to study other parameters such as how many request it, how many receive it before surgery, when it is received more than once, when it is administered at the moment of death, etc. We wish to analyze this subject in the near future.

Fr. MIGUEL ANGEL MONGE
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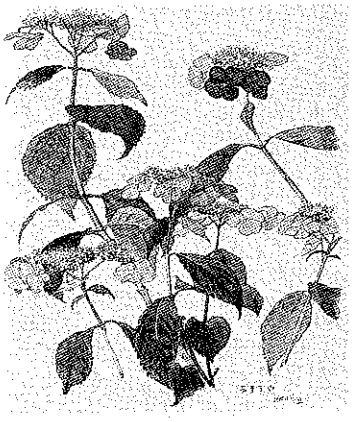
Table 2
Relation Between Anointing and Death

Anointing of the Sick	1984	1985	1986
Anointing of the Sick	370	364	422
On the day of death	85	86	114
On the day before	30	34	47
Two days before	14	17	20
Three days before	18	14	11
Four days before	9	9	13
5-15 days before	43	52	55
15-30 days	17	17	26
Over 30 days	37	33	15
Voluntary discharges	46	41	23
Discharges (after recovery)	65	45	62
Unknown	4	16	38



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The Priest and His Mission to the Sick

Over the course of the centuries the Church has made her own Christ's solicitude towards the ill, seeking to continue his gestures of charity. This testimony has been articulated in a variety of initiatives, including:

Church organisms: Caritas, the Pontifical Council for Pastoral Assistance to Health Care Workers, and the diocesan, regional, and national councils for the health ministry;

Catholic health facilities: hospitals, shelters, clinics, schools for medical and nursing training, and pastoral institutes;

encouragement of associations working in the world of health: local, national, and international associations for doctors, nurses, chaplains, volunteers, and others;

the use of the mass media

In a special way, the Church's presence has pulsated *through persons*: priests, chaplains, religious, and lay people engaged in service to the sick, both at home and at institutions.

This common effort, promoted by Vatican II, seeks to involve and give responsibility to all in the mission of charity. But it is the priest, above all, in his symbolic role and as animator of the Christian community, who has the duty to become the spokesman of the Church among her ill members.

Christ's invitation, "Go throughout the world, preach the Gospel, heal the sick," was taken up by Vatican II, which, after specifying the various aspects of the priestly ministry, concluded "Finally, [priests] should care for the sick and the dying, visiting them and comforting them in the Lord" (*PO*, no. 6).

It is, of course, disappointing that this apostolic commitment should have been relegated to the last place, and it is to be hoped that such placement is simply for practical reasons rather than a reflection of a certain pastoral mentality.

It is well known that many priests feel deeply uncomfortable about visiting the sick and the dying and prefer to delegate this apostolate to others when they do not confine it to odd moments.

It is understandable that other parish activities, such as catechesis, the animation of groups, and organization may prove more gratifying, whereas the encounter with the suffering may divest the priest of his sense of security and confront him with his own inadequacy, humanity, and occasionally impotence.

He who lets himself be betrayed by fear or pride and renounces encountering himself and his vulnerability in the sick deprives the Church of a humble, imperfect witness which is nevertheless consoling alongside those who suffer.

The priest who serenely accepts his poverty and makes himself present to the ill in their waiting, tears, and preoccupations carries out the mission of perpetuating the solicitude of the Church and the mercy of Christ.

The time devoted to the suffering is a time of love. At times one's presence alone suffices to bring about renewal; on other occasions, a smile or a good word works miracles, or a whispered prayer infusing peace and courage.

The priest who knows how to approach man in his vulnerability, seeking to understand him, becomes the Good Samaritan who opens his heart to his suffering brother and soothes his wounds.

Pastoral action may be developed in a variety of ways, including:

pastoral moments: the priest's visit to the sick both at home and at the hospital remains the most tangible sign of the Church's presence alongside the suffering;

formative moments: through homilies, lectures, and discussions on the subjects of health, illness, and death the priest educates the community and promotes a climate of greater sensitivity to its sick members;

liturgical moments: the animation of days devoted to the elderly and the ill, community Anointings accompanied by catechesis, the invitation to pray for the suffering and the dying make the liturgical context a privileged place to transmit the message of mercy;

moments of animation: the priest, aware of the need to tap the community's human potential, becomes a promoter of volunteer service, seeking to identify and provide for the training of those wishing to be involved in the world of health. In addition, insofar as possible, he offers the parish's hospitality to groups furnishing support for drug addicts, alcoholics, the elderly, and others so that they will become communities of mutual assistance and solidarity.

The Good Shepherd: A Model of Pastoral Presence

Vatican II, when referring to the priestly ministry, gives these indications: " ...They are obliged to live in this age in the midst of men, to know their sheep well, and to seek to bring back those who are not of this fold as well, so that these, too, may hear the voice of Christ and there will be one single fold and one single shepherd " (*PO*, no. 3).

The text puts forward the image of the good shepherd as the model by which the priest should be inspired for the exercise of his pastoral ministry.

Let us try, then, to comprehend at closer range the passage presented to us by John (Jn 10:11-16) to point out its pastoral content.

" I Am the Good Shepherd "

Christ presents his identity as that of the " Good Shepherd, " contrasting it with that of the mercenary who does not take his sheep to heart and abandons them when danger approaches.

Following Christ's example, the Church has sought to inculcate the virtues of the good shepherd in priests: " Of great benefit are those virtues which with good reason are highly esteemed in human society, like goodness, strength of mind, constancy, continuing care, and justice... " (*PO*, no. 3). The shepherd must let his love and pastoral care shine out, particularly when the faithful are exposed to the danger of illness and death and are more aware of the need not to be abandoned or forgotten.

" The Good Shepherd Offers His Life for His Sheep "

Christ has given his life for us. Following his example, the priest donates his life in service to his neighbor.

Dedication takes on especially human tones when it is aimed at the sick. Giving one's life becomes concrete in personally accompanying the suffering; the gift of one's time and energies becomes love in action.

" I Know My Sheep "

Christ could rely on a deep knowledge of the people he met and healed and of those as well who criticized him.

This immediate reading of their needs and intentions allowed him to understand, welcome, or confront his interlocutors.

The priest must also know people in order to be able to help them without presuming to enter into their pre-existing lived contexts or pre-ordained responses.

It is, above all, unconditional and unprejudiced listening which allows him to discover the treasures and resources of his fellows.

Vatican II, when speaking of pastoral formation, stresses the following: " The specific attitudes which greatly contribute to establishing a dialogue with men — which are the capacity to listen to others and open one's mind in a spirit of charity in the varied aspects of human community life — should be cultivated in the students. "

" And My Sheep Know Me "

Christ's relational message and style were like an open book revealing his identity to the world. In loving children, he let his tenderness come to the fore; in welcoming sinners, his mercy; in healing the sick, his humanity; in consoling the afflicted, his sensitivity.

In pastoral practice the priest must let himself shine forth, humbly and spontaneously; he cannot be the prisoner of a role in which he is incapable of expressing his humanity.

A fundamental pastoral ingredient is the person himself, with the wealth and imperfection which are mixed together in him. The more human a priest is, the more he becomes an agent of the spirit. In the helping relation, he lets himself be known, offers his humanity, becomes a friend of people, and is prepared to suffer to help others to grow.

" I Also Have Other Sheep That Are Not of This Fold "

Christ's message was aimed not only at the Jews, but at everyone, not so much at the just and healthy as at sinners and the sick.

So it is for the priest: his heart must be open to all. The persons he meets are at different levels of belief – there are the devout, committed believers, the indifferent, atheists.

Pastoral work means knowing how to relate oneself to different situations by welcoming and respecting people and to propose – not impose – the truth of love.

The approach differs as well in regard to the kinds of patients, for the disabled, the elderly, drug addicts, cancer victims, and the dying have varying experiences and concerns.

" They Will Hear My Voice "

Christ, though recognizing the resistance of man's heart, knew that his message would reach the confines of the world. For centuries generations of men have referred to his word as a source of light and hope.

The priest is sent to bear witness to the Good News and sow the word of Christ in the garden of those who undergo their Good Friday so that they will gain strength for their way. In the measure in which he manages to translate the spirit of the Gospel into the context of human relations, his very presence becomes an announcement of hope.

" They Will Become One Single Flock and One Single Shepherd "

Christ's mission is to join together all men in unity, guiding them to God, the only true shepherd.

The priest collaborates in this mission by fortifying community bonds and interpreting in sacramental rites the history and traditions of the People of God to guide them progressively to the goal of unity and true life.

The Hospital Chaplain

Being a priest in a parish is different from being one as a hospital chaplain. In the former case attention to the sick falls within the vaster context of other ministries; in the latter, the priest devotes himself exclusively to the pastoral care of the sick.

Continuous contact with the world of suffering has the advantage of maturing apostolic incisiveness, but there is also the risk of mortifying pastoral action when it is characterized by routine and not sustained by a constant commitment to self-renewal.

Pastoral creativity is stimulated by personal and group reflection, attending courses and lectures, and the constant effort to work, not in isolation, but in cooperation with others.

Today more than ever the chaplain must act in a sophisticated world requiring an effective, competent presence based on good human, pastoral, theological, and ethical preparation.

Patients and health care personnel wish to discern in him not so much a dispenser of sacraments as a humanized and humanizing voice, not so much an angel of death as a symbol of hope, not a judge who condemns, but a spokesman for forgiveness.

To help others to be reconciled with God he must first feel reconciled with himself.

Only when he has entered into the darkness of his inner world, accepting its shad-

ows, can he enter into the darkness of another to illuminate it with the light of faith.

The chaplain's ministry as a whole, to be effective and creative, must be nourished by a spirituality impregnated with faith and humanity.

A Spirituality for Suffering

The chaplain's motivations to serve the sick may differ according to the circumstances. To ensure that his presence will be meaningful and merciful, however, certain interior attitudes are needed.

These constitute that spirituality or inner cornice from which the energy sustaining pastoral service emanates. Among the dimensions included in this spirituality are the following:

* *It takes inspiration from Christ as its pastoral model*. The chaplain lets himself be permeated with the spirit of Christ in hearing his word; from the biblical reflection of his action in favor of the sick the chaplain derives indications for his pastoral work.

* *It is centered on the Paschal mystery.* The cross and resurrection of Christ illuminate the drama of pain and place it in a new light. Christ did not come to eliminate or explain suffering, but to take it on and transform it into a source of life.

The chaplain knows man through his pain. Illness becomes a school of life, and suffering, a privileged place for seeking the deepest meaning of existence.

* *It is shaped by one's own experience of suffering*. In his book *The Wounded Healer*, Henry Nouwen writes that the healer of his fellow man is the one who has allowed himself to be educated and matured by his own wounds in order to open himself and relieve the wounds of others.

The chaplain who positively integrates his own suffering — be it physical, psychological, or spiritual in nature — and succeeds in placing it at the service of his ministry has discovered a vital resource to serve the sick better.

Awareness of one's own vulnerability makes room to host the vulnerability of others; as St. Paul writes, " When I am weak, then I am strong. "

* *It involves accompanying* as expressed in the attitude of " walking with " the sick and making the most of the process rather than the results of the encounter.

This healthy approach protects the chaplain from a false sense of omnipotence linked to his concern about having to resolve people's problems or respond to their hard questions.

The acceptance of one's own poverty in the face of pain becomes a valuable pastoral instrument.

* *It recognizes in both the chaplain and the patient the agents and recipients of pastoral care*. In the dynamic of human encounter, giving is transformed into receiving, and receiving, into giving.

Th patient is not merely dependent and the object of care, but the pastoral subject, for he conveys messages and gives spontaneous lessons to whoever is wise enough to hear him out.

The chaplain who lets himself be evangelized by the suffering learns how to relativize many things and face his own vulnerability and mortality; he then becomes a teacher of all he has grasped for others.

* *It is incarnated in the human*. The priest encounters people where they are and as they are. He seeks to welcome each one without imposing conditions, offering his humanity. He does not want to feel superior to the patient or control him from a less vulnerable position. He makes an effort towards personal dialogue to bring out the inner resources of his interlocutors so that they will be channeled into the process of healing or growth.

* *It consecrates suffering* by transforming it into prayer, offering God the wounds and hopes, the memories and bonds of affection of the sufferer, inviting him to keep open to the spirit in living out the mystery of each day.

In the world of health the chaplain evidences the voice, heart, and hands of a " humane and sensitive " Church. When his pastoral action is impregnated with this spirituality, his presence is healing and consoling.

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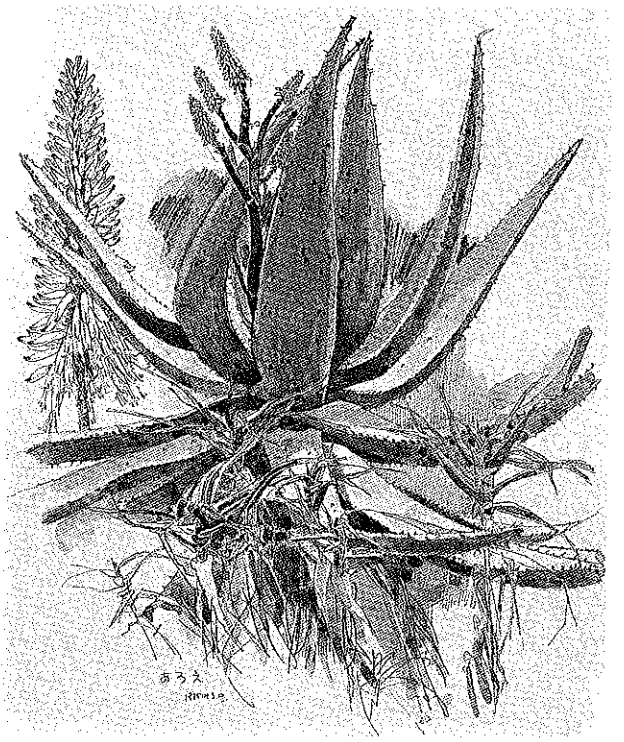
Magisterium of the Church



Excerpts from the Pope's Statements

The Family Also Counts (Spain)

May Science and Conscience Be at the Service of Life from Conception to Its Natural Conclusion

To the sick at Sant'Eugenio Hospital, EUR section of Rome, December 4, 1988.

1. Ever since Christ chose to become man, in him "every man becomes the way of the Church, especially when suffering enters into his life" (Apostolic Letter Salvifici Doloris, *3). In your midst, brothers and sisters of this numerous hospital community, the mystery of God's meeting with man takes place today, since wherever there is a group of people gathered in the Lord's name, the miracle of his presence is brought about, which is a promise and guarantee of salvation of souls and bodies. Christ himself has chosen suffering in order to transform it, through love, into a redemptive power.*

2. The season of Advent and the time of preparation for Jesus' birth find their deepest meaning in a place of suffering and care. Within these walls science and solidary love are called to defend and foster life in the name of the Lord of life, of Jesus who, being God, chose to take on human life in order to put it on the way of salvation. In the mystery of redemption the evil of suffering becomes a liberating force, because every human suffering, when united to that of the Savior, makes up "all that has still to be undergone by Christ for the sake of his body" (cf. Col. 1.24), which is the Church. Suffering serves the cause of the Kingdom of God, contributes to making straight the way of the Lord, who is coming.

Therefore, the spirit of anxious and joyful waiting which characterizes the liturgical season of Advent, illumined by the suppliant presence of the Most Holy Virgin, the Mother of God and our Mother, leads us to the understanding of the true and ultimate meaning of suffering and of service to those who suffer. It was not mere chance that it was the poor, the humble of heart, and the simple who were the first to hasten to the cave of Bethlehem, the first to behold, according to the word of the prophet, "the salvation of God." They were not guided by any human calculation, but by a light that came from on high, they had been prepared for the acceptance of that light by the discomforts of a life characterized by fatigue, privation and pain.

3. Our meeting today takes place in this huge hospital that bears the name of Saint Eugenius, Pope, directly calling to our mind another predecessor of mine of happy memory, Pius XII, Eugenio Pacelli.

When this hospital was inaugurated on 9 June 1957, the promoters of the initiative of the Pious Institute of the Holy Spirit wanted a bust of Pius XII to be unveiled there. Today, more than thirty years later, the mention of this Supreme Pontiff is once again very timely. The hospital of Sant'Eugenio, in fact, was constructed both to answer the need for health care in a rapidly growing section of Rome and as an expression of gratitude to a Pope who understood and courageously promoted the health care apostolate in the Church in Rome. At a time when such was lacking, Pius XII considered the pastoral ministry for health care as a duty of his pastoral ministry which he could not neglect.

With great foresight, the revered Pontiff recognized and affirmed that, wherever people suffer and wherever service to the suffering is given, the Church has a privileged field of activity that is in close harmony with her mission. Even more so, when intervening through his teaching on the various issues of scientific research and the practice related to preventive, curative and rehabilitative medicine, Pius XII was able to give moral norms of such enlightened wisdom that his speeches to medical doctors read like a modern textbook of bioethics. A characteristic note of his teaching is the continuous reference to the connection that should always be present between science and conscience, between medicine and morality. He said: "The person of the physician, as well as his entire activity, move continuously in the moral order and under the authority of its laws. In no statement, advice, treatment or operation will the physician find himself outside the area of morality, liberated from and independent of the fundamental principles of ethics and religion" (Pius XII, Discorsi ai Medici, *Rome, Edizioni Orizzonte Medico 6, 1961, p. 49).*

4. Today, in this hospital complex of the Seventh Health Care District of Rome, there are also present some of the professors of the Faculty of Medicine of the second University of Rome—Tor Vergata. Therefore, in this place, scholars, researchers, physicians, nurses, and volunteer workers are called in a pre-eminent and privileged way to a common commitment to serve life with love and with full respect for God's laws. The more the knowledge and instruments of prevention and treatment are perfected, the more science and conscience, professional expertise and human ethics have the duty to respond together, in a convergent and constructive harmony, to the question of life asked by the brother or sister who suffers. The greatness and the nobility, the true history of a health care structure, are composed of the gratitude which is owed to it by those who have received care and help from it, both physical and spiritual, since physical health has its own condition and support in spiritual well-being.

In only three decades since this hospital was constructed, this section of Rome has expanded beyond every forecast. In the meantime, the socialization of medicine has multiplied the demands for health care. The medical and paramedical personnel is called today to respond to ever new duties, particularly in the area of prevention and health education. Professional formation should contain, furthermore, a careful, conscientious and responsible moral formation. The more widespread diseases of our time attack in an increasing manner the physical, psychological and spiritual balance. So that a truly human and humanizing medicine can develop, it is necessary to have a new sensitivity that will safeguard the mystery of life in all its components. At the same time the violent attacks against life and its integrity are becoming more tenacious, subtle and pretentious.

5. Built in the name of a saint, constructed as an act of gratitude to a Pope who was a pioneer in paying attention to the problems connected with research and medical practice, this hospital should discover in the same motivations of its beginning an incentive to see its own service to society as a mission to fulfill with all dedication and competence. For this purpose the Church offers her own collaboration. In fact, like her Divine Master, she is close to the health care field. The extraordinary possibilities which scientific and technological progress offer medicine challenge believers, asking them for a courageous and consistent witness, so that progress, transformed into an instrument of the civilization of love, will truly be at the service of life. In defending and fostering life, from the moment of its conception to its natural conclusion, the Church is conscious of fulfilling one of her primary duties, on the doctrinal level as well as on that of practice.

To the chaplains, the sister nurses, the Pastoral Council, and the laity more dedicated to the service of the sick, I renew my heartfelt exhortation to work for a pastoral ministry in favor of ever more effective health care. Every hospital organization that is aware, in its components, of its mission is called today to accept every challenge, on whose success the future of humanity depends.

May the Lord of life, whom we are preparing to celebrate in the commemoration of his Nativity, accompany and guide your every task, sustain all those who are placed under your care and, through the intercession of the Blessed Virgin, Health of the Sick, make this place a temple where a hymn to life is sung every day.

With my Blessing!

The Holy Father's Message for the First World Day of Dialogue and Communication about AIDS

Dr. Hiroshi Nakajima
Director General
World Health Organization

In instituting the World Health Organization approximately forty years ago, the international community of peoples proposed to attain one of the highest goals to which the person of our day can aspire to ensure all peoples better physical and mental well-being through economic and health-care cooperation among States, through scientific research and the fight against all forms of illness.

The program established by the World Health Organization in view of the new millennium, "Health for all—all for health," points to the goal of this first world day of dialogue and communication about acquired immune deficiency syndrone (AIDS), which is intended to sensitize public opinion and public authorities to the struggle against an illness whose seriousness causes an understandable alarm on all levels.

I gladly associate myself with this initiative, and I wish to express my moral support, because we are all convinced that this illness affects not only the body, but rather the entire human person, as well as interpersonal relations and life in society.

The social institutions responsible for safeguarding public health are always urged to undertake all possible efforts to ensure its defense; however, that may only be done with respect for each person, and the whole person, by preventing the spread of the illness and in caring for those afflicted by it. The degree of civilization of any given society can be measured be the manner in which it responds to the needs of life and the suffering of the human person, precisely because the fragility of the mortal condition demands the greatest solidarity in the defense of the sacredness of life, from its beginning to its natural end, in every moment and phase of its evolution.

The Catholic Church, which has received from her Founder, Jesus Christ, a heritage of special and attentive relations with the suffering, and this in every age, is no less concerned today with this new category of the sick. They must be looked upon as our brothers and sisters, whose human condition requires a special form of solidarity and help.

In expressing my wishes that the observance of this first world day on AIDS may contribute to strengthening, on the international level, the common engagement against such an illness and in favor of those who are afflicted by it, I want to give my assurance that the Catholic Church through her institutions, will not fail to have a special concern for that part of suffering humanity, which is the object of my affection and prayer. From the Vatican, 28 November 1988.

IOANNES PAULUS PP. II

Serve the Sick in Fidelity to Your Charism

To the General Chapter of the Hospitaller Order of St. John of God, 25 November 1988)

Dear Brothers,

1. I welcome you most cordially, representatives of the Hospitaller Order of St. John of God, during this brief pause in the work of your general chapter, which is being held at an important time in the history of health in the world in which we live.

I thank your new Prior General, Brother Brian O'Donnell, for his significant introduction to this meeting, and I wish him every success in fulfilling the delicate task to which he has been called.

I hope that you may draw abundant spiritual fruits from your meetings for the good of your entire Order, founded to give glory to God through serving the sick. We know that every general chapter is always an event of great importance, because it not only allows one to take a look at the overall progress of the religious life according to the particular charism of foundation, but also serves to arouse new spiritual fervor and a more generous dedication to one's ideal. For you, members of the worthy Order popularly and significantly known as Fatebenefratelli, *it is mostly a question of interiorizing the sense of* Christian hospitality *which you all profess with a special vow in the Church. Your Constitutions prescribe a specific commitment "to defend and watch over a person's right to be born, to live decently, to be assisted in infirmity and to die with dignity," so that "it is always clear that the center of interest is the needy or sick person" (n. 23)*

2. Great tasks await you, dear Brothers, and the Church asks you to perform them

in the spirit of the Lord's words. "As you did it to one of the least of these my brethren, you did it to me" (Mt 25:31-40) It is in these words that you must find the basis of your concept of "service."

The Council, particularly in the first part of Gaudium et Spes, *has fully emphasized the importance and dignity of serving the sick. A theology of service can be proposed in so far as the Church shows herself as a society of Christ's disciples who are qualified and distinguished by their mutual help and love.*

In today's complex society you must distance yourselves, so to speak, from old practices, and search for a model of theology of service as a courageous step leading you to invent something new. In a way more and more in keeping with the times, you are called to rethink the fundamental relation between the Christian faith and the forms of charitable service.

Your way of witnessing to the faith will be effective to the extent that it is founded on the capacity to go out from self in order to be open to the suffering, poverty, and need of others.

Solely in this openness does your service have reason to exist, aiming at practical aid to others rather than a formal project of assistance. I think that theological reflection can no longer be separated from practical organization of service.

Thus the sick, the suffering and the needy—who at times are an inconvenience, almost a hindrance, to some people—become the persons most cherished by the one who has faith, because they are living signs of God's presence. To make room for another, to exercise the charism of hospitality, in a certain sense means to make room for Christ and make him live with you and in you.

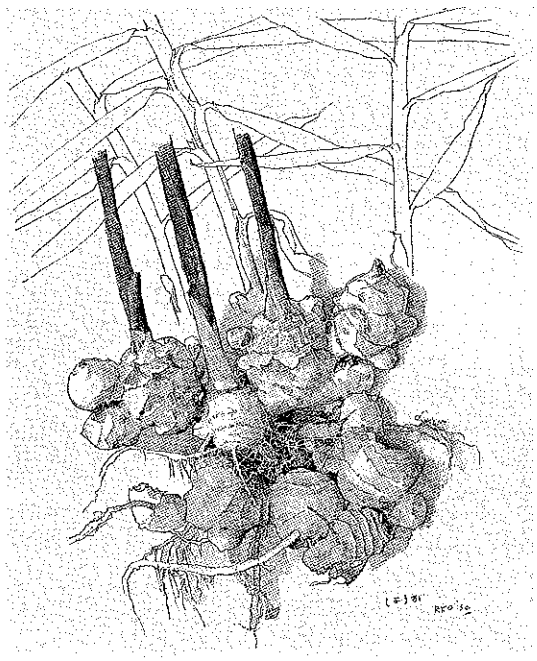
3. Your community of Brothers for the service of the sick is fully realized in the evangelic diakonia *which must always animate your work. On this also you must base your witness before your lay colleagues, who from a merely professional involvement in health care can arrive at a service conceived as an expression of love and Christian solidarity.*

Your communities can and should aim at building that "social space" needed by the new sick, whom advanced technology can no longer help and for whom the great institutions no longer cater. I think, for example, of AIDS victims, cancer patients, or of the psychiatric services.

Your communities must become the reference point in safeguarding the rights of the human person and respect for individual freedoms. Your activities in the service of the needy inspire you to a practical faith which is necessary and devoted to the one thing necessary: the Kingdom of God of which Jesus speaks, in the hope that the rest will also be given to you (cf. Mk 6:33).

Those who suffer and towards whom you exercise your compassion have much to teach you as regards the transformation of your existence as religious; let the sick person be your university!

You will effectively witness to your identity as Hospitaller Brothers of St. John of God if you base every program on real, existing needs; if you give preference to the person who is suffering; if you do not rely solely on individual opinions not in perfect harmony with the original charism which has produced noble examples of true servants *of the sick, and whose names are held in honor.*



I cannot forget that in this ideal of service in imitation of your Founder, you are seeking to bring your model of Christian hospitality to developing countries also. Thus the Church can begin, grow and coexist also where there are other religions and other lifestyles.

With this commission to love and be in solidarity with our weaker neighbor, I express my best wishes for a fruitful continuation of the work of your general chapter. Thus from your wise deliberations the whole Order will acquire the impulse necessary to continue on its way, which is so inspiring and meritorius.

I cordially bless you and your entire religious family.

" Behold your Mother! "

At the general audience in Paul VI Hall, 23 November 1988

1. The message of the Cross includes some sublime words of love, which Jesus addressed to his mother and to the beloved disciple John, present on Calvary during his agony.

St. John recounts in his Gospel that " standing by the cross of Jesus was his mother " (Jn 19:25). There was the presence of a woman — already widowed for years, as everything suggests — who was about to lose her son also. Every fiber of her being was shaken by what she had seen during the final days of the Passion, by what she felt and offered, now, beside the cross of execution. How could one prevent her from suffering and weeping? Christian tradition has perceived the dramatic experience of that Woman full of dignity and decorum, but with a broken heart, and has paused to contemplate her while participating intimately in her sorrow.

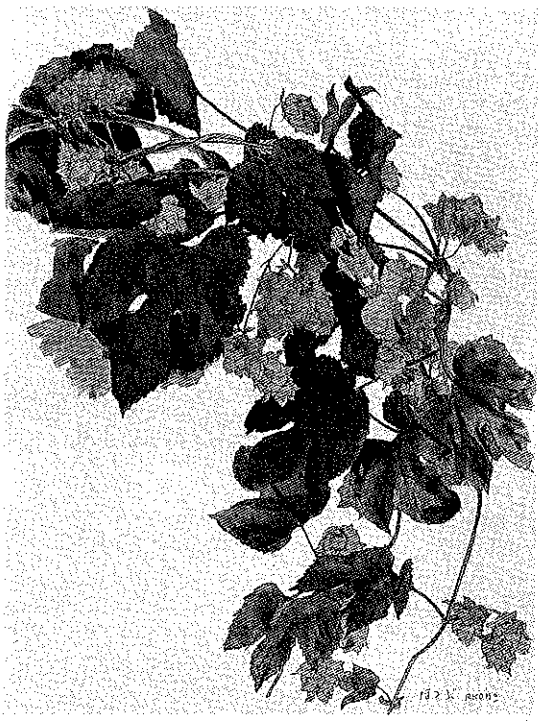
" Stabat Mater dolorosa
iuxta Crucem lacrimosa
dum pendebat Filius. "

It is not merely a question " of flesh and blood, " nor of an affection undoubtedly most noble, but simply human. Mary's presence beside the Cross indicates her commitment of total sharing in her Son's redemptive sacrifice. Mary had willed to participate to the very depth in the sufferings of Jesus because she did not reject the sword foretold to her by Simeon (cf. Lk 2:35); instead, she accepted, with Christ, the mysterious plan of the Father. She was the first to partake in that sacrifice, and she would forever remain the perfect model of all those who would agree to associate themselves unreservedly with the redemptive offering.

2. On the other hand, the maternal compassion expressed by her presence contributes to make more intense and profound the drama of that death on the Cross, so close to the drama of so many families, of so many mothers and children, reunited by death after long periods of separation for reasons of work, illness, or violence at the hands of individuals or groups.

Jesus, on seeing his mother beside the Cross, recalls the memories of Nazareth, Cana and Jerusalem; perhaps he reviews in memory the moments of Joseph's death, and then of his own separation from her, and of the solitude in which she lived during the last years, a solitude which will now be increased. Mary, for her part, considers all the things which for years and years " she had kept in her heart " (cf. Lk 2:19, 51), and now more than ever she understands them in connection with the Cross. Sorrow and faith are united in her heart. And then, at a certain point, she becomes aware that Jesus is looking at her and speaking to her from the Cross.

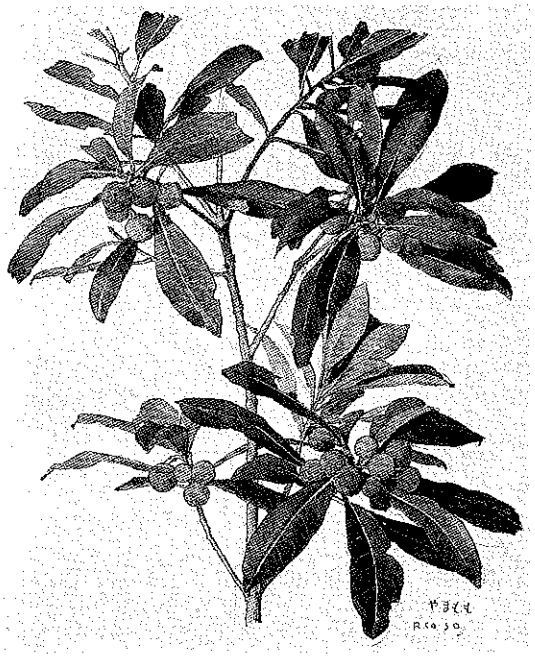
3. " When Jesus saw his mother, and the disciple whom he loved standing near, he said to his mother, 'Woman, behold, your son!' " (Jn 19:26). It is an act of tenderness and filial love. Jesus does not want his mother to remain alone. In place of himself he leaves to her as a son the disciple whom



Mary knows as the beloved one. Thus Jesus entrusts to Mary a new motherhood, asking her to treat John as her son. But the solemnity of that act of entrustment (" Woman, behold, your son! "), its situation at the very heart of the drama of the Cross, the sobriety and pithiness of the words which could be described as proper to an almost sacramental formula, suggest that over and above family relationships, the fact should be considered in the perspective of the work of salvation, where the woman-Mary was engaged with the Son of man in the mission of redemption. At the conclusion of this work, Jesus asks Mary to accept definitively the offering which he makes of himself as the victim of expiation, by now considering John as her son. It is at the price of her maternal sacrifice that she receives that new motherhood.

4. However, that filial gesture, full of messianic meaning, goes far beyond the person of the beloved disciple, designated as the son of Mary. Jesus wishes to give Mary the mission of accepting all his followers of every age as her own sons and daughters. Jesus' gesture has therefore a symbolic value.

It is not merely a gesture of a family nature, as of a son making provision for his mother, but it is a gesture of the world's Redeemer who assigns to Mary, as "woman," a role of new motherhood in relation to all those who are called to membership in the Church. In that moment, therefore, Mary is constituted — one might almost say "consecrated" — Mother of the Church by her Son on the Cross.



5. In this gift made to John and, through him, to Christ's followers and to all mankind, there is, as it were, a completion of the gift which Jesus made of himself to humanity by his death on the Cross. Mary is, as it were, "all one" with him, not only because they are mother and son "according to the flesh," but because in God's eternal plan they are contemplated, predestined and situated together at the center of the history of salvation. Thus Jesus thinks that he should involve his mother not only in his own oblation to the Father, but also in the gift of himself to humanity. Mary, on her part, is in perfect harmony with her Son in this act of oblation and of giving, as a prolongation of her Fiat *at the Annunciation.*

On the other hand, Jesus, in his Passion, is seen despoiled of everything. On Calvary his mother is still with him, and with a gesture of supreme detachment he gives her also to the entire world, before ending his mission with the sacrifice of his life. Jesus is aware that the final moment has arrived, for the Evangelist says: "After this Jesus, knowing that all was now finished..." (Jn 19:28). And he wishes to include also among the things "accomplished" this gift of his Mother to the Church and to the world.

6. It is certainly a case of spiritual motherhood, *which is realized, according to Christian tradition and the Church's teaching, in the order of grace. "Mother in the order of grace," the Second Vatican Council calls her (*Lumen Gentium, *61). It is*

therefore an essentially "supernatural" motherhood in the sphere of grace which generates divine life in man. It is an object of faith as it is also grace itself to which it is related. It does not exclude but rather implies a whole flowering of thoughts, of tender and delicate affections, of very intense sentiments of hope, trust and love, which form part of Christ's gift.

Jesus, who had experienced and appreciated Mary's maternal love in his own life, wished that his disciples also in their turn should enjoy this maternal love as an element of their relationship with him in the whole development of their spiritual life. It is a question of regarding Mary as Mother and of treating her as Mother, allowing her to form us to true docility to God, to true union with Christ, to real charity in regard to our neighbor.

7 It can also be said that this aspect of the relationship with Mary is included in the message of the Cross Indeed the Evangelist says that Jesus "then said to the disciple, 'Behold, your mother'!" (Jn 19:27) Jesus expressly asks the disciple to behave towards Mary as a son towards his mother To Mary's maternal love there should correspond a filial love Since the disciple takes the place of Jesus in regard to Mary, he is invited to love her truly as if she were his own mother It is as if Jesus were to say to him. "Love her as I have loved her." Since Jesus sees in the disciple all human beings to whom he leaves that testament of love, the request to love Mary as one's own mother is valid for all With these words Jesus lays the foundation of Marian devotion in the Church, to which he makes known, through John, his will that Mary should receive a sincere filial love from every disciple whose mother she is by the decision of Jesus himself The importance of Marian devotion, always desired by the Church, is deduced from Jesus' words at the hour of his death

8 The Evangelist concludes with the words that "from that hour the disciple took her to his own home" (Jn 19:27) This indicates that the disciple immediately responded to the will of Jesus From that moment, by taking Mary into his own home, he showed her his filial affection, he surrounded her with every care, he ensured that she could enjoy recollection and peace while waiting to be reunited with her Son, and carry out her role in the newborn Church both at Pentecost and in the subsequent years

John's action was the execution of Jesus' testament in regard to Mary; but it had a symbolic value for each one of Christ's disciples, who are asked to make room for Mary in their lives, to take her into their own homes By virtue of these words of the dying Christ, every Christian life must offer a "space" to Mary and provide for her presence

We can then conclude this reflection on the message of the Cross with an invitation which I address to each one, namely, to ask oneself how one accepts Mary into one's home, into one's life; and with an exhortation to appreciate to an ever greater extent the gift which Christ Crucified made to us by leaving us his own Mother as our mother

The Family Also Counts

Message from the Bishops of the Spanish Pastoral Commission on Patient's Day, April 30, 1989

1 "The Family Also Counts" is the slogan chosen for this year's Patient's Day Its purpose, on the one hand, is to call attention to the irreplaceable role of the family in caring for the sick and promote the necessary support so that it may carry out this role, and, on the other, to invite Christian communities to accompany the families that are undergoing the trial of illness

2 All of us have a family Within it we live out the great events of our existence birth, growth, joy, suffering, illness, and death When we get sick, the family grows ill along with us and is affected, sometimes profoundly Illness changes its plans and upsets the pace of its life; it is a source of worry and pain, concern, conflict, and emotional disequilibrium Illness puts to the test the values establishing the firmness of family ties and the solidarity of all Illness is certainly a painful, hard experience which can destabilize the family or help it to mature, destroy it or unite it more, separate it from God or draw it closer to Him

3 When we are sick, the role of our family is fundamental We need its affection and care to know that we are loved, its protection to feel secure, its company so as not to see ourselves abandoned, and its understanding and patience in order not to regard ourselves as a burden and obstacle We need its support and aid to be able to face realistically and peacefully take on illness and death

4. To deal with the hard trial of illness and be able to fulfill its function as it should, the family is not self-sufficient, it also needs support and aid Sometimes it is the patient himself who encourages and strengthens it with his will to live, serenity, and gratitude; on other occasions, the family members, by their unity and mutual assistance in household tasks; or at some points health professionals, with their information and counsel, their attitude of listening and comprehension, and their re-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spectful treatment, or the visit of a friend providing a breathing spell and relief in the face of accumulated fatigue; frequently it is faith in God which supplies a fortitude which would not otherwise be present and gives meaning to what is occurring.

5. The Gospel shows us Jesus' attitude to the anguished families that turned to Him in search of help: he does not skirt them, but is sensitive to their pain and shares it, understands their situation, comforts them and gives them consolation and hope, awakens their faith, communicates peace and joy, and offers them healing, a sign of the Kingdom of God which has come. Jesus calls people to move towards a more fraternal family where love and service to others — especially the least ones and the weak — reign. He therefore corrects offspring who turn a deaf ear to their parents, approaches the homeless, uncared-for sick, receives those who are alone, and invites his followers to do the same.

6. In this as in other respects, Jesus' behavior is the norm orienting our Christian communities. They, in turn, should be the wider family which welcomes families and helps them to become "domestic churches" consoling and attending their sick members in the name of the Jesus. For the Church, to which the Christian communities belong, is the Body of Christ, where all the members live for each other, where the neediest are regarded as the noblest members, and where all suffer when one of them is sick and all are glad when one recovers his health.

7. The message of Jesus and Paul has been clearly taken up by John Paul II in the Apostolic Exhortation Familiaris Consortio, *in which he makes a request of all of us: "An even more generous, intelligent, and prudent pastoral commitment is needed to those families which are going through difficult situations.... For example, these are the families with handicapped children or drug addicts, the families of alcoholics, the elderly, frequently forced to live alone or without adequate means of subsistence, the painful experience of widowhood, of the death of a family member which deeply mutilates and transforms the original family nucleus" (*FC *85).*

8. We offer the Christian communities some orientations for their work in this field of attention to the patient's family:

** Educate all, especially those preparing for marriage and Christian families, to live out health and face the reality of illness and death when they present themselves.*

** Collaborate with society and the health professions in conserving the health of the family, in its healing, and in the creation of wholesome social, cultural, economic, and political conditions which will enable it to enjoy good health.*

** Manifest solidarity with and closeness to all the families in the community with a sick member, especially those which are impotent to bear the burden alone, and offer them the Word of the Lord, prayer, and the community's generous service to attend them in their needs.*

** To value the dedication of families that care for their sick with solicitous and patient love and disseminate this witness in the community.*

** Accompany families that have lost a loved one.*

** To take in the sick who are left without any family and be a family for them.*

** To support and collaborate in all kinds of initiatives, activities, and associations seeking more appropriate attention to patients' families.*

9. May Mary, who was close to needy families and experienced in her own flesh the trial of the death of her Son, make our Christian communities sensitive to the needs of families that suffer and stimulate them to serve these families.
February 20, 1989

✠ JAVIER OSES FLAMARIQUE,
Bishop of Huesca
Commission President

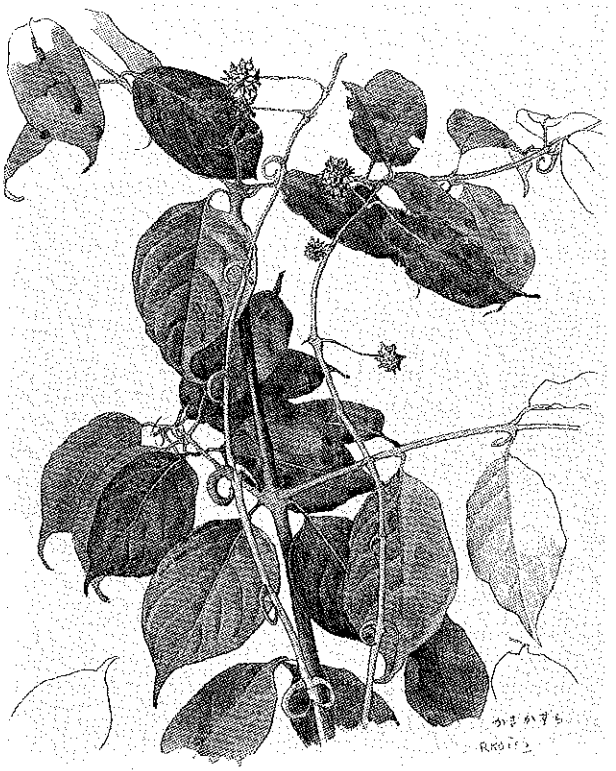
✠ TEODORO UBEDA GRAMAJE,
Bishop of Mallorca

✠ ANTONIO DEIG CLOTET,
Bishop of Menorca

✠ ROSENDO ALVAREZ GASTON,
Bishop of Jaca

✠ SANTIAGO GARCIA ARACIL,
Bishop of Jaén

Topics



Epileptic Patients and the Catholic Church

Psychiatric Patients: A Sociological and Pastoral Approach

Fighting Nicotinism, Alcoholism, and Drug Addiction

Epileptic Patients and the Catholic Church

A Talk by Dr Gian Luigi Gigli, Representative of the Pontifical Council at the International Congress on Epilepsy held in Jerusalem

I will discuss three main questions which, I think, are interesting, especially for those that are not Christians: 1. What is the conception of the epileptic patient that appears in the Gospels? 2. What has been the attitude of the Church towards the patient suffering from epilepsy? 3. What is the Church doing to improve the life of people affected by epilepsy?

1. Epilepsy patients in the Gospels

If we read in the Gospels (1) the narration of the miracles of Jesus we find several reports about healings of men possessed by evil spirits. From the description of the evangelists, one of these possessed people can be suspected to have been epileptic (Mk 1:23-26; Lk 4:33-36), and another is certainly an epileptic patient (Mt 17:14-18; Mk 9:14-27; Lk 9:37-43). This last one is the famous case described immediately following the episode of the transfiguration of Christ. Elsewhere in the Gospels Jesus is said to be healing "lunatics," a common term for epileptics at the time (Mt 4:24).

In a correct exegetic approach to the Gospels, the definition of epilepsy as diabolical possession ought not to be regarded as astonishing. First of all, in the Gospels possession does not apply only to epilepsy, but also to less stigmatizing diseases such as blindness and mutism (Mt 9:32-34 and 12:22; Lk 11:14) and even to osteoarthritis (Lk 13:10-17). In the Hebrew culture of the evangelists, in fact, the belief was still present, even if contradicted by Jesus, that disease was the punishment for someone's sins or even for his parents' sins. This appears clearly in the episode of the healing of the boy born blind (Jn 9:1-3). Moreover, diabolical possession stands very often for every kind of disease for which an organic origin could not be ascertained, particularly mental diseases, but also epilepsy. This is evident in several passages of the Gospels in which possession is simply one of the possible diseases.

His fame spread throughout Syria, and those who were suffering from diseases and painful complaints of one kind or another, the possessed, the epileptics, the paralyzed, were all brought to him, and he cured them (Mt 4.24).

That evening they brought him many who were possessed by devils. He cast out the spirits with a word and cured all who were sick. This was to fulfill the prophecy of Isaiah: "He took our sickness away and carried our diseases for us" (Mt 8.16-17)

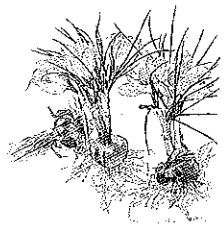
At sunset all those who had friends suffering from diseases of one kind or another brought them to him, and laying his hands on each he cured them. Devils too came out of many people, howling, "You are the son of God" (Lk 4.40-41).

Even when Jesus sends the Apostles on their mission, the evangelist reports that:

He summoned his twelve disciples and gave them authority over unclean spirits, with power to cast them out and to cure all kinds of diseases and sickness (Mt 10.1).

In summary, it is merely a superficial analysis to suggest that in the Gospels epileptic patients are simply considered to be possessed. We have to interpret every passage of the Scripture bearing in mind the knowledge and the language of the time. This is also what the Magisterium of the Church suggests to us with the Encyclical Letter of Pius XII *Divino Afflante Spiritu*. We thus observe from the description of the miracles in the Gospels that Jesus Christ passed over the earth full of compassion for all suffering men and healing all kinds of diseases to manifest his power as Son of God and to announce a greater redemption that also delivered men from sin and death.

He went around the whole of Galilee teaching in their synagogues, proclaiming the Good News of the kingdom and curing all kinds of dis-



ease and sickness among the people (Mt 4:23, (see also Mt 9:35)

This is evident when he refers to himself the old prophecy of Isaiah:

Unrolling the scroll he found the place where it is written: "The spirit of the Lord has been given to me, for he has anointed me. He has sent me to bring the good news to the poor, to proclaim liberty to captives and to the blind new sight, to set the downtrodden free, to proclaim the Lord's year of favor." He then rolled up the scroll, gave it back to the assistant and sat down. And all eyes in the synagogue were fixed on him. Then he began to speak to them, "This text is being fulfilled today even as you listen" (Lk 4:17-19).

Every healing in the Gospels is therefore not only liberation in itself, but also the symbol of a more spiritual liberation. As Jesus himself says during the miracle of the paralyzed boy (Mt 9:1-8; Mk 2:1-12; Lk 5:17-26), healings announce that the Son of Man, who has power over bodies, is also the Son of God, who has the power to deliver us from our sins and grant us eternal life.

Recently Janz published a fascinating paper about Raphael's Transfiguration, in which two chronologically consecutive episodes (i.e., the transfiguration of Christ and the healing of the epileptic boy) are placed in the same painting, one above the other, with many links, especially between Christ's and the boy's gazes and between the voice of God in the cloud and the cry of the boy during the seizure (2). Janz noted very profoundly that the healing of an epileptic boy reported with great emphasis by three of the four evangelists (Mt 17:14-18; Mk 9:14-27; Lk 9:37-43) must also have a symbolic sense in order not to be meaningless, since even at that time it was clear that there was a spontaneous and dramatic recovery after individual seizures (2).

"The other biblical stories of illness are not only miraculous cures, but also indicate a type of health where one is neither blind, deaf, nor lame towards the metaphysical entity we call God. In the story of the epileptic boy, as we see in the Gospels and in Raphael's painting, the cure loses its importance in comparison with an interpretation of the epileptic seizure as an event symbolizing death and resurrection, and thus as an eschatological sign situated right in our midst. Correspondingly, the initial cry should be conceived of as a prayer, that is, a plea from above. This seems to be the Christian message of the text, as well as that of Raphael's painting (2)."

To my knowledge, in the past theologians never caught the symbolic meaning of the epileptic seizure, while writing extensively on the salvific value of suffering. If further studies and discussions support, as I hope, the interpretation of Janz, Christians will have to regard epileptic patients as special witnesses of Christ's redeeming passion, death, and resurrection.

2. Epilepsy and canon law

Caution in looking at statements with the eyes of the time, separating what is lasting from what is temporary, does not apply only to the Gospels, but is useful also when considering the practical attitude of the Church towards epileptic patients. This historically based caution would have simplified many debates and polemic controversies about the dictates of the old Code of Canon Law concerning epilepsy (3,4).

The Code of Canon Law (*Codex Juris Canonici*) was promulgated in 1917 by Pope Benedict XV to reorganize in a structured form too many old uses and jurisprudence that had accumulated through the centuries in Church regulations. The Canon Law Code of 1917 listed several conditions as irregular to be legitimately ordained for the priesthood or to exercise the ministry once ordained. These irregularities could be *ex-defectu* (i.e., for lack of certain required conditions) or *ex-delictu* (i.e., for severe voluntary actions against Christian principles). Canon (or article) 984 dealt

with the irregularities *ex-defectu* and in the third paragraph declared irregular those

" ... Individuals who are or have been epileptics, insane, or possessed by the devil. If, after the reception of orders, they become thus afflicted but later on are certainly rid of the affliction, the Ordinary may again allow his subjects the exercise of the orders which they had received ... "

... Qui epileptici vel amentes vel a daemone possessi sunt vel fuerint, quod si post receptos ordines tales evaserint et iam liberos esse certo constet, Ordinarius potest suis subditis receptorum ordinum exercitium rursus permittere ...

It is astonishing, at first glance, that in 1917 this paragraph grouped together insanity, epilepsy, and possession. It seems indeed the perpetuation of the idea of epilepsy as a *morbus sacer*, a malefic disease. Nevertheless, several considerations make this assertion appear in a better light. First of all, it has to be regarded together with the prescript of the preceding second paragraph of Canon 984, which declared irregular for ordination

" ... Bodily defective men who on account of debility cannot safely, or on account of deformity cannot becomingly, engage in the ministry of the altar ... "

... Corpore vitiati qui secure propter debilitatem, vel decenter propter deformitatem, altaris ministerio defungi non valeant ...

The two paragraphs were strictly linked, the second dealing with physical impediments and the third with nonphysical conditions. According to Bonduelle, insanity, possession, and epilepsy were grouped together not because they were confused with each other, but in order to differentiate them from physical impediments (5). Both groups of conditions were considered irregular for the ministry because they interfered with secure and decent service at the altar. As for epilepsy, this careful preoccupation was due to the risk that the future priest could have a seizure during the celebration of the Holy Sacrifice.

Canon 984 of 1917 was the result of uses and jurisprudence documented by texts of Councils and papal letters. Lefebvre cites a text of Alexander II (Pope from 1061 to 1073) in which the Pontiff declares that " it is indecent and dangerous that, during the consecration of the Eucharist the bread should fall because of an epileptic disease (6). " It is evident that the prescripts of the Canon Law Code resulted more from pragmatic concern for the Holy Sacrifice than from overt discrimination against epileptic patients. Further support for this contention comes from two other historical considerations. Epilepsy is never mentioned in any other area of canon jurisprudence (e.g., marriage), thus implying that epileptic patients were considered neither possessed nor lacking their free will because suffering from a severe mental disease, conditions that could bring into question the validity of consent to marriage.

Furthermore, even if it is not certain that a distinction between epileptics and the possessed can be attributed to Pope Gelasius (492-496), it is nevertheless certain that medieval *Decretalia* classified the epileptic disease among the irregularities *ex defectu corporis* (i.e., for physical defects). In fact, the chapter of the *Decretalia* in which epilepsy is discussed, before the promulgation of the Code in 1917, is Title XX, *De corpore vitiatis* (about the physically sick) (6). This doctrine, regarding epilepsy as an usually severe disease creating problems of danger and decency in the celebration, is reflected in pastoral practice preceding the Code's promulgation. In fact, before ordination a papal dispensation could grant access to the priesthood if seizures were controlled; after ordination the local bishop could permit private celebration if seizures were sufficiently rare, a celebration that would never been permitted to the possessed (6).

We must also consider that the first effective therapy for epilepsy (phenobarbital) was introduced into medical practice only in the years after the promulgation of the Code. Nevertheless, Canon 984 remains open to possible recoveries when it declares, for those already ordained, that the Ordinary may again allow his subjects the exercise of the orders which they had received if they are certainly rid of the affliction.

Even more important is to

consider that the Church borrows its knowledge on scientific matters from what the scientific community of the time regards as true. If there is unwarranted discrimination in grouping epilepsy together with insanity and possession, the leading scientific theories of the time can largely account for it.

It is true that in 1917 people already knew of the brilliant work of John Hughlings Jackson and Victor Horsley, but it is also true that there were other views that received even greater credit in the scientific world of the time. Kraepelin, an outstanding figure in psychiatry, ascribed to psychiatrists broad competence in the diagnosis and treatment of epileptic patients, and many authors (e.g., Morel, Fere, Fisher, Schule, Samt, Roncoroni, Bianchi, Dellamagne) grouped together epilepsy, moral insanity, and inborn criminality (7). The leading representative of this very fashionable positivistic stream was certainly Cesare Lombroso, who, on the basis of a very large collection of statistical, anthropometrical, and psychological data, stated that " the morally insane or the inborn criminal is an epileptic in whom the seizure lasts throughout life (8) " and that " the total identity among criminals, the morally insane, and epileptics is demonstrated especially by psychological investigation (9). " Another giant of the time, Otto Binswanger (10), stated that epileptics, before anybody else, should be suspected as responsible for " murder, arson, sexual offenses (exhibitionism, pederasty, *stuprum violatum*). " More naively, in the 1880s, Morselli, director of the psychiatric hospital of Macerata, was still conducting careful and detailed observations about the relationship between seizure frequency and the lunar phases (7).

If this was the cultural atmosphere of the scientific world at the time, it is not surprising that the Canon Law Code of 1917 grouped epilepsy together with insanity and possession. The question may arise as to why Canon 984 was not changed until 1983. However, it is necessary to consider that canonists are not neurologists, but lawyers and reflect scientific changes only later. Moreover to change a law is always a slow procedure, especially in the Church, which is used to dealing with eternity, and became even slower when great psychiatrists were still writing in 1954 that epilepsy " seems to disrupt the psychic structure of the being. It is in the background of this disruption that... aggressiveness and virtual criminality occupy a central position (11). "

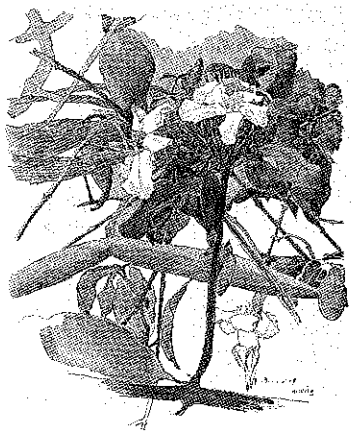
In spite of this delay, the strict prohibition of 1917 was attenuated, for those who were already ordained, by the use of that part of the same Canon 984 that provided for reintegration into the ministry for those whose seizures were judged to be controlled. This criterion became more and more frequently used as the treatment of epilepsy improved (5).

As a general comment at the end of these remarks on the Code of 1917, echoing Pope John Paul II, I would like to say that it is becoming more and more evident that Science and Faith cannot be in opposition, since for both of them the object of research is the Truth, and the Truth is only one. The Church, therefore, relies on what scientists think to be true in the natural order. If scientists offer wrong interpretations of reality, then the Church will be wrong in using scientific opinions to solve practical problems.

In 1983 a new Canon Law Code was finally promulgated by Pope John Paul II (12,13). The provisions of the old Canon 984 for candidates for the priesthood were included in Canon 1041 of the new Law, which with great simplicity declares irregular for the reception of orders:

" ...one who suffers from any form of insanity, or from any other psychological infirmity, because of which he is, after experts have been consulted, judged incapable of being able to fulfill the ministry... "

... *Qui aliqua forma laborat amentiae aliusve psychicae infirmitatis, qua, consultis peritis, inhabilis iudi-*



catur ad ministerium rite implendum...

For those who are affected by the same diseases and have already been ordained Canon 1044 prescribes that they are impeded from the exercise of orders

" ...until such time as the Ordinary, having consulted an expert, has allowed the exercise of the order in question... "

It is evident that the physical irregularities have disappeared and that the judge-

ment on mental diseases hindering the ministry is reserved to the experts. They will evaluate if in any circumstance epilepsy will produce behavioral or mental disturbances seriously interfering with the ministry. In any case, epilepsy is no longer a special impediment to becoming a priest.

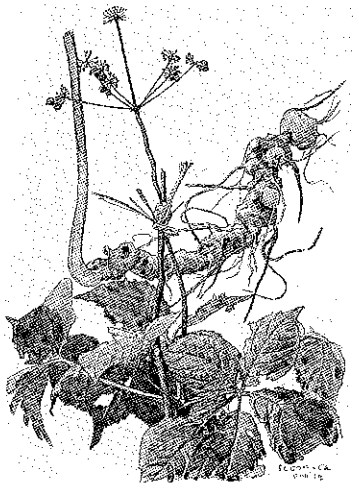
3. For a better life of epileptic patients: possible contribution for the Church

As a final part of this presentation, I would like to outline the present positive contribution that the Church can offer to ameliorate the condition of the epileptic patients. I think that the Church's contribution can be at two levels of intervention: institutional and educational. Both interventions are motivated by the compassionate and healing attitude of Jesus towards all suffering persons and by a theological tradition that looks at patients as the image of the suffering Christ perpetuated in history.

During the Renaissance, to reform health institutions meant for St. Camillus De Lellis to separate the patients in the hospital wards according to the type of disease, and for St. John of God, to abolish the imprisonment of the mentally ill. Today our challenge is to create health and research institutions in which the best possible treatment can be offered to patients and new biomedical knowledge can be acquired. Nowadays the network of Catholic health institutions remains important in the developed countries, but it is vital in many third world countries, where sometimes it coincides *tout court* with the local health system.

Two years ago the newly created Pontifical Commission for the Apostolate of Health Care Workers sent questionnaires to get information for the first Directory (Index) of the Health Care Centers run by Church organisms all over the world. As a partial result of this enquiry, a first book was published containing data on 12,000 institutions.

I am not aware of Church health institutions especially devoted to epileptic patients. This, in my opinion, does not mean lack of attention to the problem, but simply that epilepsy is regarded as one of the neurological disorders and not as a special disease.



In Church-run institutions, without any religious discrimination epileptic patients receive, along with all others, the best level of treatment possible in the local situation, and positive behavior is taught to future health workers in the affiliated nursing or medical schools.

This leads us to the educational level, which I personally consider to be the most important and most specific one for the Church. Apart from the education of health professionals, all the faithful are taught to resemble Christ, as much as they can, in their behavior towards the suffering. Each believer will hear the story of the good Samaritan (Lk 10:29-37) and the commandment to love our neighbour as ourselves (Lk 10:25-28). On many other occasions (homilies, catechism, preparation for sacraments, etc.), he will be educated to be compassionate, to care, to refrain from discrimination, to be a brother for all suffering people. How deeply this teaching will penetrate into the faithful's souls and how much it will bear fruit to break the wall of marginalization and prejudice from which epileptic patients are still suffering only God knows. In spite of all, I believe that this kind of educational work remains most important to create a more humane world.

Pope John Paul II is playing a very special role in this educational effort. He shows devotion for patients, and in every city where he stops, he visits at least one hospital. In Rome he has visited almost all the health centers. Contact with patients is part of each of his public audiences. Moreover, Providence called him to be personally in danger of dying and to lie for a long time in a hospital bed because of terrorist injuries. I am convinced that it was also on the basis of his personal experience that he published in 1985 the Apostolic Letter *Salvifici Doloris*, the first comprehensive magisterial document about suffering and that, one year later, he created *motu proprio* the Pontifical Commission for the Apostolate of Health Care Workers in order to coordinate the efforts of the Church in the health field all over the world. It is on behalf of this Pontifical Commission that I am speaking here today. These

two papal decisions are further promoting the Church's awareness of its duties in urging the faithful to love their sick brothers and sisters. Especially in the case of epileptics, Christians need to be encouraged to transfigure themselves to become Good Samaritans, seeing in the epileptic patient a symbol of Christ's suffering, death, and resurrection (2), a very special witness to our salvation, mysteriously related through his personal suffering to the redeeming suffering of Christ.

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NOTE: Lombroso's and Binswanger s citations have been translated into English by the author

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Psychiatric Patients: A Sociological and Pastoral Approach

I. Who Are They?

1. *From the most universally human standpoint*, they are the neediest and most neglected;

* because they need everything: bread, words, belonging to something — a family, a people, a country — sufficiently creative love so that they will feel useful, valuable to someone, a life worth living, with meaning, which can be shared;

* because they present a twofold difficulty for care: they often do not let themselves be helped, nor do we know how to help them on many occasions.

2. *From the standpoint of definitions*, they are dependent, unsociable, and afflicted with terrible suffering.

* Those presenting considerable physical, mental, and social destruction, running counter to the WHO's definition of health: "complete physical, mental, and social well-being."

* In terms of Jordi Gol's definition of health as "an autonomous, solidary, and joyful way of living," psychiatric patients are:

a) The radically dependent — upon a symbiotic mother and a father who is normally absent; on a family with some stigma of malediction; on some frequently unmentionable past; on inner rage and hatred which are so intense that they are brutally blocked and without access to emotion and language, or, if they gain access to these, they are unrecognizable after the defense and cosmetics; on compulsive, uncoercible conduct; and so forth.

b) The unsociable, for they lack the most basic, elementary matrix of belonging — to the mother, the land, the family, the town, society. They are frequently the strange, incomprehensible, queer ones. So strange and uncommon that they sometimes say they are from other worlds and other galaxies — above heaven and earth, knowers of good and evil, heaven and hell. For this very reason, and in one and the same movement, we marginalize them and they marginalize themselves.

c) As for a "joyful life," I have encountered "enormous suffering" in them, so broad and intense that it is often held in check in the unconscious, ferociously clamped down upon in such a way as to impede the development of life. These are the paralyzing, bloodcurdling, petrifying stories of terror, cancerous nightmares which do not disappear with the day. For them

reality is so laden with suffering that they take refuge in madness, escape into reveries, anchor themselves in childhood, and refuse to grow. Inner suffering is on occasion so intense that they have annulled sensory-motor channels. I could narrate episodes involving psychiatric patients with terribly painful forms of cancer who need no pain relievers because there is no route of access to the register of pleasure and suffering.

3. *From the standpoint of their characteristics*, they are those who have failed in building their lives.

* The incomplete: Those who have managed to attain only an embryonic, stunted identity, those who are only human larvae, like that twenty-three-year-old fellow who leads a merely biocorporal existence, with archaic, virtually placentary modalities, wherein all that matters is to satisfy oneself and attack. He need not leave his room/maternal womb (he has been there for three years now), nor does he have need of words, ideas, or relations with others. He manages and phagocytizes himself.

* The mutilated: Those coming from their homes or general hospitals whom medication has been unable to cure. This is a numerous group which has never been listened to, which has never been given the chance to have a role, which has not been integrated into a meaningful life — they have only been given medicines: the psychically mutilated whom people try to hospitalize because they are useless, because no reason for their existence is seen, because they have not managed even to cure themselves; regarding whom people say that "everything has been done for them" and they are unable to do more. They are now granted only asylum space, in the most mutilating sense of the term: a space where they will be given only food and lodging, but no possibility for mental and emotional growth or the chance to formulate and fulfill a personal life project.

* The badly formed: Those who have been interiorly emptied, the autistic and catatonic, those who do not interact, who neither give nor receive anything, those not retaining, storing, or assimilating; those who are weary of suffering and take refuge in madness and fantastic, frenzied ideations.

Those who must escape from an unbearable reality to calm their anguish and achieve artificial happiness through drugs.

* The badly treated and badly cared for: Only a single dimension of these people has been taken into account: somatic, mental, social, or spiritual. As happens with so many psychiatric patients, for whom a cure is sought exclusively by medication, no one is interested in asking them what they think and feel, who they live with, how they live, and what meaning they give to their lives. Or others who are approached solely from a psychological standpoint without providing them with medical assistance, institutional support, and an effort to find meaning so they can face their problems. Or those who are hospitalized with the fantastic aim of having them cure themselves. Finally, those who have failed in a life option and must now face a future with little time and few resources. Those who

have violated some taboo of our culture and are condemned to an isolated, shameful, and threatened life.

All of these form the vast group whose members have not been seen in a perspective of integral medicine.

4. *From the standpoint of their identity*: They are those who are not.

* Those who do not have their own name and can, therefore, have any name: God, the devil, Napoleon, the Virgin Mary.

* Those who lack inner unity and live in a divided state, broken, alternating; they may go from great euphoria to deep sadness, from being substantively good to being intrinsically bad, from living in filth to being completely immaculate.

* Those who have some nucleus which resists psychic unity: an obsessive ideation; an uncontrolled emotion, an autonomous core of malignity. They are those who depend on something — drugs, rites, uncoercible impulses. They feel "possessed" by something which forces them to think, feel, or act against what they know is normal. They are the compulsive, like the patient who just called me a moment ago in order to say nothing, simply because he felt impelled to make the call.

II. How Many Are There?

1. About a fourth of our population suffers mental disturbances which may require some kind of assistance.

2. 14% would need psychiatric care.

3. With good functioning of the means available for primary care, only 1.7% of the patients would need specialized psychiatric attention.

4. Approximately 0.2% of the population requires psychiatric hospitalization.

5. At present around 0.1% of the population is institutionalized permanently at public and private psychiatric hospitals.

III. Where Are They?

1. Those who have reached the end (that 0.1%) are at psychiatric facilities, dead to all mental, social, and spiritual life on an autonomous basis. We find only a repetitive, monotonous biocorporal life. They are the object of custody.

2. Those who have also reached the end of decline and of the destruction of their identity and are not at psychiatric facilities are distributed between the asylums and the street as vagrants and beggars. They are the object of isolation and ignorance.

3. There are some patients on the borderline between institutions and their homes; they are the ones who divide their time between the hospital and their dwellings. They are the object of struggle between the family, which wants their definitive hospitalization, and the facility, which opposes it.

4. We should pay a great deal of attention to the so-called "risk groups": the retired, women over forty, men over fifty with a low educational level and from a low socioeconomic class. Where are they? Normally, in their environment, getting by as best they can — i.e., badly. They are the object of disdain.

5. Finally, there is that 25% of the population which requires some kind of psychological assistance. They live at home, but we must ask how, what their status is. Taking refuge behind a neurotic family which conceals them, continually attacked because they are useless, parasitic, and unproductive, or having become little tyrannical monsters because people are afraid of them. Always laboring under the curse of "not getting well," in spite of the fact that they have been taken to the best doctors, have consumed the family budget, and have exhausted the family's reserves of emotional patience. They are often the object of marginalization.

IV. What Should We Do with Them? We do not know what to do with them.

1. Because we do not understand them. Not even the health sciences agree about what they are, what is happening to them, and what remedies we can offer them.

2. Because we do not tolerate them. This complaint is frequently heard: "I can't put up with it any more." They offend our good name, alter the pace of our life, engage in dangerous and improper conduct. They are a constant threat to our mediocre security. We are afraid of them and do not trust them.

3. Because people easily fall into a vicious circle: the family (if there is one) cannot take any more and turns to the doctors; the doctors prescribe and the patient is not cured, but

suffers a relapse; the family tires and requests institutionalization; the psychiatric hospitals, for lack of criteria or out of indigence, maintain institutionalization; time passes; the family withdraws and gets used to living without the ill member; the patient becomes institutionalized, and a set of rights and duties gets established; the family disappears; the circle is broken only at death.

4. Because they are easily manipulated. Because they are feared and not understood. They count for nothing. Everyone has rights over them.

* Public authorities, according to economic or social interests, backed by the school of psychiatry which best suits them, may just as well lock them up as dangerous or grant them all the rights of citizenship. They just as readily fill up psychiatric hospitals or dismantle them; they place patients in apartments, discharge them, or take them to general hospitals. Disoriented about what should be done, people dogmatize: drastic measures are taken, and " something different " from the past is done. The common denominator is that the patients are never taken into account at all, nor is their interest, opinion, or state. There is replacement, nothing more. As someone quite familiar with psychiatric hospitals and current reforms told me, the patients are not even packages — they are straw sacks, merchandise to be loaded and unloaded, shipped: they may be given freedom or locked up.

* Professionals, if they lack solid training and equally solid ethical principles, follow a reductionist medical practice: they give either pills alone or advice alone. And since it is costly and they have no time, there are few who deal with problems globally, with an eclectic therapeutic approach, relying on a team and taking into account all the institutional resources: family, preventive medicine, hospitalization, intervention in crises, and so forth.

V. The Task of the Church: We frequently do not know what to do with them either. Nevertheless, we have enormous wealth.

1. From a Gospel standpoint,

* They are Jesus' favorites.

* They are the motif by which Jesus announces his most substantial message: liberation from all slavery, interior pacification, reconciliation with the Father, the promise of salvation.

* They are the touchstone proving the authenticity of those who call themselves his disciples (" Don't stand in their way "; " Who is your neighbor? ").

2. From the standpoint of Church tradition,

* The Church has always received them instinctively. Certainly, only her most compassionate and merciful core has done so, and it should be pointed out that the other nucleus, made up of the right-minded and those of faultless conduct, has also marginalized them.

* A high percentage of psychiatric hospitals belongs to the Church. We must recall the Daughters of Charity, the Brothers of St. John of God, the Hospital Sisters, the Sisters of St. Ann, and others, who, in keeping with their charisms in large measure, take care of these patients.

3. But much remains to be done in the Church.

* Open the doors of the People of God to these persons, on the same basis as for others. This specifically means that " the economy of grace follows the law which God has imposed on it: to communicate to many (to all) what in the beginning was granted to one alone. Of all that Jesus is or has some aspects are communicated to all, and others, only to some. To all are communicated the gifts of salvation and communion: to be children, heirs, enter into the community of saints, and thus rise to heaven, sit at his right hand, and reign. "

* Starting from the fact that radical marginalization, which condemns us and separates us from God, no longer exists, thanks to Jesus, we cannot marginalize, isolate, place at a distance, prohibit. On the contrary, we must activate all that means living together, receiving, drawing near, assimilating.

* There is something specific the Church can do for psychiatric patients: remove the stigma of being ill-born, accursed. Within the family of the children of God they are welcome and blessed.

* There is also something quite proper to the Church: her merciful heart, with its capacity for loving, engendering, creating, and forming communion. There where institutions fail (families, communities, states), the Church must be able to invent and surpass herself, for she has an inexhaustible capacity for tenderness, the very same tenderness of God. Families can get tired and say, " I

can't bear any more; I'll do nothing more; I don't know what to do with this sick member of ours." This desperate judgment cannot be pronounced by the Church from the standpoint of Jesus or God the Father, whom Jesus revealed to us.

* Finally, a specific idea for Christian professionals. On the basis of my faith and my experience in the field of psychiatric illness, I would venture to note for them some concrete directions for thought:

a) Let us examine our reality without tricks or excessive defenses. This means we should not exclude the insane from our professional perspective or defend ourselves from them by saying, "I know nothing about this."

b) Once we dare to examine this whole group of patients, without marginalizations or first- and second-class divisions, we must go beyond symptoms and have the courage to pose the real problems: what is happening to make our young take drugs, why our society is so violent, what the reason is for so many failures in our institutions (family, work, community life), why we abandon the retired and invalids, why we mistreat children, why we say, "We are all a bit mad."

c) Once we have had the courage to conduct an in-depth examination, let us also have the valor to employ our economic, technical, and scientific goods, our institutional capital, the wealth of our society, our culture, and our Church, the emotional and instrumental resources provided by our preparation and our faith.

d) With a lucid diagnosis and the precise use of our resources, let us honestly pose what we can and cannot do. For instance, we may not be able to cure the insane, but we can always tolerate him. In this same direction, we should see how our resources can be most equitably distributed. For example, I agree that part of the budget should be spent on high technology interventions, but I ask what the cost is, what the consequences are, and if this means abandoning a large group such as the elderly or psychiatric patients.

e) A point which has a great deal to do with the professional practice of medicine: when we deal with the patient, whoever he may be, but especially every psychiatric patient, we must not slice him up or quarter him, but have the honesty to deal with him as a whole. Let us seriously create what is now being emptied of content: integral medicine.

MARIANO GALVE
National Coordinator for Psychiatric Pastoral Assistance Spain

Fighting Nicotinism, Alcoholism, and Drug Addiction

(Adopted by the Council of Europe Committee of Ministers on October 16, 1986 during the 400th Meeting of Ministers' Delegates)

The Committee of Ministers, in accordance with Article 15b of the Statute of the Council of Europe,

Considering that the Council of Europe aims to create closer links among its members and that one of the ways to foster this aim is to adopt common policy and regulation in the health field;

Considering that alcohol, tobacco, and drug dependence are a serious health problem involving social, psychological, and pathological aspects;

Recalling its Recommendations R(82)4 on the prevention of alcohol-related problems, especially among young people, R(82)5 on the prevention of drug addiction and the particular role of health education, and R(84)3 on the principles concerning television advertisements;

Considering the need for a flexible information and education policy, together with legislative and economic measures and regulations aiming to promote healthy ways of living and reducing risk factors, and considering also the key role that may be played by mass media and other opinion makers in the effort to make the public more sensitive to health education and to the other measures in this regard and to help it to accept them better,

Recommends to the governments of the Member States that they take into account the guidelines formulated in the document attached to this recommendation when encouraging the determination of strategies to combat nicotinism, alcoholism, and drug addiction, in collaboration with opinion makers and the mass media, and stressing the responsibility of these in shaping public attitudes towards health.

Annex to Recommendation R (86) 14
Guidelines for the Reformulation of Strategies

Objectives

1. Information and education strategies in the health sector should mainly aim to encourage healthy ways of living, promote a healthy environment, and reduce risk factors.

Policy

2. A health information and education policy should be carried out within a coordinated and integrated health care system, together with some legislative, economic, and other measures, and should also be part of a more comprehensive policy giving priority to disadvantaged social environments.

3. This policy should be flexible and applicable on a local level in order to develop public and individual responsibility. It should also take into account the differences among existing social environments and the need to provide a kind of information that can prove attractive to disadvantaged population groups.

Coordination

4. A coordinated strategy should appeal to institutions such as schools, public and private health and social bodies, families, charitable institutions, sporting and leisure clubs, and the mass media.

5. Coordination should be established:

— horizontally, among institutions, services, and individuals acting at the same level;

— vertically, among institutions, services, and individuals operating at local, regional, and national levels;

— in time, in order to cover the whole life of an individual.

Possible Role of the Mass Media

6. In cooperative efforts with the mass media, it is necessary to observe the basic principles of independence and freedom of expression common to all the Member States and to consider the political, commercial, and financial environment, which differs from one country to another, wherein the mass media operate. An effort is needed to

put the mass media in a position to encourage public and individual participation in the promotion of their own health and to strengthen the impact of educational campaigns addressed to the public at large. Collaboration with the mass media should include their participation in the formulation of strategies.

7. It is important, insofar as possible, to reduce to the minimum the discrepancies between the information disseminated by the mass media and the policy carried out by health authorities. It is particularly advisable to avoid such information's leading to the idea that people using tobacco, alcohol, and illegal drugs are to be admired more than people who do not.

8. Public authorities — and health authorities, in particular — should provide the mass media with all the data they need to fulfill their task of informing. Information should be given in an appropriate and essential form, in order to make the message clear and understandable to the public.

9. It would be advisable to ensure journalists' knowledge by organizing seminars and training courses for them, for example, or drafting guidelines and reference texts (e.g., in the area of terminology). It would be useful to encourage the creation of associations of journalists expert in health matters.

Specific Strategies

Tabacco

10. Strategies aimed at discouraging nicotinism should essentially try:

— to deter people, especially young people, from starting smoking;

— to convince smokers to stop or reduce their tobacco consumption; it would be useful, for instance:

— to forbid smoking in public places, schools, hospitals, mass transit, etc.;

— to discourage smoking in companies, offices, etc.

— to provide warnings on tobacco products.

Alcohol

11. Strategies aiming to reduce alcohol consumption should take into account all the factors — such as economic and commercial interests — that may interfere with the achievement of established goals. These include:

— to promote a moderate, responsible attitude, especially at work, in schools, and in military and sports environments;

— inform the public on the risks caused by alcohol consumption, particularly in pregnant women and young people;

— to draw the mass media's attention to the consequences of how they present alcohol consumption.

Drugs

12. Strategies for fighting drug addiction should consider the different aspects of the problem as well as the loneliness of many drug addicts within society — victims needing protection, not public curiosity — and their serious social maladjustment. It is necessary to provide information at a local level to young people and their families, to teachers and medical personnel. Some other measures can also be taken to prevent the diffusion among young people of audio-visual and other materials encouraging the use of drugs.

Evaluation

13. Health education campaigns and health information programs included in the above-mentioned framework should be accompanied by an evaluation, and the mass media should also be involved in order to be sure that topics have been accepted by the public. Evaluation should take into account the risks connected with the way educational messages or health information are perceived by different social groups. The results of evaluation should be made use of in organizing future campaigns.

Mediators

14. Health professionals, teachers, and socioeducational workers play a basic role in disseminating health information and should be provided with training and information concerning the most recent techniques and

progress in the field of health education for children and adults.

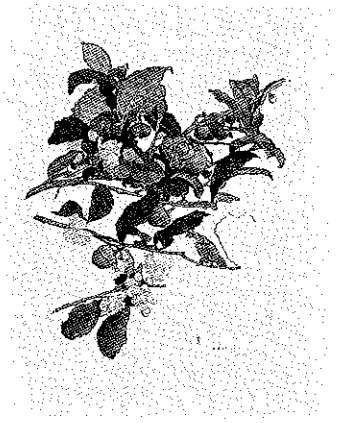
15. The necessary means should be made available to encourage and facilitate cooperation among information providers, on the one hand, and consumers' associations, unions, youth movements, and other nongovernmental organizations dealing with health and environmental problems, on the other, and to ensure the active participation of all people involved. This cooperation may be achieved by creating common teams charged with planning, carrying out, and evaluating campaigns. Whenever necessary, opinion leaders and representatives of these groups should be given adequate training.

16. The creation of a national prize should be provided for in order to encourage and reward individuals and organizations that have contributed in an essential way to formulating and implementing strategies to combat nicotinism, alcoholism, and drug addiction as inspired by the principles set forth in this Recommendation.

Marketing and Promotion Regulation

17. A responsible policy on the regulation of the promotion and marketing of tobacco, alcohol, and drugs should be adopted; whenever possible, voluntary cooperation with producers should be part of this policy.

18. It would be advisable to adopt a policy restricting every kind of tobacco and alcohol promotion — including the possibility of prohibiting it entirely in certain cases — and to take measures to avoid all improper promotion of drugs.



Testimony

Orphan Drugs
Defeating AIDS

Archdiocesan AIDS Initiative in
New York

Pastoral Care of the Sick
Workshop in Kenya

The Health Ministry
in the Archdiocese
of Port-au-Prince

Spanish Conference
on the Evangelizing Parish

The Madagascar Bishops'
Commission on Health

Respect for and Promotion of
the Human Person

International Federation
of Catholic Pharmacists

Orphan Drugs

For some years scientists have posed for society the problem heavily conditioning the fight against many endemic diseases in the Third World: the "orphan drugs." Orphan drugs is the phrase used for those pharmaceuticals which, without prospects of being used or to be used for few people or people who are not able to pay for them, are not studied or developed and produced, since they offer no economic benefit.

People affected by rare diseases, on the one hand, and millions in developing countries for whom certain drugs are beyond the possibilities of their budgets, on the other, are thus penalized.

In 1986 in this publication the foregoing problematic was also stressed in the light of a meeting held in Rome sponsored by the National Academy of Sciences "of the Forty" which concluded with an appeal to the large pharmaceutical companies not to neglect this social aspect of public health and to make a commitment – perhaps through international agreements – to study drugs to prevent or treat illnesses which mainly affect inhabitants of developing countries located, above all, in the tropical belt.

This commitment involves a vast investment of personnel and funds for which no substantial return is foreseeable.

An interesting news item of late concerned a multinational pharmaceutical enterprise which was making available free of charge to the World Health Organization large amounts of a new drug, invermectine, so that they would reach the governments of many countries. It is a compound modifying a molecule of a potent antibiotic (avermectine) capable of combatting onchocerciasis.

Onchocerciasis, as we know, is a particular form of filariasis, a parasitical disease due to a microscopic worm, the filaria, transported by a carrier, the "black fly" of the Simuliidae family, which currently affects eighteen million people in Sub-Saharan Africa and threatens a much greater number in the Middle East and Latin America.

The *onchocerca volvulus* filaria comes from the fly introduced into the organisms of people usually living in areas close to waterways where the Simuliidae flourish – hence the name of "river illness" for onchocerciasis. Among other things, the illness leads in a short time to blindness, with serious individual and social damage.

In addition to the drug's availability, campaigns to fight against this disease also require an organization and strategy developed by WHO in agreement with the Health Ministry of each country. Moreover, this is necessary to evaluate on a large scale the effects of this pharmaceutical on entire populations.

This very praiseworthy initiative, whose aim is to destroy the microfilarias present in the individuals affected and thus to reduce the incidence of the infection, is an example of what can be done to treat orphan illnesses as well. The drug enables us to interrupt the transmission of the microfilarias through the black fly and hence infection from one person to another.

This is an instance of a new mentality to strike at the root of the health and social problems conditioning the development of the Third World. Such an initiative should be esteemed, encouraged, and also extended both because of the spirit in which it is carried out and because it offers a gleam of hope for a better life for these populations.

Prof. G.B. MARINI BETTOLO
President of the Pontifical Academy of Sciences

Defeating AIDS

Closing Address by Dr. Halfdan Mahler, Director General of the World Health Organization, at the Health Ministers' Summit on AIDS held in London, January 1988

I believe the exchange of information and experience at such a high level during the past two days has inspired all of us to become much more optimistic than we were that we can and will defeat AIDS.

The Declaration of this Summit is excellent. However, the true test of this Declaration and of our intentions is action. Therefore, within four weeks from today, I will be contacting you regarding the further steps of implementation which we all seek. This Summit, marking an important step along our common path, will be followed up with great energy and commitment. We must therefore make sure that the exchange of information becomes a continuing process everywhere and receives high public visibility in order to induce as widespread optimism as possible. We must make use of this Summit as a launching pad for a sustained AIDS communication program throughout the world. You have designated 1988 as a year of communication on AIDS and I intend to promote an annual World Day of Dialogue on AIDS, the first to be on 1 December 1988.

What is the basis for my optimism? Much of it has been inspired by what I have heard at this Summit. It is conditional optimism — conditional on what you do when you return home. The conditions will be fulfilled:

- if you ensure the political commitment of your governments as a whole to fighting AIDS
- if you motivate your heads of state to take a personal interest in the fight
- if you mobilize leaders in all walks of life
- if you mobilize adequate human and financial resources for the fight
- if you devise and carry out national plans to fight AIDS as an integral part of your health system
- if you ensure the coordinated action of all sectors concerned in your country — education, culture, interior, finance, communications, and the like — by setting up, for example, a central multisectoral committee at the highest government level
- if you muster the support of nongovernmental organizations in all the sectors concerned
- if you inspire people to become health promoters to ensure that they, their families, and the communities in which they live behave in such a way as not to become infected with HIV
- if you ensure the understanding and cooperation of people at special risk
- if you make sure that HIV-positive people and AIDS patients are not discriminated against, not ostracized, not stigmatized, not marginalized
- if you pursue vigorous information and education programs, using all the appropriate media and being very active in educational establishments, starting with those for the young
- if you persuade the media to assume a socially responsible role in informing the public about AIDS and ways of preventing it
- if you train the health professions to inform and educate others and to counsel those infected with HIV, those suffering from AIDS, and their families and friends
- if you educate your health professions to provide those suffering from AIDS and the AIDS-related complex with devoted and human care
- if you ensure the safety of blood, blood products, and invasive practices on people within and outside the health system
- if you energetically promote suitable education as well as adequate information to ensure the sterility of all syringes, needles, and other instruments used in medical practice as well as other skinpiercing instruments used on people
- if you ensure that the health and social services needed to support and strengthen behavior change are indeed accessible
- if those of you who are in a position to do so support developing countries in setting up and carrying out national AIDS plans, including information and education that are appropriate to their needs and culture, and in taking measures to strengthen their health infrastructure
- if you insist that the United Nations system and all other development partners coordinate their efforts to ensure synergistic support to your countries
- if you do all of this in line with WHO's global strategy to prevent and control AIDS and in a spirit of worldwide health solidarity
- if you do all this without in any way compromising your commitment to the policies of health for all and primary health care.

Then you can be confident that you *can* and *will* slow the spread of HIV infection, starting now. So let the resolutely determined outcome of this Summit be one of world solidarity in the face of the common enemy, AIDS. We can and will stop AIDS. But first of all we will slow the spread of HIV, starting now.

Archdiocesan AIDS Initiative in New York

The Archdiocesan AIDS initiative began in August 1985 with the announcement by Cardinal O'Connor that a comprehensive program would be developed to provide health care and other necessary services for AIDS victims.

In recent years a great deal has been done to respond to the AIDS crisis within the Archdiocesis The main activities are summarized below

St. Clare's Hospital and Health Care Center

St. Clare's Hospital became the cornerstone of the Archdiocesan program to provide direct services to AIDS victims. In November 1985 the Hospital created the Spellman Center for the Care of AIDS Patients, the first comprehensive and specialized program of its kind in the City of New York In May 1986 the Hospital was designated by the State of New York as the first AIDS Center in the State. It remained the only Hospital to have received such a designation.

The Spellman Center opened the first inpatient unit of this kind in the City of New York on November 27, 1985, with fifteen beds It soon included the following services:

* An inpatient unit with sixty beds for intensive care, of which ten were for prisoners with AIDS The average number of patients hovered between 56 and 58 Up to December 31, 1986 there were 430 admissions.

* A comprehensive outpatient program offering tests for HIV infection, diagnostic and therapeutic services for AIDS and ARC, a range of psychosocial services, an AZT program, and outpatient infusion therapy. 800 outpatient visits took place in 1986.

* In November 1986 a dental service began for those admitted. On March 1, 1987 the dental program was expanded to serve outpatients, thus becoming the first hospital program in the nation for AIDS/ARC patients.

* A direct, twenty-four-hour-a-day telephone line with information and the resources available for AIDS victims. This free service had received 5000 calls by the end of 1986.

In addition to the already functioning programs, new services were to be added over the course of the next twelve to eighteen months:

* expansion of the prisoners' unit to twenty-five intensive care beds;

* creation of a thirty-three bed neuropsychiatric unit for people with dementia and neurological complications caused by HIV infection;

* creation of a residential facility for homeless AIDS patients;

* creation of a methadone program for AIDS, ARC, and HIV infection patients;

* development of an outpatient mental health program for AIDS victims

St. Clare's Hospital has been recognized in the United States and around the world as a leader in AIDS care. The Hospital and Spellman Center have been visited by national and foreign representatives of the news media, government officials from various nations, and health professionals. A noteworthy example was the visit to the Hospital by the British Health Minister and Chief of the Medical Office on January 24, 1987.

St. Vincent's Hospital and Medical Center

This is the other important AIDS care facility. Though it lacks a specialized inpatients' unit, it cares for between thirty-five and forty patients a day in the general medicine and surgery units The Hospital asked the State of New York for designation as an " AIDS Center. "

In addition to inpatient services, St. Vincent's maintains a support program for AIDS victims It is a hospice program offering nursing and psychosocial services to people in their homes. It has been nationally recognized by the Catholic Health Care Association, receiving its Award in 1986

Other Catholic Hospitals

Aside from St. Clare's and St Vincent's, the following Catholic facilities offer inpatient AIDS care: the Cabrini Medical Center, Our Lady of Mercy Medical Center, and St Vincent's Medical Center of Staten Island.

The Gift of Love

On Christmas Eve 1985, Mother Theresa, with the help of the Archdiocese of New York, opened the first AIDS residence in the City of New York, at St. Veronica's Rectory in Greenwich Village The Gift of Love, as it is now called, accommodates between twelve and fourteen persons who would otherwise not have a home. St. Clare's Hospital provides the Sisters at the residence with continuous support with the Medical Director of the Spellman Center and the Nursing Director at St. Clare's, who regularly visit The Gift of Love

The New York Medical College

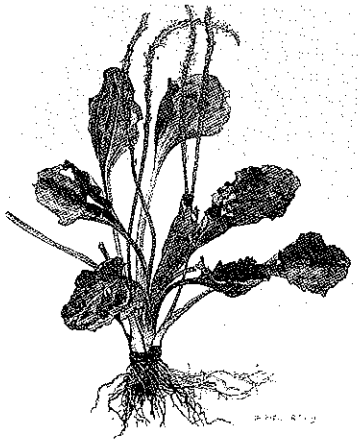
At the start of the Archdiocesan AIDS program the New York Medical College was designated to coordinate research and development of resources among Archdiocesan institutions and facilities. In August 1985 the AIDS Study and Care Center was created to this end under the direction of Dr Gary Wormser

The Center's staff offered technical assistance to St. Clare's Hospital in the initial phases of development of the Spellman Center program. In addition, the Hospital has worked with the Department of Community and Preventive Medicine at the New York Medical College in gathering and analyzing AIDS-related epidemiological data

In global terms, the AIDS Study and Care Center has focused its work on clinical and laboratory research into the causes, treatment, and prevention of AIDS The Center's specialized knowledge has been continuously available to numerous affiliated hospitals

MSGR. JAMES P. CASSIDY
Ecclesiastical Assistant of the International Federation of Catholic Medical Associations

Pastoral Care of the Sick Workshop in Kenya



A Good Song Cannot Be Forgotten

" . . I do not believe God exists. If he did, he would have remembered me and I would not have lived such a life I have never lived. I have always been sick, in and out of hospitals, and now this illness It is the end . . "

" . . For people of the Luo and Luhya tribes, neighbours would be notified that one has died in a homestead by a loud cry. . . "

" . . If an old man of the Akamba tribe died, his body could only be carried by grandsons to the grave. His body would be laid with his head facing toward the East to indicate that his presence was still with the family, who remembered as they faced East on rising each morning. . . "

You may wonder where the above words are being spoken, by whom and why The place is Kenya in Karen, near Nairobi, at a Pastoral Care of the Sick Workshop under the expert guidance and facilitation of Father Arnaldo Pangrazzi of the Order of St. Camillus and with the organization of the Medical Department of the Kenya Catholic Secretariat with funds made available by Missio, West Germany. This seminar in December 1987 was a " follow-up " to the 1986 workshops in Kenya which Father Gian Marco Dal Bon wrote about in issue no. 5 (1987/2) of *Dolentium Hominum*. In his article, Father Gian Marco commented that " a good song cannot be forgotten. It needs to be heard again " He expressed the hope that opportunities be offered on an ongoing basis. His prayer was answered in the 1987 workshops on Pastoral Care of the Sick, again offered in Kenya, by Father Arnaldo Pangrazzi. All were well-attended and deeply appreciated.

The quotations with which this article began are from one of those workshops with a very specific theme — and one theme only — as requested by the participants one year previously. The five-day seminar was on the critical theme in life of dying and death, which bring about the dynamic of grief. It was the outcome of a felt need by persons in pastoral care in Kenya to address this topic at greater depth. It used personal components (level of experience, fantasy) and pastoral education with a variety of methodology (role-play, " verbatim ").

The first quotation with which we started is from an actual dialogue in a hospital visit between the Chaplain and a woman who was seriously ill and who said, " I have never lived " — a statement indicating profound sadness. It is important for people when they are dying to look back on their life and feel some value because they have lived

The second and third quotations occurred on the fourth day of the seminar when the participants had grouped themselves into national groups to recall and share some of the social and religious ways of grieving within the nationality or tribe. The groupings were:

* Kikuyu (10 participants).
* Irish (10 participants)
* International (2 from Italy, 2 from India and 1 from Belgium)
* Akamba (5 Participants).
* Luhya and Luo (5 participants).

The reports of each group showed similarities and differences and were extremely interesting and beneficial to those who were fortunate enough to hear the presentations The sharing and identification of some of the rituals gave an idea of how important culture was in defining our ways of grieving. Because persons are born in Italy or Kenya or in Uganda, they absorb from their forefathers some of the style of grieving particular to that group. In order to say good-bye to people, we need some rituals. They are a part of life. Some are simple; some are more detailed. There is a variety and richness about how people say good-bye after a loved one dies, about the social dimensions of grieving, according to one's nationality or tribe. In some groupings it was noted that rituals vary according to whether a man or woman has died and also whether the woman was pregnant. In this respect there was a connection between death and life. It was interesting to observe some of the elements to which the culture was sensitive The culture in which we live helps to channel some of our grief through the process of ritual, e.g coming to Church, staying around the dead body, sprinkling holy water, accompanying the coffin, through the use of prayer, of flowers.

The seminar highlighted " people helping people " in the resources of those with a life-threatening disease. Family was an important resource. Support groups

were another. People with life-threatening diseases have stated that they receive the most help from others who have had the same illness. Helping support groups to emerge and carry on are important tasks for Chaplains and pastoral caring persons. The members of support groups have channeled their energy to be life-giving toward others. Healing, caring, supportive communities have a great deal of power which needs to be unlocked. They need leaders to accompany them so their power can be utilized. "People helping people" is an important project in human life which enables people to bring to action their resources to address their crises.

The first day of the seminar concentrated on "Dying and Death as Part of Life" with reflection, first of all, on how Jesus died. From this reflection the participants moved to personal exercises connected with their own experience of death and caring for the dying, to a fantasy about their own death. They went on to examine the stages of dying outlined by Dr. Elizabeth Kübler-Ross to be kept in mind as a general frame of reference, always remembering that persons going through crisis have their own dynamics in addressing their illness. The use of the Psalms in terminal illness was considered as well as present-day encounters with seriously ill persons through "verbatims."

The second day of the seminar touched on dying and death in a very particular situation — a successful businessman diagnosed to have cancer of the lungs. Vital issues were addressed on this study. They included communication of the truth, making biomedical, ethical choices, conflicts on moral issues, myths and fears about cancer, role of family and support groups for those with life-threatening diseases.

The third day of the seminar highlighted approaching the moment of death and ministry to the family. As soon as a person dies, the focus of our caring becomes the family, specially when there has been a tragedy. We entrust the person who has died to God and take care of the living. An example of a tragedy was reviewed in a "verbatim" on the emergency room with emphasis on the Chaplain's ministry to the mother of a 20-year-old young man who was brought into the hospital already dead, due to a car accident.

The fourth day was devoted to the "grieving process" and included the variety of religious and social traditions in the death of persons as well as grief related to many other losses in life (status, culture, health, material losses, financial losses, friends, self-esteem). One of the most recurring themes in life is grief. It is important to realize that grief is part of life.

Every loss means crisis with potential for disaster and new growth. According to the way a loss is handled, it can be an experience of new growth, of discovery, of movement. It depends on each person's ability to transform the experience.

Kinds of grieving were studied along with use of story-telling in grief over loss. In addition to the cultural side of grief, there are stories related to sorrow, to pain, which may give insight. Factors related to our response to loss, especially inner resources, were considered. The grieving process was seen as a holistic experience. Whenever we grieve, it is our whole being that grieves — spiritually, physically, emotionally, socially. Helps in the grieving process were identified.

Day Five of the seminar was devoted to evaluation, conclusion, and summary of the previous five days. The seed had been sown in a variety of soils. All were enabled to go further on their own journey. All had benefited personally through the experience and felt better able to help other people. It was sincerely hoped that Father Pangrazzi's hard work would have its reward in the way pastoral caring persons in Kenya would be able to share the good news he had brought to them.

The seminar started with a reflection on Jesus as model. In the New Testament the model of salvation is the cross and resurrection of Jesus. In the Old Testament the model of salvation is the Exodus. The participants were requested to make a summary of the seminar using the Exodus for their life-story. They were asked to identify times or places in their lives that might be compared to Egypt, where they felt un-free, to the desert, where they were searching and perhaps experiencing pain, and to the promised land of new arrivals, new beginnings. The participants were reminded to reflect on images of the Bible and personalize them for their own life. "Letting go" — so much a part of death and dying — contains within itself the seed of a new beginning. The darkness of the tomb held in some ways for Jesus the moment of the Resurrection. Times of grief may be ways of new beginnings.

Before departing on their journeys into different parts of Kenya, all agreed that the seminar on "Death: Dying and Grief" has been a growth-filled experience, a song never to be forgotten. They were inspired to move with the sound of the drums of those dying and grieving, convinced that pastoral caring persons are not setting the tune by adjusting their rhythm to the music they hear.

SR. JEAN SCHULTIES
Medical Mission Sisters

The Health Ministry in the Archdiocese of Port-au-Prince

Health needs are immense in Haiti. Since the beginnings of evangelization the Church has been the leading healthcare provider for the population.

The first hospice for native patients was founded in Port-au-Prince in 1878 by Catholic lay people encouraged by the second Archbishop of Port-au-Prince. This hospice became the St Francis De Sales Hospital, which is owned by the Archbishopric of Port-au-Prince, one of the best-run hospitals in the country. Health care is one of the Archdiocese's pastoral priorities. In this regard, the local Church has favored the creation of hospitals, clinics, and dispensaries in the Archdiocese. The Archbishopric has created hospitals and dispensaries. It encourages the religious congregations to create them in parishes. And when the hospital is state-owned, the local Church encourages hospital sisters to offer their services for the care of the sick, the relief of suffering, and also for a health ministry which will enable the patient to have the opportunity to encounter God and his suffering Son, Jesus, during his hospital stay and in his illness and be converted.

The Church is thus present in hospitals, clinics, care facilities, dispensaries, homes for the retired, through hospital sisters and the chaplains at these centers.

The health care ministry is something we take very much to heart, for we are convinced that the Lord encounters the sick through the humble, devoted service of priests and men and women religious at health facilities.

"I was sick, and you visited me" (Mt 25:37)

Rural health aids. The Archdiocese of Port-au-Prince, to respond to the needs of rural towns in the health area, worked out a project for rural health involving first aid and the prevention of infectious diseases.

The health aids are trained at the Rural Catechesis Center of the Archdiocese in Port-au-Prince.

For a rural population of over a million inhabitants in the Archdiocese, there are barely ten resident doctors; they do not visit outlying rural areas.

There are no passable roads in the little rural communities; only the health aids wish to take care of the country people, providing first aid in the event of accidents, epidemics, and natural disasters.

The most common illnesses in the countryside are tuberculosis, avitaminosis, intestinal worms, diarrhea, influenza, and fevers.

For example, tuberculosis is currently affecting a whole section of a parish on the mountain known as Fonds Verrettes. Thanks to a religious, two medical assistants, and a health worker, the Church is engaged in the fight against tuberculosis. In one family, the mother and three children have the disease.

The training of the health aids or rural health workers is carried out in three phases:

1) preparation according to the method of the International Red Cross for first aid in the case of accidents and to prevent infectious diseases. The cooperation of the Haitian Red Cross is being offered. These aids are recruited in rural environments, chosen by the inhabitants themselves, and presented by their parish priests. The vast majority are catechists.

2) Prepared aids then have a year of experience in a rural setting and a period of training at the Center to become familiar with tropical diseases and community medicine. Women aids take a course on obstetrics and puericulture.

3) During the third phase of training, the aids, having become health care workers, are initiated into rural pharmacology and pharmacopoeia so as to know how to use medicinal plants in the care of the sick.

At present two groups of catechists are receiving training at the Rural Health Aid Center in Port-au-Prince. The first is made up of eleven catechists; the second, of twenty-two. At the end of June the group of thirty-three aids will return to the parishes which sent them. After completing the first phase of their training, they will work in the rural environment, particularly in the prevention of illnesses by means of the theoretical and practical teaching of hygiene in the villages: building latrines, disposing of residues, the care of water sources, prospecting and cleaning wells, the prevention of contagious diseases among children such as pertussis and measles, the fight against malnutrition and flu epidemics, and the prevention of tuberculosis.

Over a three-year period the Archdiocese hopes to prepare about three hundred health care workers for the sixty-one parishes. The most serious problem proves to be the expense of maintaining the catechists during their stay in Port-au-Prince. Each session of twenty future aids costs the Archbishopric from $900 to $1000. The German Agency MISEREOR helped to build the Center. It is comprehensible that maintenance, improvements, and organization of sessions are costly for a poor diocese and population.

Through the Rural Health Aid Training Center we try to help the poorest. The poorest are accident victims, those suffering from malnutrition, those lacking basic care; the poorest are the sick from rural regions who have no money or means to seek a cure and who die *in situ*.

One of the priorities for rural populations is health and medical assistance.

Spanish Conference on the Evangelizing Parish: Health Ministry Subsection

Conclusions

Those participating in the Health Ministry Subsection offer a summary of our work and the conclusions approved unanimously.

1. Current Status of the Pastoral Care of the Sick in Parishes

On analyzing the current status of the pastoral care of the sick in parishes we have observed a series of important gaps together with achievements which cause us to view the future of this ministry with hope

1. In some parishes there is a lack of sensitivity to this pastoral care of the sick.

2. A large proportion of our parish communities today carry on a health ministry based on the Sacraments, focused on and reduced to visiting the sick, providing them with Confession and Communion, and helping them die with final assistance.

3. The parish health ministry continues to be "clericalized," though the number of lay people joining it as pastoral workers is gradually increasing

4. Many of our parish communities continue to treat their sick paternalistically as the recipients of their care and attention while not acknowledging the central position reserved for them by Jesus, the Lord, and not integrating them into parishes as active, full members and evangelizers. The architectural barriers of our parishes and our blindness as regards recognizing them continue to impede easy access to celebrations and encounters by the sick and handicapped.

5. Christian communities have not taken up their mission to educate people to live out meaningfully health, illness, suffering, physical decline, and death.

6. A large proportion of parishes are not familiar with health problems and situations in the area and the corresponding legislation and, for this reason, do not involve themselves in the tasks of promoting health, preventing illness, and improving care.

7. Parishes sometimes neglect attention to the neediest and most overlooked patients and their families: the elderly ill, the chronically, terminally, and mentally ill, the handicapped, alcoholics, AIDS victims, etc.

8. There is also a group of parishes which, in recognizing the profoundly human and evangelical dimension of this ministry, devote great care to visiting all the sick, including those who are most distant, celebrate community anointings, promote the creation of groups and offer them means to form themselves, show concern for the neediest sick and their families, get involved with neighborhood health problems, and try to integrate the sick into society and into the Christian community as full-fledged members

2. The Parish Community's Contributions to the Patient and His Family

The parish community evangelizes the sick and their relatives, accepting them and respecting them as they are and not treating them with false and useless compassion, but as responsible, mature persons, caring for them and assisting them with solicitude, taking a deep interest in their problems, accompanying them in their solitude, fighting for their rights, praying for them, and helping them to live out their situation in faith with the Word, the Sacraments, and selfless service.

A parish community which evangelizes the sick and their families in this way becomes an evangelizing community in the midst of the world, for its solidarity with the sick is one of the privileged signs which Christ has entrusted to His Church to manifest the arrival of the Kingdom. It is an expressive, eloquent sign in a world like ours, which forgets or marginalizes the sick, and it is a sign which authenticates the community and makes Christian love present in our increasingly secularized society

3. The Patient's Contribution to the Parish Community

The patient is evangelized by the community, but, in turn, he evangelizes and enriches it through his illness.

1. The sick help the community to be realistic in a world like ours, which lives on appearances, for they help us to know the human being better, with his fragility and limitation, and with a very considerable wealth of energy

2. The patient is a call to live out Gospel values forgotten in life and practice: the gratuitousness of existence, complete poverty, becoming detached and "traveling light," the strength of love, integrity put to the test, and so on.

3. The patient teaches us to relativize values and things which are being made absolute and are dehumanizing man: efficiency at all costs, esteeming people for what they have, not for what they are, power, and success.

4. The patient represents the concrete face of a poor person inviting us, from his predicament, to human solidarity, helpful and selfless love, and the vindication of his rights.

5. The patient spurs questions on the meaning of life, suffering, death. He purifies our image of God and displays the most original and striking aspects of the Christian God: a suffering God who out of love shares in man's pain to the very depth and in this way saves him. The patient is a witness to the Paschal Mystery, of Christ rising in life from the depths of weakness.

6. The sick, when they undergo illness meaningfully, are living

witnesses to the possibility of fighting against illness and taking it on with love, maintaining one's serenity and even joy, and maturing in human and Christian terms.

7. The sick show the Christian community its most authentic being (being poor and knowing one is weak and in need of salvation) and uncover and specify its mission and the way to carry it out (through the least ones and the poor).

4. Attitudes Which Must Be Fostered So That the Parish Will Provide Better Service and Allow Itself to Be Evangelized by the Sick and Their Families

The Parish community, to let itself be evangelized by the sick and their families and provide them with better service, should approach them and accompany them with deep respect and joy, with an attitude of poverty and service, with unmasked authenticity, selflessly and gratuitously, with gestures rather than words, sharing in their waiting and their hope, in a community — not individualistic — manner, finding support in prayer and the power of the Spirit.

5. Actions to Be Fostered in the Parish Community for Better Service to the Sick and Their Families

To achieve better service to the sick and their families the parish community should foster the following actions:

1. To know the health care situation in the community and that of the sick, especially the neediest.

2. To create awareness among all the members of the community concerning pastoral care of the sick and their responsibility therein.

3. To educate children, young people, and adults to live out meaningfully health, illness, suffering, decline, and death.

4. To work so that the parish will be a healthy and healing community.

5. To know and discover the sick, particularly the neediest and most neglected, helping and accompanying them in the process of their illness.

6. To integrate the sick into the community as active, full members, recognizing their irreplaceable mission and valuable contribution and allowing ourselves to be evangelized by them.

7. To collaborate with other organizations to integrate them into society.

8. To renew profoundly the sacramental ministry for the sick.

9. To organize health apostolate groups, make them known, and facilitate their necessary and adequate training.

10. To pay attention to the problems and difficulties of the family of the home or hospital patient, as well as of the deceased, and offer it the help and support it needs.

6. Structures and Channels to Be Used

To carry out its mission in this field of health and the ill, the parish community should:

1. Use the channels which already exist: ordinary preaching, meetings for study and reflection of the movements for families, patients, and others, marriage preparation courses, community celebrations with the sick, the catechesis of children and young people, religious instruction at schools, the Church's publications, radio programs, and so on.

2. Promote relations and cooperation with religious assistance services at hospitals.

3. Coordinate action with the health apostolate groups in the area corresponding to the archpriest.

4. Establish relations and collaborate with the diocesan organisms for the health ministry.

7. Conclusions

On the basis of the situation we have observed and our reflections, the participants in the Health Ministry Subsection have approved the following conclusions:

1. Parishes and other Christian communities should discover and take up evangelizing action in the field of health and the ill.

2. They should strive to know the health care situation and that of the sick, especially the neediest and most neglected.

3. They should take on the task of educating children, young people, and adults, whether healthy or ill, to live out meaningfully health, illness, suffering, physical or psychic decline, and death, using the channels at their disposal to this end: preaching, catechesis, religious instruction at schools, marriage preparation courses, meetings of married couples, community celebrations with the sick, publications, radio programs, and so on.

4. They should be healthy communities and sources of health for the sick, offering them the Word of God, which heals, having them feel they are accepted and loved as such, and freeing them from the most painful consequences of illness, such as feeling isolated, alone, useless, and a burden on others.

They should also be a source of health for the healthy, freeing them from their selfishness and fear of illness and the sick, thanks to contact with patients.

Finally, they should be a source of health for our world by disseminating a greater dose of humanity in it and teaching us to love the life we have received from the love of God.

5. They should create awareness among all the members of the community of their responsibility in promoting health and caring for the sick.

6. They should visit the sick with great dedication, approaching and accompanying them in the process of their illness with deep respect and joy, with an attitude of poverty and service, selflessly and gratuitously, with gestures rather than words, sharing in their waiting and hope, and finding support in prayer and the power of the Spirit.

7. They should profoundly renew the celebration of the sacraments of the sick, particularly Anointing, while promoting a change in mentality in this regard, celebrating the Anointing of the Sick at the proper time and occasionally in a community manner.

8. They should integrate the sick into their communities as active, full members, recognizing and stimulating their evangelizing presence. A community cannot evangelize without including the sick. Only if it is aware of this fact will it try to remove architectural and mental barriers which keep them from playing an active role and seek adequate channels so that they will participate fully in community life.

9. They should collaborate in integrating the sick into society.

10. They should receive and attend the neediest and most neglected patients in the community: the elderly ill, chronic, terminal, and psychiatric patients, alcoholics and drug addicts, and AIDS victims.

11. They should show concern for the families of the sick who are hospitalized or at home, along with those who have suffered the loss of a loved one, and offer them the help and support they need.

12. They should value, attend, and coordinate the members of the community caring for the sick on behalf of the community itself so that they will not feel alone and isolated. To this end, they should:

- Seek to find people not only of good will, but with the qualities needed to carry out such a delicate mission.

- Foster a sense of the Church in them; i.e., they should feel sent by the community, which entrusts to them the care of "its sick."

- Facilitate information which will help them to mature in faith, know the world of the sick, and prepare themselves to carry out their mission.

- Form teams or groups of pastoral workers to get to know the sick, approach them, serve them, help them in faith, make the parish aware, and coordinate its action with the sick.

13. They should incorporate Christian health professionals into pastoral work in parishes to make known health realities and the possibilities for action to benefit health and the sick through the parish community.

14. They should celebrate Patient's Day, offering a leading role in both its preparation and realization to the sick and those attending them.

15. The Diocesan Delegations for the Health Ministry should promote relations and collaboration among the health apostolate groups in the area of the archpriest and in the diocese and with the Religious Assistance Services at hospitals and other facilities, along with encounters and day-long exchanges of experiences and background.

16. The Bishops' Pastoral Commission should offer orientations on the health ministry in parishes.

17. The Health Ministry Department of the Bishops' Pastoral Commission should prepare simple educational materials for those engaged in the health apostolate in parishes.

Madrid, November 1988

The Madacascar Bishops' Commission on Health

1 In November 1986 the Madagascar Bishops' Conference established its Commission for the Health Ministry dealing with patients and their families, health personnel, and hospitals It thus responded to the wish of the Holy Father, John Paul II.

On February 11, 1985, through the Motu Proprio *Dolentium Hominum*, the Pope created the Pontifical Commission for the Apostolate of Health Care Workers. By means of this Commission, which has now become the Pontifical Council for Pastoral Assistance to Health Care Workers (Apostolic Constitution *Pastor Bonus*, Articles 152-153, June 28, 1988), the Holy Father invited all the episcopates to create their own Health Commissions to be a sign of the " profound concern the Church has always had for the world of suffering, " thereby following the example of Jesus, who " first of all addressed those suffering and needing help " (*Salvifici Doloris*, no 16, February 11, 1984).

2 After two years of activity, what results have been obtained by this Madagascar Bishops' Commission and what are its projects for the future? The Commission was structured into three working groups responding to three different pastoral objectives:

• The *first group* is particularly concerned with *continuing education* of sisters and lay people engaged in diverse health tasks (dispensaries, leper hospitals, and nutrition centers, for instance) depending directly on the Church or on government organisms employing some members of religious congregations

In close collaboration with the Union of Women's Major Superiors of Madagascar and its " Health " branch, the Commission is working on continuing education Over the past two years updating sessions have been organized nationally involving:

• technical updating (new aspects of medicine, new treatments);

• moral reflection, in the light of the Gospel and pontifical teaching, on medical activity and current problems challenging Christian conscience;

• a day devoted to deepening spirituality

• The *second group* is made up of hospital chaplains and those helping them in pastoral care at hospitals An initial national meeting took place in Tananarivo, June 22-23, 1988. The topics dealt with were: " Who are the chaplains and pastoral workers at hospitals? "; " Who are the people entrusted to our pastoral care? "; and " What means are at our disposal to ensure pastoral assistance in health care? " The Conclusions of this meeting may be summarized as follows:

a) The health ministry should deal with patients and their families, all health care workers (doctors, medical students, nurses, and other health professionals), since they are the ones who " decide " when it comes to medical practice and those primarily responsible for the quality of life at the hospital, and also the remaining hospital personnel at every level (director, administrator, employees)

b) To be able to reach all patients and their families and all health care workers it is necessary to form a Pastoral Team responsible for the hospital chaplaincy Priests, sisters, and lay people should share responsibility on this Team on a full-time basis and in conformity with the personal charisms of the members. It is necessary for every diocese to have at least one priest especially devoted to the spiritual encouragement of the world of health At the least, every hospital of some size should have an officially appointed chaplain; he should work in close collaboration with the parishes the patients are from. It is important that the women religious especially devoted to the spiritual encouragement of hospital environments be different from those sisters directly employed in hospital services and medicine As regards lay people, particular attention should be paid to the young people in Catholic Action groups: at hospitals they will find a concrete apostolic commitment At the same time, on this Pastoral Team health professionals (doctors, students, nurses) should be the " first evangelizers " in their work surroundings. Patients themselves may be invited to collaborate in this ministry, as the members of the Fraternity of Patients are already doing

c) A third conclusion was also inevitable: the need for a definite place where the Pastoral Team can maintain its presence on a stable, permanent basis. A place for worship on the hospital premises and a chaplaincy next to the church to receive people are necessary. In this respect, the example and achievements of the Camillian Fathers at Fianarantsoa are particularly eloquent

• The Commission's *third group*, on " theological reflection, " took on the goal of collecting and disseminating pontifical documents on the human person, suffering, and bioethics. Through the Catholic daily newspaper *Lakroan'i Magadasikara*, the Church's thought and Magisterium are made known to the general public as regards the problems of medical ethics. This group has also prepared a proposal for a Pastoral Letter which will be submitted to the Madagascar Bishops' Conference; the letter would deal with human love, the fertility of the couple, and respect for nascent life in the light of *Humanae Vitae*, *Familiaris Consortio*, and *Donum Vitae*. The letter, entitled *He Created Them in His Image*, is addressed to the entire People of God, to all men of good will living in Madagascar, with a special intention for health professionals and the nation's leaders.

Projects for the future are limited Three objectives have been proposed for 1989:

• As a priority, the Commission will focus on organizing a first Meeting of Catholic Physicians in Tananarivo, to reflect with them on their medical responsibilities, revive the demands of professional conscience, reappraise the Christian meaning of the sick, of suffering, and of the " medical vocation " in the light of the Gospel, and fight against the seductions and corrupting power of money. The Commission will be supported by the Christian Health Center, a movement founded by the late lamented Fr Legrange which groups together over five hundred Christian health professionals in Madagascar.

• The Commission will encourage and participate in the Continuing Education Session for Sisters The previous one took place in May 1987.

• As an extension of the Pastoral Letter *He Created Them in His Image*, the Commission intends to uphold and expand into each Diocese the action of the FTK Movement, which deals with natural family planning and accompanying young married couples The encouragement of the setting in motion of Diocesan Pastoral Assistance to the Family may come within the activity of the Commission for the Health Apostolate

Respect for and Promotion of the Human Person in Modern Medicine

First Congress on Medical Ethics at the Pontifical Catholic University of Chile

Instrumental technical progress in modern medicine and the new and numerous applications to man of biological knowledge, along with more lucid awareness of the rights of the human person, have in recent years brought out the ethical dimension of clinical practice and biomedical research. The foregoing has transformed medical ethics into an area of vital interest for a broad range of scientific and humanistic disciplines.

For over ten years the Faculty of Medicine at the Pontifical Catholic University of Chile has in a sustained way been dealing with the practice of medical ethics and the development of teaching and research in this field. To this end it has promoted courses for undergraduates and advanced, specialized training for some of its professors to provide such instruction. This concern recently led to the creation of the Associate Teaching Unit for Medical Ethics, which is responsible for teaching, research, and extension courses in Medical Ethics, Medical Anthropology, and the Philosophy of Science at the Faculty for both undergraduates and postgraduates.

As a way of contributing to ethical reflection which will orient clinical practice and biomedical research in conformity with the essential rights of the person, the Associate Teaching Unit for Medical Ethics organized the first Congress on Medical Ethics at the Faculty of Medicine of the Pontifical Catholic University of Chile, July 26-29, 1988. The event, entitled "Respect for and Promotion of the Human Person in Modern Medicine," was part of the ceremonies held to celebrate the Centennial of the founding of the University. As speakers and panelists there were twenty-four outstanding personalities from Chile and other countries representing various medical, biological, juridical, philosophical, and theological disciplines.

The Congress was inaugurated by the Grand Chancellor of the University, Cardinal Juan Francisco Fresno Larrain, and the opening address was delivered by the University Rector, Dr. Juan de Dios Vial Correa. In his talk Dr. Vial stressed that medicine was a privileged place of encounter with man and pointed out that better than in many other activities today one touches therein the mystery of man and his limits; he proposed that, starting from medicine, one can very effectively help to correct spiritual deviations which, more than any material danger, are a threat to humanity.

The lectures and panels were organized around four themes:

I) Basic Ethical Questions in Biology and Medicine;

II) Medical Ethics and Human Reproduction;

III) Ethics, Health Policy, and Economics;

IV) Medical Education and the Teaching of Medical Ethics.

In connection with the first Congress topic, "Basic Ethical Questions in Biology and Medicine," Dr. Gonzalo Herranz of the Bioethics Group at the Navarra Faculty of Medicine, Spain, spoke on "The Conception of the Human Being as a Person and Its Ethical Implications in Biology and Medicine." The Chilean Professor of Psychiatry, Dr. Armando Roa, then dealt with the problem of "Scientific-Biomedical Research: Ethical and Anthropological Foundations." Swiss Philosopher Georges Cottier examined two subjects of great current interest and complexity: "Ideas of a Christian Medical Ethic: Problems, Challenges, and Applicability to the Modern World" and "The Distinction Between Artificial and Natural and Its Consequences for Biomedical Ethics." In this topic Theologian Ramon Garcia de Haro of Rome's John Paul II Institute and Professor Domingo Basso of the Philosophy and Theology Faculties of Argentina's Pontifical Catholic University also participated.

As for the subject of "Medical Ethics and Human Reproduction," the talk of French Geneticist Marie-Odile Réthoré stood out on "The Ethical Aspects of Fertilization Technology," along with that of English Pediatrician Richard West on the ethical problems of genetic counseling and prenatal diagnosis. Chilean Gynecologist-Obstetrician Patricio Mena presented a contribution grounded in his vast experience in applying and evaluating natural family planning methods.

The words of Health Minister Juan Giaconi brought out the significance of the papers on "Medical Ethics, Health Policy, and Economics," which were followed by an animated discussion.

The presence of doctors from different countries on the panel devoted to the teaching of medical ethics offered the chance to contrast varying experiences and ways of conceiving this instruction, which was regarded unanimously by the panelists as an essential dimension in the training of biomedical scientists and professionals and not as a mere complement.

Each one of the six Congress sessions was followed by a period dedicated to questions from the audience. The number and seriousness of queries represented an eloquent sign of the interest and profit with which the nearly three hundred people in attendance followed the unfolding of the event. Though a good many of these were doctors, nurses, midwives, biologists, and students preparing for such professions, it was also a welcome surprise for the organizers to observe a great many professionals and students representing dentistry, veterinary medicine, psychology, law, social work, history, education, and other fields; the social significance of the topics dealt with at the Congress and the widespread concern they generate were thereby confirmed — even more so, if we recall the ample coverage the event received in the mass media, both the press and television.

Comments by lecturers, panelists, and those attending were quite positive, far exceeding the organizers' expectations. The dominant remark was that this academic meeting had created a twofold awareness in all those involved: on the one hand, the observation of the relevance of ethical and anthropological considerations to the adequate practice of biomedical professions at present and, on the other, perception of the great void today in the training of biomedical professionals as regards humanistic preparation which can balance and orient the scientific-technical aspects. In this connection, on several occasions stress was laid on the role of the Medicine Faculty at our University for its decided support of the development of Medical Ethics.

and related disciplines and for the way it has dealt with the problem.

Perhaps the most important of the main ideas which to a greater or lesser extent were present in all the talks was the insistence upon the novelty and radicalness of the ethical problems our culture faces as a result of the colossal increase in man's power over the biological processes affecting him, particularly those having to do with procreation. In the face of these challenges, it is urgent and indispensable to reflect in depth to conceive of original and humane responses. There was insistence on the need for interdisciplinary work and, above all, for the training of medical and scientific professionals in philosophical and theological disciplines to be able to take on and orient the existential reality of problems from the standpoint of their own task.

The objectives formulated in the organization of the Congress were fully attained; nevertheless, for the Faculty the work remains not only of collecting and publishing the abundant material constituting the lectures, but also the responsibility and commitment to hold Congresses on Medical Ethics at the Medicine Faculty of the Pontifical Catholic University of Chile on a biennial basis. We sincerely hope that this has been only the first and most modest installment.

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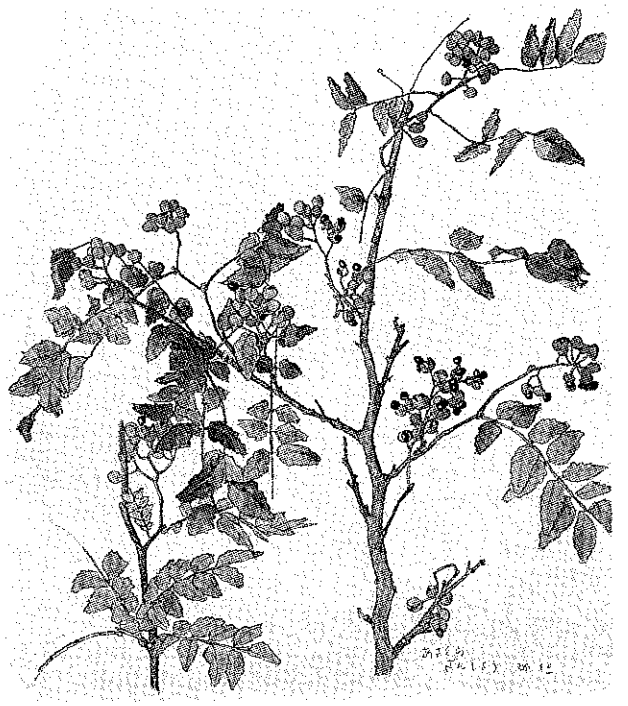
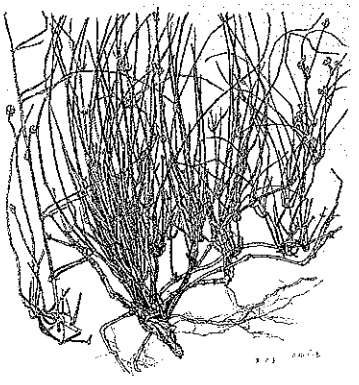
Associate Teaching Unit on Medical Ethics, Faculty of Medicine Pontifical Catholic University of Chile





International Federation of Catholic Pharmacists

Pharmacists from ten nations meeting in Salzburg for the Federal Sessions of the FIPC, September 9-10, 1988, were consulted about requests for authorization to place on the market pharmaceuticals to be used for abortion.

Continuing their reflection along the lines defined in 1972 at the Rhode St. Genese meeting and in 1975 at the FIPC International Congress in Bruges, they refer first of all to Gospel teaching to affirm that every human being is a creature of God.

* They recognize that the human embryo is not biological material, but a human being whose weakness and innocence demand from society watchful attention and loving care

* They state that *abortifacient products* (still called contragestives) cannot be regarded as medicines in the proper sense of the term since their aim is to interrupt life, not to protect it

* They recall that their professional function, as desired by public authorities and recognized by society, is to protect life in all of its stages.

* They affirm that a pharmacist, when faced with a request under medical prescription for any compound to be used abortively, has the right to refuse to satisfy it on account of conscientious objection.

His right to conscientious objection should be recognized; it is already recognized in legislation for health professionals in the case of voluntary interruption of pregnancy.

* They invite all pharmacists, whatever their philosophical and religious convictions may be, to reflect on the grave consequences for society and individuals and the risk of trivializing abortion due to the appearance of new substances. In this way abortion can escape all medical control.

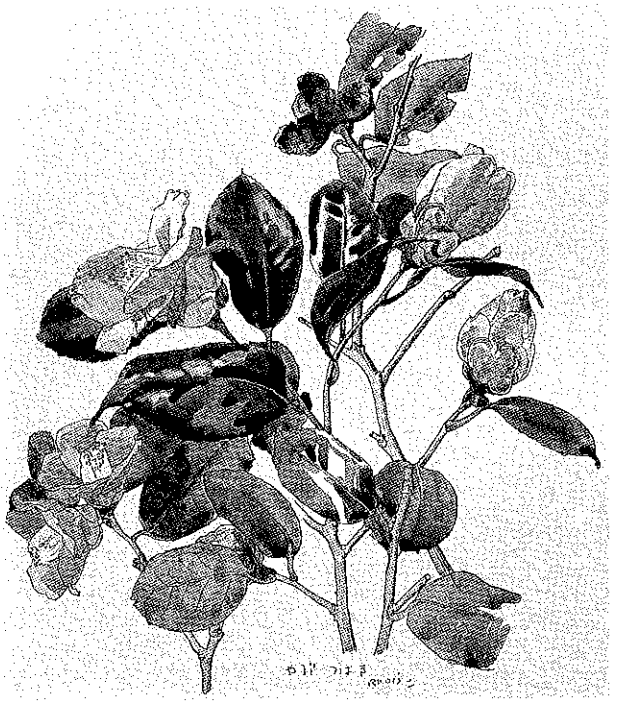
* They consider that, in keeping with the argument used, each woman's freedom to choose whether to conserve or destroy her child cannot be superior to the pharmacist's freedom to choose whether or not to participate in such destruction.

Aware of the evolution in mentality and the unlimited possibilities opened up by scientific research, the pharmacists belonging to FIPC do not wish to appear to be against scientific progress. They are, however, deeply concerned about its use to the detriment of fundamental rights of the living being. They know that the most legitimate prohibitions, like the most sacred laws, are readily transgressed, but believe in the value of witness to awaken consciences.

* They will strive to participate actively in all reflection and action whose aim is to promote education of the current mentality, especially among the young, and effective solidarity as regards expectant mothers with difficulties.

* They will bear witness in every circumstance, by their way of thinking and acting, to their respect for life and the dignity they recognize in each human being, even if he appears in decline or useless in the eyes of society.

Activity of the Pontifical Council



Talks

Chronicles and News from Meetings

Talks

Health for All, Justice for All

A Talk by Archbishop Fiorenzo Angelini at the Congress on Health Cooperation Between Italy and Latin America
Rome May 3 1989

The World Health Organization's program setting the goal of "health for all by the year 2000" may seem utopian. The demand for health emerging from vast areas of the Third World and enormous sectors of the most highly industrialized countries as well with growing insistence makes it necessary, however, that this goal be reached.

The defense and recovery of health represent fundamental human rights which, as the result of justice, are also a condition for peace, according to the profound insight of the prophet Isaiah, "the fruit of justice and peace" (*Is* 32:17).

Perhaps no criterion for evaluating the effective achievement of justice in the world is so concrete, indisputable, and discriminating as that of health and its promotion.

In the world we live in today, two thirds of the human beings born at the same time die thirty years before the remaining third of their fellow men. There is a vast gap between north and south in infant mortality. And if our attention then turns to living conditions, the differences are scandalous.

This reality has today been rendered more tragic and unacceptable by the fact that, thanks to ever more widely diffused images, the well-off world is a daily spectator of the injustice of which so many of our sisters and brothers are victims.

The very close relationship between the achievement of justice and the defense and promotion of health has been made particularly clear by the appearance and rapid spread of the AIDS epidemic, which, going against all previsions, has also attacked the industrialized countries, still impotent in the face of this scourge.

Sociological data and historical reflection on this serious and sad phenomenon lead to some rather bitter considerations. Even if only out of selfish calculation rather than a proper act of justice the richest countries had exported advanced technologies in the past to the poorest countries, creating suitable health facilities and distributing essential drugs in such a way as to ensure juster and more humane living conditions, we would not be faced today with a world which, now devoid of boundaries, calls together everyone. Furthermore, as John Paul II has recalled, if the social question has acquired a worldwide scale, it is because the demand for justice can be satisfied only at this level [1] I thus stated that the goal of health for all by the year 2000 is not a dream, but a challenge for more fortunate brothers and sisters and countries coming from the poorest lands and the countless number of those suffering.

The task and activity of the Pontifical Council for Pastoral Assistance to Health Care Workers, which I have the honor and responsibility of heading, have enabled me to observe in the concreteness of diverse situations that cooperation in the field of health is at once a contribution to human advancement in justice and the fruit of greater justice in the world.

1. Health Cooperation as a Contribution to Human Advancement in Justice

Safeguarding health and fighting against all physical and psychic illness are fully in line with the defense of life, the primary fundamental human right. The defense and advancement of life are the presupposition for affirming every other right.

Italy, which has made such substantial efforts through systematic programs of assistance to developing countries, has made and is making a decisive contribution to peace, because its work is aimed at activating cooperation in those sectors which principally manifest the persistence of very serious injustices And this occurs because cooperation increasingly seeks to go beyond the limited sphere of collaboration among States and governments and move towards cooperation among peoples. And under this aspect, no sector shows so much capacity for aggregation and inclusion as does that of health care, for in the defense and promotion of life all recognize one another and wish to meet, independently of ideological, political, cultural, behavioral, and even religious differences.

Love and pro-life culture, joined to the religious sentiment, are the oldest, most universal, and unrenounceable aspiration of man It stands at the root of the need for and duty of justice. Indeed, if for millennia there has been debate on *how* we can and should live on an individual and collective level, everyone, however, accepts the principle vindicating the primary right to life and health of each and every human being.

Health, justice, and peace are three inseparably linked terms. Better health conditions extend justice, which lays the foundations for peace. The Christian orientation in this regard comes from Christ himself, who, in the perspective of love among all men, began his ministry by healing the sick. And the history of Christian evangelization is the history of men and women who, though looking to a heavenly dimension of salvation, started from care of the sick and the weak to move towards more humane living conditions.[2]

2. Health Cooperation As the Fruit of Greater Justice in the World

Health cooperation on an international level is not only a contribution, but also the fruit, effect, and consequence of greater justice.

Thanks to progress which is always advancing by virtue of an uncontainable inner force, a new fusion of races and peoples is now taking place in the world. The rapidity and extent of means of transport favor migrations which over the span of a few years will radically change the picture of the distribution of world population. This extraordinary phenomenon, which year by year is gradually erasing traditional borders, while, on the one hand, reflecting a need for greater justice, poses completely new problems for health care as well, on the other. A merely defensive, partial health policy would prove useless and sterile. Participation and sharing will either be constructed in goodness or their absence will be suffered in its most dramatic consequences.

Prospects may be thrilling, but may also become threatening. I feel that at the root of certain evils of our time is the conscious or unconscious fear of accepting the relentless march of history towards ever-increasing fusion of the world's peoples Indeed, whereas science and technology continually discover new forms of defense of life and possibilities for safeguarding health, even on the level of regulations we find the spreading practice of abortion and euthanasia and anti-life population control.

The quality of life as a luminous achievement of our time is

threatened by the temptation to discriminate, at the cost of the lives of others.

How can life be against itself? How can we assume a better future for mankind if part of mankind is to pay the price? Social justice is such if it looks to all humanity, and there is doubtless no surer yardstick to evaluate the real fruits of greater social justice than the spread of health cooperation. And in this regard even the most valid, effective programs can bear fruit only if they are animated by the real need for justice. Cooperation either produces civilization and is the fruit of civilization or becomes just a new way of perpetuating division and injustice.

The sentiment of justice which must animate every cooperative initiative among peoples, particularly on the plane of medicine and health, must start from the awareness that in our time, more than in the past, the way forward for the human race either will be the work of all or will not exist.

The economic category alone cannot offer a measure of true development: while the rich countries are debtors in resources in relation to the poorest ones, these are bearers of values which consumer society has unfortunately forgotten or even combatted.

The biblical dream seeing the peoples coming from east and west to meet and be seated at the single banquet of the Kingdom of God translates into spiritual terms an aspiration flowing from all human beings' demand for life.

It is time for this aspiration to be translated into concrete, rational, realistic, but convergent initiatives. The world will be saved or lost as a whole. And on the level of collaboration among peoples, salvation is first of all called health, the defense and promotion of life.

The Church, within her province, intends to stand alongside all those seeking and wishing to cooperate to build a juster world. The Church does not have technical solutions to offer and does not propose economic and political programs or manifest preferences for one group or another, provided the dignity of man is properly respected and promoted [3]. For States, just as for the Church, man must be the way of all real and lasting progress in truth and justice [4].

[1] JOHN PAUL II, the Encyclical *Sollicitudo Rei Socialis*, 10.

[2] JOHN PAUL II, the Apostolic Letter *Salvifici Doloris*, 27.

[3] JOHN PAUL II, the Encyclical *Sollicitudo Rei Socialis*, 41.

[4] JOHN PAUL II, the Encyclical *Redemptor Hominis*, 14; *Salvifici Doloris*, 3.

Ethics in Disaster Medicine

A Talk by Archbishop Fiorenzo Angelini at the International Conference on Disaster Medicine Havana, Cuba, July 4, 1989

First of all, please allow me to express my feelings of sincere satisfaction on being in this country and in this noble city for the third time within a brief period. I convey my respectful greeting to His Excellency President Fidel Castro and my deepest gratitude to the Honorable Julio Teja, Minister of Health, and to the organizers of this important international meeting for the invitation to take part.

The Church, especially through the Office I represent, pays close attention to the problems which will be discussed here. They are in fact subjects which, in view of their social dimension, in singular fashion bring to light the current inter-dependence among peoples and the consequent need for increasing international cooperation, a topic which is at the core of the recent papal encyclical on the Church's social concern in line with an operative ecumenism which is a premise for development in justice and peace. Recent and not-so-recent catastrophic events have shown that the *solidarity* prompted by the urgency and extent of emerging situations has often opened the way to overcoming ideological and political barriers in the name of this ethical imperative.

Medicine, as a science, as research, and as an art at the service of life, by nature responds to an ethical exigency, an unrenounceable duty. This character of medicine, acknowledged by all, becomes more evident when its contribution is required by natural catastrophes or brought on by technological progress which is not sufficiently respectful of the primary value of safeguarding and promoting human life and the environment in which it is born, grows, and expresses itself in all its wealth.

It would not be difficult to establish a periodization of human history, indicating the key dates for very serious calamities. Nevertheless, as we approach our own time, we observe a singular and almost contradictory difference: in the past large-scale epidemics and famines, above all, provoked enormous disasters; with the progress of science and technology many of these risks have been erased or contained; however, modern development has itself given rise to very serious catastrophes with names such as Hiroshima, Three Mile Island, Bophal, Chernobyl, and Armenia, without mentioning the threat of ecological decay and pollution in different parts of the world.

If at one time it was the sky, the earth, and the sea that took their victims, now progress also does so. And it does not seem to be a lesser contradiction — if we restrict ourselves to research and medical science — that, while a rapid rise in wellbeing, extraordinary progress in the treatment of many illnesses, and a vertical drop in infant mortality are being recorded, at the same time assaults on unborn life are legitimated through abortion, there is no hestitation about practicing genetic manipulation, and systems favoring euthanasia are introduced.

These alarming contradictions of our time, which, in view of their vast dimensions, fall within the category of an emergency, repropose the need to recover basic ethical values which, before being dictated by particular ideologies or a religious creed, are rooted in the natural and fundamental human right to life, to its defense and promotion in each and every person. We cannot and must not consent to the culture of death, but, rather, promote, defend, and reinforce the culture of life from the moment of conception to its natural close.

To speak of the ethics of disaster medicine, I think, involves some presuppositions and essential indications.

Presuppositions

* Disaster medicine involves urgency. It should not be forgotten, however, that medicine as such is always characterized by urgency. Indeed, as a service to the greatest good — i.e., life — medicine never arrives too soon. The peril hidden in the very fragility of the human condition establishes a continued emergency.

Anyone somewhat familiar with the places of suffering and care well knows how many illnesses could have been prevented, arrested in time, or cared for better if the intervention had been prompter. Moreover, the very insistence on the need for preventive medicine stresses the fact that in medicine there is habitually an emergency.

* The fatality and fortuitousness of disasters are, in reality, apparent. History demonstrates that we

are virtually faced with a determinism of the calamities themselves. Hence the exigence — thoroughly ethical — not only of making available beforehand the instruments for rapid intervention, but of providing for public education on the subjects of disasters and calamities. Ethics excludes interventions left up to discretionary power, emotionality, and improvisation

* Public officials in their respective spheres have a permanent moral duty, as regards prevention, to prepare instruments of information and formation which in an increasingly thoroughgoing and detailed manner will limit the unforeseeableness of the calamitous event The broad development of the mass media favors greater coordination in data-gathering, the exchange of experiences, the organization of aid, and so forth

In other words, adequate structuring of emergency medical intervention demands an ongoing effort to limit the emergency itself. Health education, the condition for effective, increasingly widespread defense and promotion of health, must involve disaster medicine as well.

That being stated, to speak of the ethicality of emergency interventions involves taking on certain fundamental orientations which, I feel, may be summarized as follows

Essential Ethical Indications

There is no philosophical conception or religious vision of the world and man which fails to recognize in the human condition some impassable limits Such limits explain the occurrence of the unforeseeable. The ethical moment is thus established by the need to defend oneself from the limit which can compromise a certain value; and since human life is the maximum value, the more serious the limit imposed by the calamity is, the more peremptory the ethical duty to intervene is Not, indeed, to intervene in a general sense, but in the manner which is humanly and professionally most adequate. In other words, disaster medicine must be applied medicine to the maximum of its possibilities.

Secondly, an emergency calls together everyone. It is up to technicians, sustained by political forces, to indicate the structures suitable for the fruitfulness of international cooperation, which in the face of emergency problems is first of all interpellated by an ethical and moral question. As John Paul II points out in the Encyclical *Sollicitudo Rei Socialis* (no. 33), " The moral character of development and its necessary promotion are exalted when there is the most rigorous respect for all the demands deriving from the order of the truth and good proper to the human creature. "

A third fundamental orientation follows from this. Disaster medicine, in its concrete application, must reflect a hierarchy of values at whose summit is the defense of life in its integral dimension

It may happen that an emergency is regarded as a moment apart. As a result, what has been avoided or saved by the timeliness and effectiveness of urgent intervention may occur later on through ineptitude or negligence by those who should not have considered the emergency to be over.

It is in fact morality that indicates all the duties, on the level of awakening public opinion as well, for someone responsible for the interventions of disaster medicine. We must thus regard as misleading the not uncommon tendency of the mass media in cases of urgency or serious calamity to present needed timely intervention as something to boast about, as an exceptional merit. Assistance the day after is just as obligatory as immediate action. Indeed, life, in its continuity, is an uninterrupted demand for prevention, service, and defense.

On the other hand, no preventive action or timely intervention will prove adequate if it does not start from the conviction that for the defense of life no stone should be left unturned. Only an ethical vision and choice can provide the strength to delay surrender to the utmost in the face of the disproportion between the human means available and the need

This disproportion may lead one to accept — at least implicitly — an attitude of fatalism, which is all the more inevitable when a transcendent vision of the events accompanying human history is lacking

Experience records and teaches, in spite of us, that catastrophes themselves, even those to which man is an accomplice, in fact perform an educational function. We are witnessing impressive analogies between the human condition and that which is more simply biological. As after the most devastating floods the land is more fertile, so mankind, when tried by catastrophes, must bring to maturity a greater awareness of the value of life.

This hard lesson of history evidently reproposes to us the supreme value of life. This value represents the truth emerging from every catastrophe

Certainly, if man had always remembered the primary duty to defend his own life and those of others, the list of disasters which have afflicted his history would have been shorter. But a lesson learned with difficulty and at a high price may have more effective and long-lasting consequences. In this sense, I believe that we must insist on the need for every effort — individual or community, public or private — to preserve, defend, and upgrade the environment in which man lives to be accompanied by an ecology of the spirit hinging upon exaltation of the value of life.

The need for development, in its richest acceptation, to favor the quality of life, reproposes its moral dimension. " The moral character of development cannot dispense either with respect for the beings forming visible nature, which the Greeks, alluding precisely to the *order* that marks it, called the *cosmos*.. " (John Paul II, *Sollicitudo Rei Socialis*, no. 34).

The Catholic Church, in the area corresponding to it, has always felt directly committed to calling for and sustaining every effort to affirm a moral dimension to development and, consequently, to the defense of human life in the orderly context of man's " habitat. " At the same time, however, she renews her conviction, based on faith in Christ's message, that only unconditional respect for the life of each and every person in all its expressions provides the foundation for every intervention by man to defend himself and his environment to be ethically sustainable and proposable.

All limitation and discrimination introduced into the concept of life translate into an instrument gravely restricting the defense of its quality. And not just this, but the Church reaffirms the certainty that only through acceptance of the principle that life is at the summit of human values is constructive encounter among peoples possible, in the concrete sector of disaster medicine as well. This specific branch of research, science, and medical practice directly falls within the prospect advanced by the World Health Organization in proposing " health for all by the year 2000. "

To demonstrate solidarity among peoples, however, we must not await calamities and disasters. It is necessary to anticipate and prepare for a better future worthy of every human life. Many developing countries are still going through situations of dramatic emergency in individual and collective life. To be concerned about these situations, as the Church's doctrine teaches, entails action reflecting strict justice.

The international community can now and will always find the Church directly and indirectly engaged in the effort to favor every initiative which, in the name of the defense and promotion of life, promotes its quality as well in the field of preventing and fighting the consequences of the most serious and unforeseeable calamities.

Pastoral Orientations on Longevity and the Quality of Life

A Report by Fr José L Redrado to the Study Day on the Elderly and Pastoral Implications organized in Rome, June 6 1989, by the Italian National Council for the Health Apostolate

Introduction

The Pontifical Council for Pastoral Assistance to Health Care Workers promoted and coordinated in November 1988 an International Conference on "Longevity and the Quality of Life." It was the third conference organized by our Office. The preceding ones were on "Pharmaceuticals at the Service of Human Life" (the first) and "The Humanization of Medicine" (the second).

This scientific, cultural, humanistic, and pastoral activity reflects the aims of the Pontifical Council assigned by the Pope (cf. Motu Proprio *Dolentium Hominum*, no. 6): to stimulate, promote, coordinate, and collaborate with the local Churches and closely follow health care programs and their pastoral repercussions for the Church.

Conscious of this responsibility, each year, in addition to other activities, we organize an International Conference on a health topic of current interest, such as this recent one, longevity, or that which will be dealt with this year, AIDS (November 13-15, 1989). It affords a good opportunity for high-level encounters and study; our Conferences in fact attract illustrious professors, scientists, Nobel Prize winners, Pontifical Academicians, and government health officials.

Longevity and the Quality of Life Content and Pastoral Orientations

1. Content

The Conference was structured around the following basic points: scientific aspects (research, biology, chemistry, and pharmacology of old age), demographic criteria, mental and psychological problems, ethical aspects, and experiences reported during a roundtable discussion entitled "The Song of Life," which stressed the final years of life, their quality, and problems for care — a survey of values expressed from the most diverse points in our geography: Japan, India, Africa, the Pacific, Nigeria, Tunisia, China, and West Germany.

Careful study of the Conference *Proceedings* offers a vision of the main problems present in the world of the elderly. In summary form, I would list the following aspects:

a) medicine's capacity to increase longevity and improve the quality of life (life is, in fact, longer today and its quality has improved);

b) our world is heading towards progressive aging, and we are entering a century of aging of the population;

c) it is necessary to make room for the elderly in our technical, developed world;

d) the family relation is increasingly difficult: divided, geographically dispersed families and the tendency to live more and more independently will create new problems for the elderly;

e) the aging of the population could lead us to an aging of society, with all the economic, cultural, psychological, political, and generational decline which that would involve;

f) in a world having a preference for strength, beauty, materialism, and physical appearance reaching old age represents a disturbance — it is not desired and is kept as far removed as possible;

g) society and the family in particular tend to free themselves from the presence, "uncomfortable and useless," of the elderly.

2. Pastoral Orientations

The entire Conference unfolded in a pastoral atmosphere, with stress on "serving the elderly." The most substantial teachings may be found in the words of the Holy Father, in Cardinal Lustiger's Opening Address, and in Monsignor Tettamanzi's talk on ethical aspects of advanced age.

In his address John Paul II requested that participants take away with them and bring to maturity sensitivity to the problems of the elderly.

* The elderly's wellbeing does not depend on medicine alone: families and public organisms also come into play.

* It is not enough to satisfy the primary needs connected with longevity: the demands posed by the elderly's personal dignity must also be taken into account.

* The prospects for life in a certain sense without age depend on the quality of life.

* Rich countries must not forget the less developed ones, where proper care is guaranteed for only a few.

* Large pharmaceutical producers should see to it that developing nations are supplied with necessary drugs which have fallen into disuse as no longer required in rich countries.

* A renewed commitment to safeguard, defend, and promote man's whole personality.

* Placing oneself at the service of the elderly means rendering meritorious service to the lives of all, for it signifies to make possible the full unfolding of human potentialities, which, since they are peculiar to each stage of life, enrich them all.

* A commitment to the elderly can contribute to making the Psalm's words concrete: "In old age they will still bear fruit; they will be vigorous and thriving to announce how upright the Lord is."

* Another positive aspect — of unity — involves moving towards renewed exploitation of the experience and knowledge of the elderly, their wisdom — something difficult for our culture, but which meant so much in the oral tradition. In archaic society the elderly were those who knew; oral tradition regarded them as a living archive. An African proverb thus states, "Every time an old man dies, a library disappears." To count on them and give them a place in modern society is not just a humanitarian, but also a pastoral act.

* Longevity was a privilege for the patriarchs, who died at a very advanced age. Long life is a gift of God, a time of grace, a period God grants to our freedom; a series of values arise from this: thanksgiving, hope, joy. Who am I if not the expression of Abraham, Zechariah, and old Simeon? "Blessed be the Lord, the God of Israel. Now, Lord, your servant can die in peace."

The pastoral aspect also involves affirming that the elderly must be persons and must come to be such increasingly. This is a dynamic aspect which is not lost with age.

Dignity, autonomy, progressive realization, and the need for communion are basic values which can and must be exercised by the elderly in addition to participation in social life and in the life of the Church, as John Paul II recalled in Monaco of Bavaria:

"Old age is the crowning moment of life's stages. It bears the harvest of what has been learned and experienced, the harvest of what has been achieved and reached, the harvest of what has been suffered and borne. As at the end of a great symphony the dominant themes of life return for a powerful, sonorous synthesis. And this exclusive resonance confers wisdom. .. Wisdom confers distance, but not a distance of estrangement from the world; it allows man to rise above things, without despising them; it makes us see the world with the eyes and heart of God."

Conclusions

With the International Conference on Longevity and the Quality of Life, the Pontifical Council believes it has contributed to making the subject and its importance better known, emphasizing longevity and quality as two terms having an impact on family, cultural, political, and generational life. Our Conference also stressed the dignity of the elderly, the principle of solidarity, and the need for public and family supporting structures which respect their dignity, autonomy, and progressive realization. Finally, at this International Conference we wanted to manifest that in old age values such as thanksgiving, hope, and joy can be experienced and that this stage represents the crowning point of a whole lifetime

Chronicles and News from Meetings

SOUTH AFRICA

Health As a Platform for Encounters

Archbishop Fiorenzo Angelini, President of the Pontifical Council for Pastoral Assistance to Health Care Workers, and Fr José L. Redrado, O.H., Secretary, were guests of the Department of Health Care and Education of the Southern African Catholic Bishops' Conference on their visit to Transvaal, February 10-14 1989

Because of a very heavy schedule it was not possible to leave the Transvaal area, yet in the short time over 1,000 kilometers were covered by car. Visited were Catholic hospitals in Warmbaths (St. Vincent's), Pretoria (Marifont Maternity Hospital, Little Company of Mary Hospital and Hospice), Johannesburg (Kenridge Hospital and Nazareth House), the Clinic of the Stigmatine Fathers in De Wildt, and also a mine hospital in Witbank.

One of the meetings addressed by Archbishop Angelini involved the Transvaal Natural Family Planning Teachers in Ackerville, with twenty-five teachers and two priests. Here Archbishop Angelini made special mention of an article he had written about *Humanae Vitae* and the importance of this document in the work of the teachers. He later addressed a meeting of the Catholic Nurses' Guild in Johannesburg Cathedral Hall which was attended by over seventy nurses from the Johannesburg-Pietersburg areas, along with delegates from the Lesotho Catholic Nurses' Guild. Highlights of this meeting were the inauguration of the Pimville Branch of the Guild, the installing of the new National Spiritual Advisor of the Guild, Fr. Remi Makobane, O.M.I., the blessing of the hands of all the nurses and priests in attendance, and the presentation to Archbishop Angelini of a gift by the Guild. Bishop Mansuet D. Biyase had specially flown up from Eshowe for this meeting, as he is Vice Chairman of the Commission of Christian Service, under which the Catholic Nurses' Guild falls.

Next was the meeting of the Catholic Health Care Association, which was held in Kenridge Hospital, Johannesburg. Bishop Reginald Orsmond was also present here. Many vital issues relating to Catholic hospitals and clinics are posed at such meetings, and there is an Ethics Committee which examines conflicts with the teaching of the Church wherein Catholic hospitals must take a stand. Here, too, Lesotho was represented by Sister Virginia Ginet of the Lesotho Catholic Bishops' Conference Secretariat. Sisters from Namibia attended as well.

At all three gatherings Archbishop Angelini addressed those present and explained the work of the Pontifical Council and the importance of everyone engaged in the Church's health care apostolate.

Private meetings were also held. One was with Dr J.H. Lombard, Director for Infectious Diseases, Department of National Health and Population Development, in the Civitas Buildings, Pretoria. Dr. Lombard gave a talk with overhead projections on the AIDS situation in Africa. Dr. H.J. Steyn, Deputy Director General of the Department of National Health and Population Development, came as well to meet Archbishop Angelini and speak with him.

There followed a meeting with Dr. Ruben Sher, Head of the Serology and Immunology Department at the South African Institute of Medical Research. Mrs. Lily Battaglia provided translation from Italian to English, and very much ground in the whole area of AIDS was covered. A tour of the AIDS Information and Training Centre was then undertaken, and various staff members were met. A book on *The Quest of Health* by Marias Malan was presented to Archbishop Angelini and Fr. Redrado by the Head of the Institute.

These meetings were important because the Pontifical Council will be devoting its fourth International Conference at the Vatican in November 1989 to AIDS, with speakers from all over the world, including Dr. Sher.

A very short tour of Seweto was organized by Sister Michael, a Mercy Sister of St. Matthew's School, and the party was taken to Mshenguville, where the most appalling poverty is found. They also visited Regina Mundi Church in Seweto.

Archbishop Angelini and Fr. Redrado were guests of the Apostolic Delegate, the Most Reverend Ambrose De Paoli, and the Auditor, Monsignor Mario Casari, and stayed at the Delegation in Pretoria.

A vast amount of activity filled these four days, and through this visit we now know how much zeal and interest exists in the Pontifical Council for Pastoral Assistance to Health Care Workers.

MISS P.A. MCGREGOR

LOURDES

Pilgrimage to the Marian Shrine

The national presidencies of the Italian Catholic Medical Association and Pharmacists' Association organized a trip to Lourdes for 130 people, including professionals and members of their families, June 2-6, 1989. The spiritual guide of the pilgrimage to the famous Marian sanctuary was the President of our Pontifical Council, Archbishop Fiorenzo Angelini.

The pilgrims' disposition and specific professional status, so closely related to the most evident facet of this citadel of Mary, where the suffering of people from all over the world keeps its appointment each day, deeply marked the stay, spontaneously endowing it with the character of a colloquium on science and faith.

The morning gathering around the Eucharistic table represented a moment of reflection and personal stocktaking on the spiritual life, and the ideal occasion for focusing the day's concerns, in the awareness that Lourdes offers multiple and unexpected encounters with God, who passes nearby or waits at the mystical grotto of Massabielle, present in the numberless, serene faces of those at prayer, so many of whom come in wheelchairs or on stretchers. The Eucharistic Concelebration in the grotto in the early hours of Sunday, June 4 was especially moving.

Ample room was left for personal prayer and reflection. Among shared moments, particularly noteworthy were the stations of the Cross, with commentary by doctors and pharmacists, and the Eucharistic procession in the afternoon. The participants had the privilege of following immediately behind the Officiant, Archbishop Angelini, who was bearing the Most Holy Sacrament, in their capacity as associates of the Medical Bureau; with close attention and emotion they observed the blessing of different groups of patients arrayed in the esplanade.

Awaited with interest and carried out most successfully was the round table on "Miracles at Lourdes" in the Medical Bureau Auditorium, whose Director, Dr. Teodoro Mangiapan, was the fully competent, attentive, and courteous interlocutor. The illustrious clinician brought the guests into the discussion with the knowledge and scientific experience of over twenty years concerning the humanly inexplicable healings at Lourdes, devoting considerable attention to the most recent one and making available relevant scientific documents. Between Dr. Mangiapan and the qualified visitors an interesting colloquium emerged on the healing of a malignant tumor in the right tibia of a young person from Paterno, Sicily, who in 1976, around Christmastime, several months after a pilgrimage to Lourdes, noticed the first signs of healing. The Medical Bureau, after several years of follow-up and verification, by majority decision on July 28, 1980 declared this healing "in the conditions in which it took place and has been maintained to be a phenomenon contrary to the observations and previsions of medical experience and scientifically unexplainable."

The discussion, which occupied the entire morning of June 5 and several hours of the afternoon, proved to be an interesting and expert meeting for study, with prearranged and spontaneous remarks; the President of our Pontifical Council, co-moderator with Dr. Mangiapan at the round table, brought to bear his broad experience as a priest and theologian, setting forth clearly the thought and teaching of the Church in this regard.

The variable weather, cold and rainy for nearly the whole stay, did not interfere with the unfolding of the program, including the evening when the characteristic *aux flambeaux* procession in honor of the Blessed Virgin Mary brought a flood of thousands and thousands of faithful into the vast sanctuary enclosure.

For Archbishop Angelini there was occasion to visit the Most Reverend Jean Sahuquet, Bishop of Tarbes and Lourdes, at his local residence. In open and cordial dialogue numerous shared interests were touched upon centering on pastoral service in the field of human health and suffering, and certain initiatives to be realized in the very near future in fraternal collaboration were outlined.

Participants in the pilgrimage included the Undersecretary of the Pontifical Council, Fr. Felice Ruffini, M.I.; Fr. Simone Tonini, former Abbot General of the Silvestrini Benedictines; Professor Nenna, European President of the Catholic Medical Associations; Professor Domenico Di Virgilio and Dr. Lino Mottironi, Presidents of the Catholic physicians and pharmacists of Italy, respectively, along with some members of the two presidencies; Dr. Giacomo Leopardi, President of the Association of Italian Pharmacists; and a number of Consultors and experts of the Pontifical Council.

Perfect organization and assistance was provided by the Roman Pilgrimage Institute.

FR. FELICE RUFFINI, M.I.
Undersecretary of the Pontifical Council for Pastoral Assistance to Health Care Workers

POLAND

Visit to Health Facilities

At the request of the Polish Bishops' Conference, the President of our Office, Archbishop Fiorenzo Angelini, visited Poland for the fifth time, June 20-24, 1989. He was accompanied by the Undersecretary of the Pontifical Council, Fr. Felice Ruffini.

The intensive, detailed program, prepared by the Conference Secretary, Archbishop Bronislaw Dabrowski, took Archbishop Angelini to Tarnow, Warsaw, and Gdansk to meet health professionals and patients at "citizens' hospitals" and specialized gatherings and some government officials for exchanges on the topic of human health, which the Church has always defended because she is close to those suffering and all who commit themselves to protecting and assisting life from the first instant to its natural conclusion.

Three moments may be regarded as a summary of this new and rich experience.

* There are a great many health care workers in Poland engaged in offering Christian witness in the world of medicine and they proceed in unision with their Bishops and the priests who attend them. They are aware of the limits imposed by the worrisome economic crisis and have realized that not everything should be awaited from on high, but they themselves must take responsibility for facing the situation, compensating on their own initiative wherever the State still cannot intervene.

Archbishop Angelini found attentive interlocutors and fertile ground. At Tarnow, Warsaw, and Gdansk his talks were received as expressions of fraternal solidarity and the presentation of a "code of conduct" taught by the Church. By way of summary, we include excerpts from the fundamental passages:

The defense of life demands the collaboration of all, beyond ideologies, races, and religions... Government authorities responsible for public health need the collaboration of all engaged in the care of man... One of the State's prime duties is the care of the sick... Medicine is for life, and to go against life is a betrayal. Life is a reality which every doctor is obliged to respect. The physician is not just any professional, but a person with a specific vocation and mission whose purpose is to collaborate with God; the doctor

continues the work of creation by God, of Redemption by Christ, for in defending life he is concerned not with illness, but with man, composed of body and soul. We cannot care for the body and neglect the soul... This holds true for all, including those who do not have the Christian faith.

We were touched when some patients spontaneously praised their doctors, exalting their human and professional endowments. At the Gdansk hospital a woman patient asked Archbishop Angelini to request that the Pope have a special badge made to be given to all the physicians who remained to care for the sick and did not abandon them.

* The second significant moment involved exchanges with some governmental and political figures who wished to meet our President.

Very important was the conversation with Foreing Affairs Minister Tadeusz Olechowski, in which the Director of the Office for Relations with the West, Dr. Fekecz, participated. The meeting had been requested by the Ministry itself, which wished to express its own appreciation and that of the Government for the Pontifical Council's fraternal assistance to health facilities in Poland, provided with discretion and without publicity. Sincere appreciation was also expressed for the Church's pacification efforts, along with deep admiration of the Holy Father's activity around the world.

At Tarnow the President of the Province also wished to receive Archbishop Angelini at the City Hall, once the seat of local government and now a museum, to pay homage to the Church's labors in favor of the Polish people, especially in the field of health.

At 9:30 p.m. on June 21 State Television broadcast an interview with our President granted at the residence of Cardinal Primate Jozef Glemp; it appeared as part of the *Panorama* program.

Of great interest was Lech Walesa's visit to Archbishop Angelini at the headquarters of the Bishops' Conference.

* The third moment of special significance involved the faith and religiosity of the Polish people. Bishops and priests are loved as the true and only Pastors described by the Gospel.

At Tarnow the Seminary, with 300 young students, provides 40 new priests each year. In Gdansk, which rose from the ashes after the last war — having been destroyed in the fabric of its Church life as well — there are today 150 seminarians and twenty new priests a year. At the Warsaw seminary there are about 400 seminarians, and 50 ordinations each year. These figures are impressive and also convey how alive the faith is coming from a purification of suffering and hard trial.

The example of pastoral life, reaching a level of admirable, authentic magisterium in Archbishop Bronislaw Dabrowski, in the Most Reverend Jerzy Ablewicz, Archbishop of Tarnow, and the Most Reverend Tadeusz Gocloski, Bishop of Gdansk, is a powerful spur for the activity of the Pontifical Council.

CUBA

Joining Wills

In slightly over a year our Pontifical Council has been invited three times to visit Cuba: first by the local Church and twice thereafter by the nation's Government.

The third visit, July 2-8, 1989, was basically motivated by participation in the Second International Conference on Disasters, along with different meetings with the local Church and representatives of the Cuban Government and the opportunity to observe several health facilities.

The visit was made by Archbishop Fiorenzo Angelini, President of this Office, Fr. José Luis Redrado, Secretary, and Professor Corrado Manni, Consultor of our Council and Director of the Institute of Anaesthesiology and Resuscitation at the Catholic University of the Sacred Heart, Rome.

The truth is that this visit was preceded by rich encounters, intense dialogue, and extensive correspondence. At our headquarters we had occasion, on April 20, 1989, to receive and dialogue with the President of the Cuban Bishops' Conference, the Most Reverend Jaime Ortega, and Bishop Mariano Vivancos, in charge of the health apostolate in Cuba. We also received Dr. Julio Teja, Cuban Health Minister, during his visit to Rome, May 3-5, 1989, and Dr. José Felipe Carneado, Chief of the Cuban Office for Religious Affairs, on May 27.

Both Monsignor Ortega and Dr. Carneado bore official invitations – from the Church and the Government, respectively – for a visit by the Holy Father to Cuba and, at the same time, wished to make contact with a number of religious institutes in the health field with a view towards their possible entry into Cuba, which would be guaranteed by a *Pastoral Protocol*, an agreement between the local Church and the Cuban Health Ministry.

Program of Activities

* *Talk at the Conference*. We participated in the opening ceremony on July 4. It was presided over by Dr. Rosa Elena Simeon, President of the Cuban Academy of Sciences. The presidency was also made up of Brigadier-General Guillermo Rodriguez del Pozo, Chief of the General Staff for Civil Defense; Major-General Pascual Rodriguez Braza, Deputy Minister of the Interior; and Army General Vladimir Govoroz, Chief of Civil Defense in the USSR.

After the inaugural ceremony, Archbishop Angelini assumed the presidency and introduced the first speakers: Dr. Albert Giesseek, representative of the United Nations Office for the Coordination of Disaster Relief; Dr. Claude Deville, of the Emergency Program of the Pan-American Health Bureau; and Dr. Juve Vitani, President of the League of Red Cross Societies. Finally, Archbishop Angelini spoke on "Ethics in Diaster Medicine," stressing to the audience that medicine must be at the service of life – as an ethical exigency. Monsignor Angelini's complete talk appears in this issue. In the afternoon the Conference continued with the papers scheduled for different halls; in one, at which Archbishop Angelini also presided, Professor Corrado Manni delivered a lecture on "Functions of the Emergency Department in Disasters," bringing out the role and importance of such departments and how their means are to be used in those circumstances: tasks, structures, multidisciplinary organization, etc.

* *Visit to Health and Civil Authorities*. At the Health Ministry we met with Dr. Julio Teja and several collaborators. The main topic of our conversation was the importance of friendship and cooperation, with respect to both the entry of men and women religious to work at Cuban health facilities and the possibility that doctors would come to Rome to exchange ideas and gain additional knowledge in different specialties.

At the Foreign Affairs Ministry we met with Dr. Isidoro Malmierca, the Minister. Here again attention was focused on the health

field. Archbishop Angelini pointed out that it was beyond all ideologies, parties, and religions. In this area there is room for only one question: What does man need? Our response should always be to approach him to help him. The objective of health involves not only medicines and hospitals but hygiene, diet, and ecology. The Minister stressed our agreement on a common language and the fact that President Castro had on several occasions stated that for health care women religious were needed, for they were an example of consecration, sacrifice, and effort. The Minister added, "Monsignor Angelini, your visit makes us more confident and serves to support this duty we have to guarantee health."

* *Interview with Dr. Carlos Rafael Rodriguez, Vice President of the State Councils and Ministries.* Dr. Rodriguez showed interest in the unfolding of our work and the Conference; in regard to the topic, he reminded us that Cuba had given aid in certain disasters – in Peru, Nicaragua, and Armenia, for example. Of special interest in this visit was the presence of Dr. Carneado, engaged in the study of the *Pastoral Protocol* providing for the entry of men and women religious into the country to work in the health field, an aspect Vice President Rodriguez was deeply interested in.

After these visits, during which we were accompanied by the Apostolic Pro-Nuncio, the Most Reverend Faustino Sainz Muñoz, and the Auditor of the Nunciature, Monsignor Pierre Christophe, an encounter took place at the Nunciature attended by the Ministers visited and qualified representatives of the Ministries; we were also honored by the presence of Monsignor Ortega, Monsignor Vivancos, and the team coordinating the health apostolate in Cuba.

* *Health Facilities Visited.* We stopped at the Polyclinic and Family Doctor Bureau in Calabazar, a town in Boyeros. We noted the organization, the attention offered, the degree of integration into the human community, and, above all, the objective of reaching everyone with health care.

In the Province of Pinar del Rio we visited units of the national health system. We were accompanied throughout the day by the Apostolic Pro-Nuncio, the Deputy Minister, Dr. Abelardo Ramirez, and the former Cuban Ambassador to the Holy See, Dr. Estevez. The day's schedule had been carefully prepared. We visited State-run Abel Santamaria General Hospital, with 600 beds and 1,019 employees. We were informed about how a positive change and real health-care development had become possibile in a poor province like Pinar del Rio. In the same area we also visited a Family Doctor Bureau, a Home for the Aged, and an electronics factory. In Pinar del Rio we met with the local Ordinary as well, Bishop José Siro Gonzalez, who accompanied us on the visits.

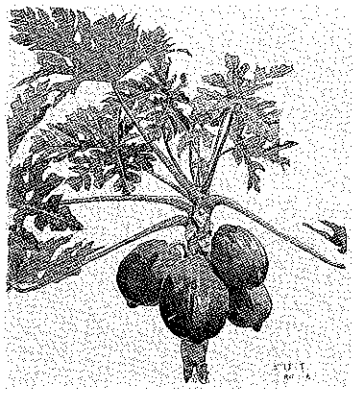
* *In Contact with the Local Church.* As was mentioned above, we met with Monsignor Faustino Sainz Munoz, the Apostolic Pro-Nuncio, and Monsignor Pierre Christophe, Auditor of the Nunciature, along with a group of Cuban bishops: Monsignor Ortega, Monsignor Vivancos, Monsignor Siro Gonalez, Monsignor Céspedes, Secretary of the Cuban Bishops' Conference, and Monsignor Adolfo Rodriguez, Bishop of Camagüey.

Especially important were the meetings with the National Health Apostolate group for Cuba, coordinated by Br. Manuel Colliga, O.H., and with the religious superiors working in Cuba in the field of health. At the first meeting we reflected on a draft text of the *Pastoral Protocol* prepared by the group and intended to be an Agreement between the public Health Ministry and the Cuban Bishops' Conference, a project with had been under study for some time and in which our Office was playing a very active role, since it involved the entry of men and women religious to work at public health facilities. Archbishop Angelini stressed the importance of the agreement and its pastoral dimension. The meeting with religious superiors in the health field was attended by fifteen representatives. The urgency and responsibility of meeting needs with additional personnel and responding to the offer being made to us were brought out. At present some 131 religious women are working at Church-run facilities and two State institutions, a leprosarium and center for the mentally retarded. The main steps being taken were reviewed: the support of our Office and the Nunciature, visits by Monsignor Ortega and Monsignor Vivancos to Rome, Spain, and Mexico, and the work of the Commission responsible for drafting the *Protocol*.

This experience of three visits to Cuba in just over a year has served to demonstrate to us once again how important the topic of health is and how it brings together efforts and wills. During these visits we observed the place health occupies in the interests of the State as well as the efforts made and the ground gained in the Cuban health apostolate, an evolution marked by so many encounters, new ways of acting, concerns, and testimony. We sincerely hope that this new step, this collaboration being sought, will serve to break down barriers and join wills, to provide a richer evangelizing presence of the Church in Cuba!

Finally, we noted the joyful expectation with which the Pope's visit to Cuba is being awaited, by both bishops and faithful and the Cuban Government.

Fr. JOSE LUIS REDRADO



ROME

Our Office's Participation in Several Meetings

1. Meeting at the Vatican of the Metropolitan Archbishops of the Ecclesiastical Provinces of the United States, March 8-10, 1989

Archbishop Angelini attended this meeting in his capacity as President of the Pontifical Council and acted as a spokesman for certain points relating to the promotion, encouragement, and coordination of the health ministry within the overall framework of pastoral practice. He stressed that the health apostolate occupied a privileged place in evangelization, referring to the importance of spiritual assistance to the sick, the operativeness of health associations, and the Magisterium of the Church in regard to research and technical progress.

2. Health, Environment, and Development

This was the topic for a meeting held in Rome, May 3-15, 1989, at which health cooperation linking Italy, Latin America, and the Caribbean was discussed. Engaged in reflection were the Italian Foreign Affairs Ministry, the Pan American Health Organization, and the World Health Organization. Archbishop Angelini's talk on "Health for All in Justice for All" is included in this issue. This was a good opportunity to strengthen the bonds of friendship with a great many Health Ministers from Latin America, since, aside from the scientifically oriented meeting, there was a chance for personal exchanges and also a special dinner offered by the Council at which twenty Latin American Health Ministers were present, along with other figures.

3. Meeting of the Pontifical Council for the Family

The plenary session of the Pontifical Council for the Family took place in Rome, June 12-16, 1989. Archbishop Angelini forms part of the Council's Presidential Committee and attended all the work sessions. The meeting was especially concerned with the problems of young married couples: pastoral attention, difficulties in living together, the sacraments, and permanent formation.

4. Meeting at the Pontifical Council for Justice and Peace

On March 14 a meeting chaired by Cardinal Roger Etchegaray took place. It was attended by representatives of different Pontifical Offices. Our Council was represented by Fr. José L. Redrado. The purpose of the meeting was to evaluate the World Peace Day held each year on January 1 and also to propose various topics for the next Day.

5. Italian National Council for the Health Apostolate

On June 6, 1989 a meeting was held at the headquarters of the Italian Bishops' Conference to reflect on the problems and pastoral care of the elderly. Fr. José L. Redrado presented a paper — published in this issue — on the pastoral orientations deriving from the texts of the Conference organized by our Office on "Longevity and the Quality of Life."

6. Christian Communities in Moslem Environments

A Seminar on Christian Communities in Moslem Environments was held at the Lateran University, June 1-3, 1989. Many researchers, professors, and representatives of Pontifical Offices participated. Our Council was represented by Fr. Jean Marie Mpendawatu, a priest from Zaire and regular collaborator of this department.

Throughout the reflection, the meeting point for the two communities was seen to reside in cultural and charitable works. For some time Christians have done — and continue to do — highly esteemed work in the fields of education and care of the sick. The best schools and hospitals are usually run by Christians (religious institutes) and are open to all without distinction. *The importance and quality of the school and hospital infrastructure in those countries where Christians are a minority constitutes living testimony of God's love for all men and, at the same time, a platform for collaboration and dialogue between the two communities.*

OTHER ACTIVITIES

* *Viterbo*. On January 10, 1989 Archbishop Fiorenzo Angelini presided at the presentation of two doctoral theses, *The Marian Dimension of St. Camillus*, and *A Study of the Fourth Vow of the Camillians*. Fr. Felice Ruffini, Undersecretary of our Council, authored the former, and Fr. Emilio Spogli, Vice President of the Camillianum and Consultor of our Office, the latter. To the congratulations already received we wish to add our own, those of the Council, and those of our journal. Considerable progress has been made on a journey which must continue.

* *Gaeta*. On June 25 the Pope visited the Archdiocese of Gaeta. Within a busy schedule, the Holy Father had a very warm, positive, and faith-filled encounter with the sick gathered at the Civita Marian Sanctuary. After this meeting with the Pope the Eucharistic Celebration, presided over by Archbishop Angelini, took place.

* Fr. José L. Redrado attended several meetings in the Diocese of Albano on the occasion of Suffering Day (March 5, 1989). He also spoke on humanity in medicine before a group of Catholic physicians from the diocese (March 19, 1989).

In *Rome* he addressed the volunteers at St. Camillus hospital (February 24, 1989). In addition, Fr. Redrado gave a talk to a group of Capuchins serving as chaplains at several hospitals in Italy.

* *Meetings*. Numerous meetings have been held at the Pontifical Council, basically to deal with ordinary work and, in particular, the preparation of major gatherings, such as the Fourth International Conference organized by our Office, devoted to AIDS, November 13-15, 1989.

News from Around the World

VATICAN CITY

Humanae Vitae Twenty Years After the Publication of Pope Paul VI's Encyclical

On the initiative of the Pontifical Council for the Family, a meeting of the Bishops responsible for the Episcopal Commissions for the Family from sixty Bishops' Conferences took place at the Vatican, November 7-8, 1988. Reflection and the exchange of experiences dealt with the problems posed by marriage and the family in our day, twenty years after the appearance of the Encyclical *Humanae Vitae*. The participants, among whom were many lay people expert on the subject, brought out the validity and current interest of this pontifical document. Special attention was devoted to several key issues in family morality, such as the moral conscience of spouses and the Magisterium and, once again, the problem of those who have remarried after divorce.

Obey the Truth and Respect *Humanae Vitae*

The Holy Father reaffirmed the obligatory nature of the moral norm taught in the Encyclical *Humanae Vitae* in his words to those attending the Second International Moral Theology Conference. At the conclusion of his talk, the Pope stated, " Always seek the Truth, respect the truth openly, obey the Truth. There is no greater joy than this search, this respect, and this obedience. "

A Russian Given the Humanity in Medicine Award for 1988

During the International Conference organized by the Pontifical Council for Pastoral Assistance to Health Care Workers devoted to " Longevity and the Quality of Life, " Russian Psychiatrist Anatoly Koryagin received the Humanity in Medicine Award for 1988.

The Church, Mater et Magister Alongside Those Affected by the Drama of AIDS

The Church, taking seriously " the joys and hopes, sadness and anguish " of man in our time, also feels responsible for the serious problem of AIDS.

Two initiatives deserve special mention:

1) The one taken by the Pontifical Council for Pastoral Assistance to Health Care Workers in devoting its fourth International Conference to the study of this vital current issue. Fundamental problems and topics related to the central theme (" To Live: Why? ") will be dealt with Since it appeared, AIDS has been closely connected with existential crises, the crisis in education and the formation of consciences, the absence of a religious sense, and the rejection of the human meaning of life.

2) The initiative of CELAM in Latin America in holding a meeting in Sao Paolo, Brazil on AIDS, November 7-11, 1988. It was organized by the Pastoral Office for the Family of the Council of the Latin American Episcopate in collaboration with CARITAS International and the Archdiocesis of Sao Paolo The event brought together forty participants: bishops, experts, and pastoral workers. Among the main topics were the diagnosis of the illness and a theological vision of the reality of AIDS and the values of sexuality in the family context. The aim of the meeting was to share data relevant to pastoral action among high risk groups.

CUBA

Sociomedical Facilities for the Elderly Need to Be Humanized

Over the past several years the Cuban government has made a great effort to find a solution to the numerous problems of senior citizens and thereby ensure for this group a way of life without social marginalization. To this end various sociomedical facilities have been created as a response to the multiple needs of these people; in most cases, they no longer have a family, or, where the family exists, it is unable to meet their needs. Obviously, much remains to be done. In addition, there is awareness that the facilities should leave room for personal commitment and initiative among the beneficiaries so that they may realize themselves as persons.

STRASBOURG, FRANCE

The Protection of Human Life Begins at Conception

The Policy Commission of the European Parliament unanimously approved a bill on genetic manipulation at the request of the Law and Citizens' Rights Commission The excerpts from the bill quoted below are self-explanatory:

* " The right to life begins at the moment of conception. "

* " The protection of human life from its conception on and the protection of genetic identity are rooted in human dignity "

* " As regards scientific research and medicine, no experiment on embryos is authorized. It is needful to eliminate the risk connected with eugenic processes. Therapeutic practices affecting embryos are acceptable only if their objective is closely linked to the well-being of the human life in question. "

GUAYAQUIL, ECUADOR

The Inestimable Value of Spirituality in the Health Ministry

The Archdiocesis of Guayaquil, Ecuador, deeply committed to pastoral service to our suffering brothers and sisters, looks towards the future with faith and optimism. Those responsible for this apostolic sector propose to:

* increase the number of pastoral groups, particularly in parishes;

* continue to promote and stimulate initiatives (lectures, study days, seminars) to humanize and Christianize health services;

* propagate devotion to the green scapular of the Blessed Virgin, giving it to patients with the text of the prayer which accompanies it;

* unite prayer and the Eucharist so that God will give needed strength and faithfulness to pastoral workers who through this ministry strive to take Christ to the sick, so that their spiritual life will progress and they may work at the same time for their complete salvation.

ZAIRE

The Maternal, Formative, and Charitable Presence of the Church in the World of Health Afflicted by AIDS

The Church in Zaire, alongside other Christian communities, organisms, and research centers for health and development, has been manifesting its always maternal, formative, and charitable presence in the world of suffering which is living through — fearfully, but also hopefully — the drama represented by AIDS, as may be gathered from the information provided by the Most Reverend Bakole Wa Kunga, responsible for this sector within the Zaire Bishops' Conference, to this Pontifical Council.

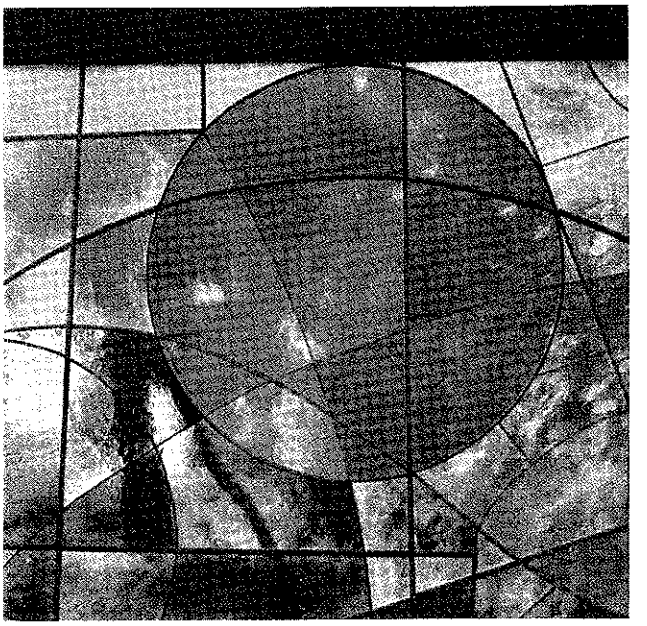
IFCU (International Federation of Catholic Universities)

The IFCU leadership has sent a questionnaire to all the Rectors of the Federation on bioethics at Catholic universities. The survey has a twofold purpose:

* for IFCU's International Group for Bioethics Studies, it would serve as an inventory of the resources for reflection and then provide the possibility of more regularly requesting research workers from our universities to collaborate on research projects developed by the Group on an international level;

* for all the member universities, it would guarantee better information on bioethics specialists, activities, teaching, etc

PONTIFICIUM
CONSILIUM
DE APOSTOLATU
PRO VALETUDINIS
ADMINISTRIS



IV CONFÉRENCE
INTERNATIONALE
FOURTH INTERNATIONAL
CONFERENCE
13–14–15 NOVEMBRE–NOVEMBER
1989
CITÉ DU VATICAN
VATICAN CITY

VIVRE, POURQUOI?
TO LIVE: WHY?

TO LIVE: WHY?

In choosing the complex problems linked to the modern epidemic of the acquired immunodeficiency syndrome (AIDS) as the topic for its fourth International Conference, the Pontifical Council for Pastoral Assistance to Health Care Workers has sought to group them under the title " To Live: Why? " In reality, among the forms of pathology which have stricken man throughout history, AIDS, more than any other, combines illness and behavior, physical pathology and psychic-spiritual pathology

The unexpected manifestation and threatening spread of AIDS have evidenced in a singular way that many imbalances between the First and Third Worlds, between developed and developing countries, not only are based on serious injustices, but are at the root of an existential crisis of man today.

The quality of health is closely linked to the quality of life For this reason, the safeguarding and recovery of health also call for the safeguarding and recovery of the quality of life in its psychophysical integrity, which is not exhausted by material well-being, but demands the defense and affirmation of the primary human values

The Church, viewing man as her " way, " in the words of John Paul II, is particularly sensitive to the drama undergone by AIDS patients and decidedly joins in the commitment by science and public authorities to offer further reason for hope not only to AIDS victims, but to all working to assist them and combat this disease

This International Conference is witnessing contributions by many of the leading scientists and experts in the field The aim is that from this collective effort there may arise a constructive, operative proposal capable of uniting our best forces to face together an illness whose analysis can and must offer a valuable lesson on life

✠ Fiorenzo Angelini
President

VIVRE, POURQUOI?

Choisissant pour thème de la IV Conférence Internationale, les problèmes complexes liés à l'épidémie actuelle du Syndrôme de l'Imunodéficience acquise (AIDS), le Conseil Pontifical pour la Pastorale des Services de la Santé a voulu les synthétiser en cette formule lapidaire: « Vivre, pourquoi? » En réalité, parmi les atteintes pathologiques qui ont touché l'homme, au cours de son histoire, le SIDA, allie plus que toute autre forme, maladie et comportement, pathologie physique et pathologie mentale et spirituelle

La manifestation imprévisible et l'extension menaçante du SIDA ont mis en évidence, d'une manière singulière, comment de nombreux déséquilibres entre le premier et le tiers monde, entre Pays développés et Pays en voie de développement, se basent non seulement sur de graves injustices, mais sont à l'origine d'une crise existentielle de l'homme d'aujord'hui

La qualité de la santé est étroitement liée à la qualité de la vie C'est pourquoi, la sauvergarde et le retour à la santé mettent en cause la sauvergarde et le retour à la qualité de la vie dans son intégrité psycho-physique, laquelle ne se contente pas du bien-être matériel, mais exige la défense et l'affirmation des valeurs humaines fondamentales

L'Eglise qui, selon les propres paroles de Jean-Paul II, regarde vers l'homme comme vers sa propre « route », se montre particulièrement sensible au drame vécu par les malades du SIDA, et s'associe étroitement à l'engagement de la science et des pouvoirs publics en vue d'offrir un nouveau motif d'espérance, non seulement aux victimes du SIDA, mais à tous ceux qui se dévouent pour les assister et pour combattre ce mal

La Conférence Internationale sur le SIDA bénéficie du concours de nombreux scientifiques et experts en la matière Que de ce apport conjugué puisse jaillir une proposition constructive et opérationnelle, capable de rassembler les forces les meilleures pour affronter en commun un mal, dont l'analyse pourra et devra offrir une précieuse leçon de vie, c'est là notre objectif

✠ Fiorenzo Angelini
Président

LUNDI 13 NOVEMBRE

PRÉSIDENCE

S.E. Mgr FIORENZO ANGELINI
Président du Conseil Pontifical pour la Pastorale des Services de la Santé

S.E. Prof GB MARINI BETTOLO
Président de l'Académie Pontificale des Sciences

9h00

DÉBUT DES TRAVAUX

9h30

OUVERTURE

SIDA: science et conscience

M le Cardinal JOHN JOSEPH O'CONNOR
Archevêque de New-York

10h00

SIDA: un signe des temps?

P GEORGES COTTIER O P
Secrétaire général de la Commission Théologique Internationale

10h30

SIDA: importance de la science de base

Prof BARUC S BLUMBERG
Prix Nobel de Médecine
Directeur de l'Institut de la Recherche sur le Cancer, Philadelphie (U S A)

11h00

Intervalle

11h10

SIDA: nature du virus

Prof ROBERT C GALLO
Directeur du Laboraroire de Biologie Cellulaire Institut National de la Recherche sur le Cancer, Bethesda (U S A)

11h40

Prof LUC MONTAGNIER
Directeur de la Division d'Oncologie Virale Institut Pasteur Paris (France)

12h10

Prof ARSÈNE BURNY
Directeur du Département de Biologie Moléculaire Université de Bruxelles (Belgique)

12h40

SIDA: épidémiologie internationale

Prof JONATHAN MANN
Directeur du Programme spécial de lutte contre le SIDA
Organisation Mondiale de la Santé, Genève (Suisse)

15h00

Modérateur: Prof CLARENCE GIBBS
Directeur Adjoint du Laboratoire d'Etudes du Système Nerveux Central, Bethesda (U S A)

Considérations épidémiologiques sur le SIDA

Prof WILLIAM BLATTNER
Directeur de l'Institut National d'Etudes Oncologiques sur la Famille, Bethesda (U S A)

15h30

Le diagnostic du SIDA: expérience en Afrique du Sud

Prof RUBEN SHER
Chef du Département de Sérologie et d'immunologie de l'Institut de Recherche Médicale de Johannesburg (Afrique du Sud)

16h00

SIDA: aspects éthiques généraux

Mgr CARLO CAFFARRA
Président de l'Institut Jean-Paul II pour les Etudes sur le Mariage et la Famille de l'Université Pontificale du Latran Rome

16h30

Modulation du Système immunitaire

Prof FRITZ MELCHERS
Directeur de l'Institut d'Immunologie de Bâle (Suisse)

17h00

Intervalle

17h10

Le SIDA: prévention et immunologie

Prof DANI P BOLOGNESI
Directeur du Département de Chirurgie du Centre Médical Universitaire « Duke », Durham (U S A)

17h40

SIDA: interferon-gamma et anticorps

Prof ADOLFO TURANO
Directeur de l'Institut de Microbiologie de l'Université de Brescia (Italie)

18h10

Usage clinique des interferons et des interleukins: perspectives

Prof MICHEL REVEL
Directeur du Département de Virologie à l'Institut des Sciences Weizmann de Revohot (Israël)

18h40

Le point sur le SIDA dans la recherche du vaccin

Prof DANIEL ZAGURY
Directeur du Laboratoire de Physiologie Cellulaire de l'Université Pierre et Marie Curie, Paris (France)

MARDI 14 NOVEMBRE

9h00

Modérateur: Prof ANTONIO SANNA
Professeur Honoraire de Microbiologie à l'Université du Sacré-Cœur, Rome

Pédiatrie et SIDA

Prof WADE P PARKS
Directeur du Département de Pédiatrie de l'Université de Miami (U S A)

9h30

Thérapeutique antivirale dans le rétrovirus humain: perspectives

Prof ERIK DE CLERCQ
Directeur de la Division de Microbiologie de l'Université Catholique de Louvain (Belgique)

10h30

Les médicaments antiviraux dans l'infection HIV

Dr ROBERT YARCHOAN
Chercheur honoraire de l'Institut National de Santé (NCI) Bethesda (U S A)

11h00

Intervalle

11h10

Thérapeutique et problèmes d'éthique médicale

Prof EDMUND PELLEGRINO
Directeur de l'Institut d'Ethique Joseph et Rose Kennedy de l'Université Georgetown, Washington (U S A)

11h40

Le SIDA: étude clinique

Prof LUIGI ORTONA
Directeur de l'Institut des Maladies Infectieuses de l'Université Catholique du Sacré-Cœur, Rome

12h10

Le SIDA: thérapie intensive

Prof CORRADO MANNI
Directeur de l'Institut d'Anesthésie et de Réanimation de l'Université Catholique du Sacré-Cœur Rome

15h00

Modérateur: Prof FREDERICK C ROBBINS
Prix Nobel de Médecine President de l'Academie Nationale de Médecine (U S A)

La prévention: personne humaine et responsabilité

Prof. SERGIO COTTA
Professeur de Philosophie de Droit à la Faculté de Droit de l'Université « La Sapienza ». Rome

15h30

SIDA: aspects psychologiques et neuropsychiatriques

Prof CARLO LORENZO CAZZULLO
Directeur de la Clinique de Neuropsychiatrie de l'Université de Milan (Italie)

16h00

Synthèse et conclusions

Prof MICHAEL FELDMAN
Directeur de l'Institut Weizmann, Rehovot (Israël)

16h30

Table Ronde

Droits et devoirs de la personne, de la communauté et des institutions

Modérateur: Prof CESARE MIRABELLI
Professeur de Droit Ecclésiastique à l'Université « Tor Vergata » Rome

SIDA et secret professional

P JAVIER ELIZARI, CSSR
Directeur de l'Institut Supérieur des Sciences Morales Madrid (Espagne)

SIDA et Institutions pénales

Prof ERNESTO UGO SAVONA
Professeur à l'Institut National de Justice, Washington (U S A)

17h15

Table Ronde

SIDA et problèmes d'assistance

Modérateur: Prof ELIO GUZZANTI
Directeur Scientifique à l'Hôpital « Bambino Gesù » Rome

Mère THÉRÈSE DE CALCUTTA
Prix Nobel de la Paix

Dr GERHARD MEIER
Secrétaire Général de la « Caritas Internationalis »

Monseigneur IVAN MARIN
Sous-Secrétaire du Conseil Pontifical « Cor Unum »

Mme CECILIA MOLOANTOA
Sécrétaire du Bureau de Santé Union des Conférence Episcopales d'Afrique Australe Johannesburg

Mme HELEN TAYLOR-THOMPSON
Présidente du Conseil d'Administration de la « Mission Mildway » Londres (Grande-Bretagne)

Prof LUHRUMA ZIRIMWABAGABO
Cliniques Universitaires de Kinshasa (Zaïre)

Mlle JOSEPHINA AZZOLINI
Infirmière Hospitalière, San Paolo (Brésil)

18h30

Le SIDA: son actualité dans les pays de mission

P CHARLES SCHLECK, CSC
Sous-Secrétaire de la Congrégation pour l'Evangélisation des Peuples

MERCREDI 15 NOVEMBRE

9h00

Le SIDA: châtiment de Dieu?

Prof ROCCO BUTTIGLIONE
Vice-Recteur de l'Académie internationale de Philosophie
Principauté de Liechtenstein

9h20

Table Ronde

Le SIDA: la famille et la société s'interrogent

Modérateur: S E Mgr JEAN-FRANÇOIS ARRIGHI
Vice-Président du Conseil Pontifical pour la Famille

SIDA et procréation responsable

Prof Mgr ELIO SGRECCIA
Directeur du Centre de Bioéthique de l'Université Catholique du Sacré-Cœur, Rome

SIDA et intégrité de la famille

M l'Abbé RAYMOND C. O'BRIEN
Professeur à l'Institut de Droit « Columbus » de l'Université Catholique, Washington (USA)

Le SIDA et l'Armée

Lieutenant-Colonel ROBERT REDFIELD MC
Directeur du Département de la Recherche sur le rétrovirus à l'Institut Militaire « Walter Reed » de Recherche (U S A)

Prévention du SIDA

Prof AUGUST WILHELM VON EIFF
Directeur de la Clinique Médicale de L'Université de Bonn (Allemagne Fédérale)

10h30

Intervalle

10h40

Modérateur: Prof FRANCESCO ANTONIO MANZOLI
Directeur Général de l'Institut Supérieur de la Santé d'Italie, Rome

SIDA et drogue

M L'Abbé MARIO PICCHI
Président du Centre Italien de Solidarité, Rome

11h00

Le SIDA et les médias

S.E Mgr JOHN P. FOLEY
Président du Conseil Pontifical pour les Communications Sociales

11h20

L'opinion publique et le SIDA

Dr ALBERTO MICHELINI
Journaliste, Député au Parlement Européen

11h40

Le SIDA et l'homme: «Chemin de l'Eglise et de l'Etat»

Prof. BONIFACIO HONINGS
Professeur de Théologie Morale à l'Université Pontificale du Latran, Rome

12h00

SIDA et problèmes sociaux

Prof JACQUES CROZEMARIE
Président de l'Association de Recherche sur le Cancer, Villejuif (France)

12h20

L'impact de l'épidémie du SIDA sur l'opinion publique

Dr ROBERT K GREY
Président du Conseil d'Administration de la Compagnie Internationale des Affaires Publiques Hiel e Knowlton

15h00

Modérateur: Prof ALESSANDRO BERETTA ANGUISSOLA
Président du Conseil Supérieur de la Santé d'Italie

Position de l'Eglise Orthodoxe face au SIDA

S E Mgr ATHÉNAGORAS ZACOPOULOS
Métropolite Orthodoxe de Fochis (Grèce)

15h20

Initiatives des Communautés Européennes dans la recherche sur le SIDA

Prof PAOLO MARIA FASELLA
Directeur Général de la Science, de la Recherche et du Développement de la Commission des Communautés Européennes, Bruxelles (Belgique)

15h40

La Pastorale de la solidarité

S E Mgr DIONIGI TETTAMANZI
Archevêque d'Ancona-Osimo
Professeur de Théologie Morale

16h00

La Pastorale de l'espérance

S.E. Mgr KARL LEHMANN
Evêque de Mayence (Allemagne Fédérale)

16h30

Législation sur le SIDA en divers Pays du monde

Dr HIROSHI NAKAJIMA
Directeur Général de l'Organisation Mondiale de la Santé (O M.S.) Genève (Suisse)

17h00

Action unitaire des Etats dans la lutte contre le SIDA

S. Exc. M. GIULIO ANDREOTTI
Président du Conseil des Ministres de l'Italie

MONDAY, NOVEMBER 13

PRESIDENCY

Archbishop FIORENZO ANGELINI
President of the Pontifical Council for Pastoral Assistance to Health Care Workers

HE Prof GIOVANNI BATTISTA MARINI BETTOLO
President of the Pontifical Academy of Sciences

9:00 a m

COMMENCEMENT OF CONFERENCE

9:30 a m

OPENING ADDRESS

AIDS: Between Science and Conscience
JOHN Cardinal O'CONNOR
Archbishop of New York

10:00 a m

AIDS: A Sign of the Times?
Fr GEORGES COTTIER O P
General Secretary of the International Theology Commission

10:30 a m

The Importance of Basic Science for the AIDS Epidemic
Professor BARUC S BLUMBERG
Nobel Prize Winner in Medicine
Director of the Cancer Research Institute
Philadelphia, USA

11:00 a m

Intermission

11:00 a m

On the Nature of the AIDS Virus
Professor ROBERT C GALLO
Director, Laboratory of Tumor Cell Biology
National Cancer Institute, Bethesda USA

11:40 a m

Professor LUC MONTAGNIER
Director of the Division of Viral Oncology
Pasteur Institute, Paris France

12:10 a m

Professor ARSÈNE BURNY
Director of the Department of Molecular Biology
University of Brussels Belgium

12:40 a m

The International Epidemiology of AIDS
Professor JONATHAN MANN
Director of the AIDS Program of the World Health Organization (WHO), Geneva Switzerland

3:00 p m

Moderator: Professor CLARENCE GIBBS
Associate Director of the Laboratory for Central Nervous System Studies
Bethesda, USA

Epidemiological Considerations on AIDS
Professor WILLIAM BLATTNER
Director of Family Studies at the National Cancer Institute, Bethesda, USA

3:30 p m

The Diagnostics of AIDS in the Experience of Southern African Countries
Professor RUBEN SHER
Head of the Serology and Immunology Department Institute for Medical Research Johannesburg, South Africa

4:00 p m

Monsignor CARLO CAFFARRA
Dean of the John Paul II Institute for Marriage and Family Studies at the Lateran Pontifical University Rome

4:30 p m

The Modulation of the Immune System
Professor FRITZ MELCHERS
Director of the Immunology Institute of Basel Switzerland

5:00 p m

Intermission

5:10 p m

Immunological Prevention of AIDS
Professor DANI P BOLOGNESI
Professor of Biology at the Duke University Medical Center
Durham USA

5:40 p m

Interferon-Gamma and Antibodies in AIDS
Professor ADOLFO TURANO
Director of the Microbiology Institute at the University of Brescia, Italy

6:10 p m

Prospect of the Clinical Uses of Interferons and Interleukins
Professor MICHEL REVEL
Head Department of Virology The Weizmann Institute of Science, Rehovot Israel

6:40 p m

Information on Progress in AIDS Vaccine Research
Professor DANIEL ZAGURY
Directory of the Cellular Physiology Laboratory at Pierre and Marie Curie University Paris, France

TUESDAY, NOVEMBER 14

9:00 a m
Moderator: Professor ANTONIO SANNA
Emeritus Professor of Microbiology
at the Catholic University of the Sacred Heart, Rome

Pediatrics and AIDS
Professor WADE P PARKS
Head of the Pediatrics Department
at the University of Miami, USA

9:30 a m
Prospects for Antiviral Drugs
for Human Retroviruses
professor ERIK DE CLERCQ
Director of the Microbiology Division
at the Catholic University of Louvain, Belgium

10:30 a m
Clinical Evaluation of Antiviral Drugs
for HIV Infection
Dr ROBERT YARCHOAN
Senior Investigator, N.C.I. National Institutes
of Health, Bethesda, USA

11:00 a m
Intermission

11:10 a m
Therapeutic Treatment and Problems
in Medical Ethics
Professor EDMUND PELLEGRINO
Director of the Joseph and Rose Kennedy Institute
of Ethics at Georgetown University
Washington, USA

11:40 a m
AIDS from a Clinical Standpoint
Professor LUIGI ORTONA
Director of the Infectious Disease Institute
at the Catholic University of the Sacred Heart, Rome

12:10 a m
Intensive Therapy for AIDS
Professor CORRADO MANNI
Director of the Anesthesiology and Resuscitation
Institute at the Catholic University
of the Sacred Heart, Rome

3:00 p m
Moderator: Prof FREDERICK C ROBBINS
Nobel Prize Winner in Medicine
President of the National Academy of Medicine, USA

The Human Person and Responsibility
in Preventive Behavior
Professor SERGIO COTTA
Professor of Philosophy of Law
at the Jurisprudence Faculty
of La Sapienza University, Rome

3:30 p m
Psychological and Neuropsychiatric Aspects
of AIDS
Professor CARLO LORENZO CAZZULLO
Director of the Neuropsychiatric Clinic
at the University of Milan, Italy

4:00 p m
Summary Conclusion
Professor MICHAEL FELDMAN
Professor of Cell Biology at the Weizmann Institute
Rehovot, Israel

4:30 p m
Round Table
Rights and Duties of the Person,
the Community, and Institutions
Moderator: Professor CESARE MIRABELLI
Professor of Ecclesiastical Law
at Tor Vergata University, Rome

AIDS and Professional Secrecy
Fr JAVIER ELIZARI, C SS R
Director of the Advanced Institute
for Moral Sciences, Madrid, Spain

AIDS and Penal Institutions
Professor ERNESTO UGO SAVONA
Professor at the National Institute of Justice
Washington, USA

5:15 p m
Round Table
AIDS and Problems in Assistance
Moderator: Professor ELIO GUZZANTI
Scientific Director
of the Child Jesus Hospital, Rome

Mother THERESA OF CALCUTTA
Winner of the Nobel Peace Prize

Dr GERHARD MEIER
General Secretary of Caritas Internationalis

Monsignor IVAN MARIN
Undersecretary of the Pontifical Council
Cor Unum

Mrs. CECILIA MOLOANTOA
Secretary, Health Care and Education Dept
Southern Africa Bishops' Conference

Mrs HELEN TAYLOR-THOMPSON
Chairman of the Board of Governors
of the Mildmay Mission, London

Professor LUHRUMA ZIRIMWABAGABO
University Clinics of Kinshasa, Zaire

Miss JOSEPHINA AZZOLINI
Professional nurse, São Paolo, Brazil

6:30 p m
The Problems of AIDS in Mission Countries
Fr CHARLES SCHLECK, C S C
Undersecretary of the Congregation
for the Evangelization of Peoples

9:00 a m

Is AIDS a Divine Punishment?

Professor ROCCO BUTTIGLIONE
Pro-Rector of the International Academy of Philosophy, Principality of Liechtenstein

9:20 a m

Round Table

AIDS as a Problem of the Family and Society

Moderator: H E Msgr JEAN-FRANÇOIS ARRIGHI
Vice President of the Pontifical Council for the Family

AIDS and Responsible Procreation

Monsignor ELIO SGRECCIA
Director of the Bioethics Center at the Catholic University of the Sacred Heart, Rome

AIDS and the Integrity of the Family

Fr RAYMOND C O'BRIEN
Associate Professor at the Columbus School of the Law of The Catholic University Washington, USA

AIDS in the Armed Forces

Lt. Col ROBERT REDFIELD MC
Chief, Department of Retrovirus Research Walter Reed Army Institute of Research, USA

Instructions on the Prevention of AIDS

Professor AUGUST WILHELM VON EIFF
Director of the Bonn University Medical Clinic West Germany

10:30 a m

Intermission

10:40 a m

Moderator: Prof FRANCESCO ANTONIO MANZOLI
General Director of the Italian Superior Institute of Health, Rome

AIDS and Drugs

Fr MARIO PICCHI
President of the Italian Center for Solidarity, Rome

11:00 a m

AIDS and Social Communications

Archbishop JOHN P FOLEY
President of the Pontifical Council for Social Communications

11:20 a m

Public Opinion and AIDS

Hon ALBERTO MICHELINI
Journalist, Member of the European Parliament

11:40 a m

AIDS and Man as the Way of Church and State

Fr BONIFACIO HONINGS
Professor of Moral Theology at the Lateran Pontifical University, Rome

12:00 a m

Aids and Social Problems

Professor JACQUES CROZEMARIE
President of the Cancer Research Association Villejuif, France

12:20 a m

The Impact on Public Opinion of the AIDS Epidemic

Dr ROBERT K GREY
Chairman, Hill and Knowlton Public Affairs Worldwide Company

3:00 p m

Moderator: Prof ALESSANDRO BERETTA ANGUISSOLA
President of the Italian Superior Council of Health

The Opinion of the Greek Orthodox Church on AIDS

H E. Msgr ATHENAGORAS ZOCOPOULOS
Orthodox Metropolitan of Fokkis Greece

3:20 p m

European Initiatives for Research on AIDS

Professor PAOLO MARIA FASELLA
General Director for Science, Research, and Development of the European Economic Community, Brussels

3:40 p m

The Pastoral Approach of Solidarity

H E Msgr DIONIGI TETTAMANZI
Archbishop of Ancona-Osimo Professor of Moral Theology

4:00 p m

The Pastoral Approach of Hope

H E. Msgr. KARL LEHMANN
Bishop of Mainz West Germany

4:30 p m

AIDS Legislation in Different Countries around the World

Professor HIROSHI NAKAJIMA
Director-General of the World Health Organization (WHO) Geneva

5:00 p m

Unitary Action by States against AIDS

Hon GIULIO ANDREOTTI
President of the Italian Council of Ministers