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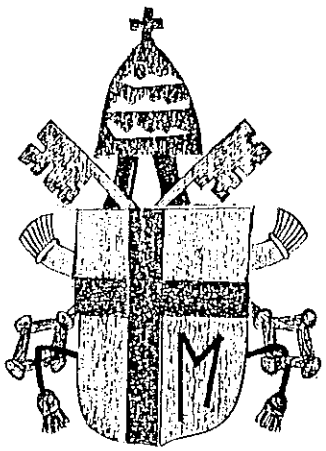

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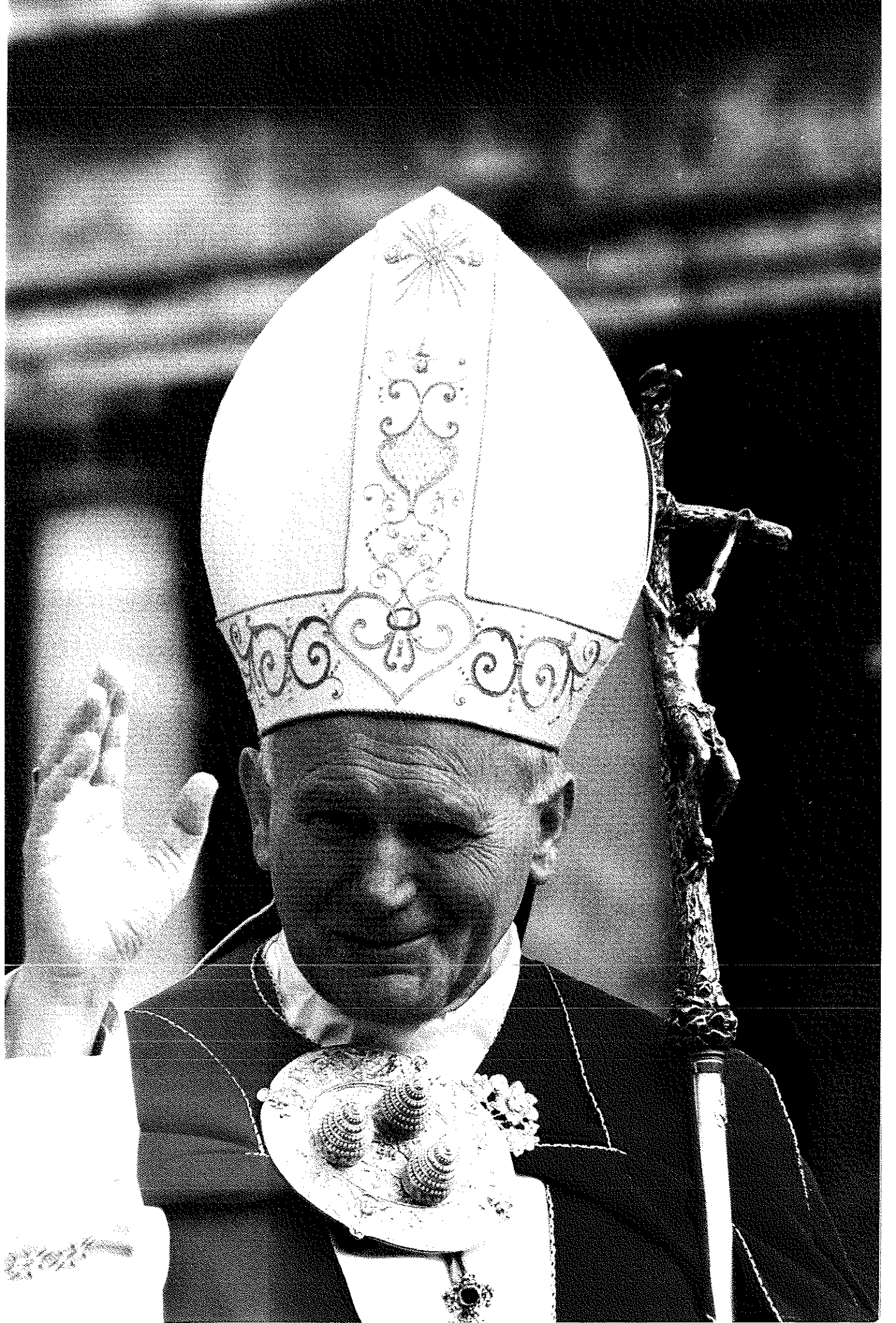


Note on Natural Regulation and Methods of Observing Fertility

PONTIFICIUM CONSILIUM PRO FAMILIA

One of the areas that comes within the ambit of the Church's teaching is the lawful ordering of the transmission of the human life. Its responsible regulation can be achieved through recourse to periodic continence according to the woman's natural cycle. In this teaching, the methods of observing fertility, commonly called methods of natural regulation of fertility, logically occupy a very important place.

Married persons who find themselves in a position of having to use periodic continence in order to postpone the conception of a child must acquire the conviction that the methods of observing fertility have an adequate scientific basis and that they are not difficult to learn. Furthermore, periodic continence for valid reasons — without which, if practised for selfish motives, it would not be a virtue — constitutes a way of living marital chastity and, therefore, is not only practicable but strengthens mutual love, whereas, on the other hand, contraception destroys it.

For this reason, the basic texts of recent Supreme Pontiffs on the lawful and responsible regulation of births (cf. *Humanae Vitae* 16, 24; *Familiaris Consortio*, 31-33, 35) express the hope that medical science will succeed in providing an increasingly certain basis for the methods of observing fertility. Advances made in recent years give ground for this hope, although these methods have not been sufficiently made known.

In order to promote greater appreciation and deeper understanding of the teaching of the Church on the natural regulation of fertility with this Note, this Pontifical Council intends to:

1. encourage medical faculties and bio-medical research institutes etc., professors, researchers and students, to pursue the scientific study of the methods of observing fertility, so as to be able to advise couples to practise the natural regulation of births while respecting the moral values of human sexuality;

2. encourage marriage counsellors to acquire expertise in scientific advances in this field, so as to be able to advise couples to practise the natural regulation of births effectively by using the methods of observing fertility;

3. urge married Christians who are trained and have experienced the validity of these diagnostic methods to reflect on the good they can do for others by spreading the methods through word of mouth and witness;

4. invite organizations and groups which work for the family and for life to offer, in their own appropriate fields, information and education about the methods of observing fertility in the context of their service to human values and human rights.

In this way, the obstacle will be surmounted that comes from the absence of, or serious shortcomings in, formation based on the Church's teaching in a field that vitally concerns the dignity of the human person and the spiritual growth of married people.

28 February 1989

EDOUARD Cardinal GAGNON
President

Most. Rev. JEAN FRANÇOIS ARRIGHI
Vice President

The Sick and the Suffering

IN THE APOSTOLIC EXHORTATION CHRISTIFIDELES LAICI

People are called to joy. Nevertheless, each day they experience many forms of suffering and pain. The Synod Fathers in addressing men and women affected by these various forms of suffering and pain used the following words in their final *Message*: "You who are abandoned and pushed to the edges of our consumer society; you who are sick, people with disabilities, the poor and hungry, migrants and prisoners, refugees, unemployed, abandoned children and old people who feel alone; you who are victims of war and all kinds of violence: the Church reminds you that she shares your suffering. She takes it to the Lord, who in turn associates you with his redeeming Passion. You are brought to life in the light of his resurrection. We need you to teach the whole world what love is. We will do everything we can so that you may find your rightful place in the Church and in society." [1]

In the context of such a limitless world as human suffering, we now turn our attention to all those struck down by sickness in its various forms: sickness is indeed the most frequent and common expression of human suffering.

The Lord addresses his call to each and every one. *Even the sick are sent forth as labourers into the Lord's vineyard*: the weight that wearies the body's members and dissipates the soul's serenity is far from dispensing a person from working in the vineyard. Instead, the sick are called to live their human and Christian vocation and to participate in the growth of the Kingdom of God in a *new and even more valuable manner*. The words of the apostle Paul ought to become their approach to life or, better yet, cast an illumination to permit them to see the meaning of grace in their very situation: "In my flesh I complete what is lacking in Christ's afflictions for the sake of his body, that is, the Church" (*Col* 1:24). Precisely in arriving at this realization, the apostle is raised up in joy: "I rejoice in my sufferings for your sake" (*Col* 1:24). In the same way many of the sick can become bearers of the "joy inspired by the Holy Spirit in much affliction" (*1 Thes* 1:6) and witnesses to Jesus' resurrection. A handicapped person expressed these sentiments in a presentation in the Synod Hall: "It is very important to make clear that Christians who live in situations of illness, pain and old age are called by God not only to unite their suffering to Christ's Passion but also to receive in themselves now, and to transmit to others, the power of renewal and the joy of the risen Christ (cf. *2 Cor* 4:10-11; *1 Pt* 4:13; *Rom* 8:18 ff)." [2]

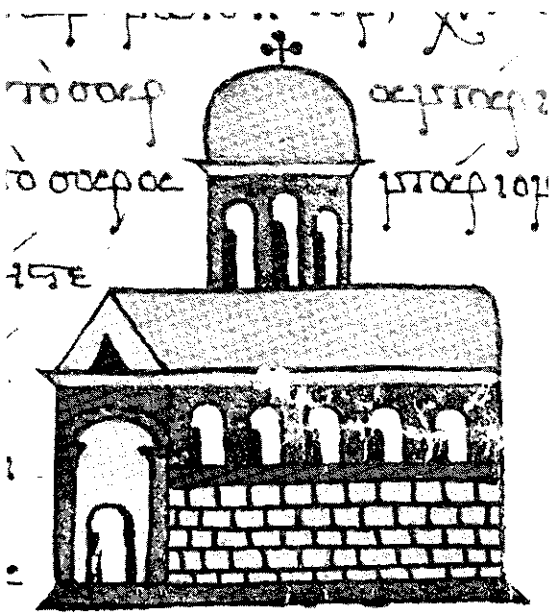
... In the Apostolic Letter *Salvifici Doloris*, [we read,] "Born in the mystery of Redemption in the Cross of Christ, the Church has to try to *meet* man in a special way on the path of suffering. In this meeting man 'becomes the way for the Church,' and this is one of the most important ways." [3] At this moment *the suffering individual is the way of the Church* because that person is, first of all, the way of Christ Himself, who is the Good Samaritan who "does not pass by," but "had compassion on him, went to him ... bound up his wounds ... took care of him" (*Lk* 10:32-34).

From century to century the Christian community in revealing and communicating its healing love and the consolation of Jesus Christ has reenacted the Gospel parable of the Good Samaritan in caring for the vast multitude of persons who are sick and suffering. This came about through the untiring commitment of all those who have taken care of the sick and suffering as a result of science and the medical arts as well as the skilled and generous service of health-care workers. Today there is an increase in the presence of lay women and men in Catholic hospital and healthcare institutions. At times the lay faithful's presence in these institutions is total and exclusive. It is to just such people — doctors, nurses, other healthcare workers, volunteers — that the call becomes the living sign of Jesus Christ and his Church in shoving love towards the sick and suffering. (53)

It is necessary that this most precious heritage, which the Church has received from Jesus Christ, "Physician of the body and the spirit," [4] must never diminish but always come to be more valued and enriched through renewal and deci-

sive initiatives of *pastoral activity for and with the sick and suffering*. This activity must be capable of sustaining and fostering attention, nearness, presence, listening, dialogue, sharing, and real help toward individuals in moments when sickness and suffering sorely test not only faith in life but also faith in God and his love as Father.

One of the basic objectives of this renewed and intensified pastoral action, which must involve all components of the ecclesial community in a coordinated way, is an attitude which looks upon the sick person, the bearer of a handicap, or



the suffering individual, not simply as an *object* of the Church's love and service, but as an *active and responsible participant in the work of evangelization and salvation*. From this perspective the Church has to let the good news resound within a society and culture which, having lost the sense of human suffering, "censors" all talk on such a hard reality of life. The good news is the proclamation that suffering can even have a positive meaning for the individual and for society itself, since each person is called to a form of participation in the salvific suffering of Christ and in the joy of resurrection, as well as, thereby, to become a force for the sanctification and building up of the Church.

The proclamation of this good news gains credibility when it is not simply voiced in words, but passes into a testimony of life, in the case of both all those who lovingly care for the sick, the handicapped and the suffering and the suffering themselves, who are increasingly and responsible for made more conscious of their place and task within and on behalf of the Church.

In order that "the civilization of love" can flourish and produce fruit in this vast world of human pain, I invite all to reread and meditate on the Apostolic Letter, *Salvifici Doloris*, whose concluding lines I am again pleased to propose: "There should come together in spirit beneath the Cross of Calvary all suffering people who believe in Christ, and particularly those who suffer because of their faith in him who is the Crucified and Risen One, so that the offering of their sufferings may hasten the fulfilment of the prayer of the Saviour himself that all may be one. Let there also gather beneath the Cross all people of good will, for on this Cross is the 'Redeemer of Man,' the Man of Sorrows, who has taken upon himself the physical and moral sufferings of the people of all times, so that *in love* they may find the salvific meaning of their sorrow and valid answers to all their questions.

"*Together with Mary*, Mother of Christ, who *stood beneath the Cross*, we pause beside all the crosses of contemporary man and we ask all of you *who suffer* to support us. We ask precisely you who are weak to *become a source of strength* for the Church and humanity. In the terrible battle between the forces of good and evil revealed to our eyes by our modern world, may your suffering in union the Cross of Christ be victorious."[5]

[1] The Seventh Ordinary General Assembly of the Synod of Bishops (1987), *Per Concilii Semitas ad Populum Dei Nuntius*, 12.

[2] *Propositio* 53

[3] John Paul II, Apostolic Letter *Salvifici Doloris*, 3: AAS 76 (1984), 203.

[4] Saint Ignatius of Antioch, *Ad Ephesios*, *VII*, 2: S. *Ch* 10,64

[5] John Paul II, Apostolic Letter *Salvifici Doloris*, 31: AAS 76 (1984), 249-250

The Health Care Ministry in *Christifideles Laici*

John Paul II's lengthy Apostolic Exhortation gathering together, interpreting, and translating into operative directives the conclusions of the Synod of Bishops on the vocation and mission of lay people in the Church and in the world includes the dimension of health, or, if you will, of the health care ministry. The term *dimension* is only apparently general; also some time ago it might have been understood as theologically vague and even improper. It is, however, a term dear to the theology of an anthropological cut of the Holy Father, who, for example, in the Encyclical *Redemptoris Mater*, speaks of the Marian dimension as a life definition inspired by the Virgin.[1] A *dimension* is what connotes something according to its height, breadth, and depth, but also according to time and space. And if we read *Christifideles Laici* from the standpoint of the health care ministry, we discover a kind of attention to the world of suffering, health, and medicine which, in being rooted in the fundamental principle of the defense of life and the integral dignity of the human person, from conception to natural death, assumes the form precisely of a *dimension*, i.e., as a lived experience of the Gospel message in its capacity to be a finished synthesis of all human values as well. The pontifical document, however, though not neglecting to call attention to the fundamental principles of doctrine, seeks to read them in the *now* of human history. It in fact states,

> "In the loving and generous welcoming of every human life, especially if weak and ill, the Church today is living out a fundamental moment of her mission, all the more necessary the more a culture of death has become dominant."[2]

Everything in the field of research, of human achievements, is and must be at the service of life, and life must never be their slave. Progress poses challenges involving bioethics. This is the moment, then, when "Christians must exercise their responsibility as the masters of science and technology, not slaves,"[3] since the "holder" of the right to life "is the human being in every phase of his development ... and in every condition, whether this involves health or illness, perfection or handicap, wealth or indigence."[4]

The health ministry dimension appears more clearly, though, when the papal document recalls that the human condition, whatever its concrete forms may be, is marked by suffering. Indeed, "man is called to joy, but daily experiences very many forms of suffering and pain."[5] The principle particularly dear to John Paul II again presents itself: if man, as a creature of God, is "the way of the Church,"[6] he is such in a "special manner" when struck by suffering.[7] Here, then, is the passage — so logical as to appear obvious — to the health care dimension of the Church's pastoral action: "The Christian community," *Christifideles Laici* recalls, "has retranscribed from age to age in the immense multitude of sick and suffering persons, the Gospel parable of the Good Samaritan, revealing and communicating the healing, consoling love of Jesus Christ."[8] The Church's pastoral presence, at all times and thus today as well, in the health care dimension takes on its complete, integral character, inasmuch as it is in a position to involve the whole People of God and all the laity without exception. In fact, "today, in Catholic hospitals and clinics themselves as well, the presence of the lay faithful, both men and women, is constantly increasing and sometimes becomes total and exclusive: they — doctors, nurses, other health care workers, volunteers — are precisely the ones called to be the living images of Christ and his Church in love towards the sick and suffering."[9]

The Health Care Ministry as a Reflection of the Gospel

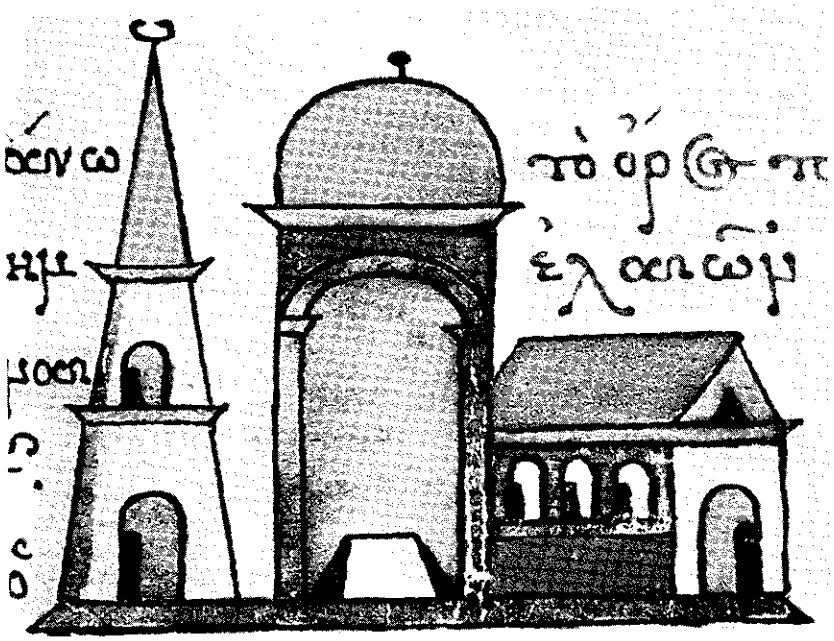
Christifideles Laici confirms that it is necessary for the heritage received from Christ, physician "of the flesh and of the spirit,"[10] not only not to be diminished, but rather to be "increasingly turned to account and enriched through a renewal and decided relaunching of pastoral

action *for and with* the sick and suffering."[11]

Renewal and relaunching are expressly mentioned. Why? There are two reasons; one, of a supernatural order, and the other, human, but not on this account less urgent or intransgressible. The supernatural motive finds "its most significant expression in sacramental celebration with and for the ill, as fortitude in pain and weakness, as hope in despair, as a place of meeting and rejoicing."[12] Indeed, one of the objectives of this renewed, intensified pastoral action, "which cannot fail to involve — and in coordinated fashion — *all the components* of the Church community,"[13] is to regard those who suffer not just as recipients of charitable action, but rather as *active and responsible subjects* of the work of evangelization and salvation. It is a task, then, of the health care ministry to reaffirm within society and the various cultures "that human suffering can also have a positive meaning for man and society itself." Only in this way can the "civilization of love" bear fruit in the vast world of human pain.[14]

The reason — which we might term "human" — for the need and urgency of a renewal and relaunching of the health care ministry is provided by a circumstance that is a characteristic proper to our time. For the first time in its multimillenial history all mankind is aware of the enormous burden of suffering weighing upon a large part of the human race.

We are approaching the fifth centennial of the colonization of the "new world." The chronicles of those far-off years, which were also a significant moment in the work of evengelization, mainly recalled the ignorance, primitiveness, and, on occasion, even the savagery of the "discovered" peoples. The mentality of the "civilizers" seemed largely to consider the new peoples' state of inferiority to be inevitable and taken for granted. Today these people make up two-thirds of the world's population and experience a condition of poverty, hunger, and illness about which no believer or nonbeliever, no human being may claim not to be informed. Every day on our television screens there is a succession of appalling images of the indigence and infirmity afflicting the greater part of our sisters and brothers. The human community and, in the first place, the Church community, must regard passivity in the face of this immense pain as an inexcusable offense. This is why the Church's voice, coinciding with the explosion of the mass media, has been raised ever more frequently and vigorously not only to denounce the condition of pain of such a



vast portion of the human race, but to press for international solidarity, to stress the entirely modern principle — defended and explained with singular clarity by John Paul II in the Encyclical *Sollicitudo Rei Socialis* — of the growing interdependence among all the peoples of the earth. But without peace solidarity cannot grow. Nevertheless, since its origins mankind has experienced division and wars through clashes provoked by the egoism of a few, by the juxtaposition of economic interests, by ideological and even religious discrimination. Without peace there can no affirmation of justice. But how can peace be promoted, if not by moving from men's meeting around what is truly close to the hearts of all, that is, the defense and promotion of life, the struggle against suffering, illness, pain?

10

This is the priority reason which can ensure a real renewal and relaunching of pastoral action in health. It immediately appears clear, however, that human reasons and supernatural motivation are interwoven. And, in fact, *Christifideles Laici* recalls that every form of solidarity, in order to be stable and effective, needs the support of *charity*. "Charity ... animates and sustains industrious solidarity attentive to the totality of the human being's needs."[15] Indeed, paradoxically, such charity becomes more necessary the more institutions become complex in organization and, thinking they can manage all available space, end up being ruined by impersonal functionalism, by exaggerated bureaucracy, by unjust private interests, by easy, organized disengagement."[16] The recent episode of the death of many elderly people provoked or favored at apparently advanced public facilities confirms the need for every form of assistance to be sustained by an interior charitable impulse, to which Christian volunteers provide prophetic witness.[17]

An authentic culture must be a culture of life, but a real, efficacious culture of life requires the support of love, of charity.[18]

It is charity which makes it possible to transform care into a contribution to approaching suffering positively.

In one of his vigorous statements, at a meeting of senior citizens' groups from Italian dioceses, John Paul II asserted that, "according to the divine plan, every single human being is a life in growth, from the first spark of existence to the final breath."[19] This concept, taken up again in *Christifideles Laici*,[20] recalls the duty never to delimit the human condition with parameters of sheer utilitarianism, even if masked under the appearance of a social aim. If, in fact, charity itself were to be exhausted in serving the suffering in forms of assistance dictated exclusively by *compassion* or nourished only by an ascetic purpose looking to the spiritual perfection of those exercising them, the boundless world of suffering would remain entrusted to the discretionary generosity of a few. Awareness of the constructive and redemptive value of suffering must, however, grow — a value whose recovery is a condition for the progress of civilization, a premise for building a culture and a world of peace. No legislation, not even the most advanced, can ensure this road for mankind; to travel it, there is need for the support of a higher faith, of a charity finding its nourishment in grace.

The renewal and relaunching of the care health ministry is perhaps the modern name for evangelization: a modern name for a perennial truth, since the Lord has announced in advance — with extraordinary clarity and in words accessible to all — that we shall be judged precisely on the way we have dealt with those suffering.[21]

The health dimension of pastoral care belongs as a qualification to pastoral care as a whole, to the point that, if it remains true that the health care ministry does not exhaust the sphere of pastoral care in general, the latter cannot dispense with the health dimension in order to be such. This dimension, defined as the culture of and service to life, derives from the very heart of the mission of Chist, who came to give his life and bestow it in abundance.[22]

✠ FIORENZO ANGELINI
President

[1] *Redemptoris Mater*, 45
[2] *Christifideles Laici*, 38.
[3] *Message of the Synod Fathers* (1987), propositio 36
[4] *Christifideles Laici*, 38.
[5] *Ibid*., 53.
[6] *Redemptor Hominis*, 14.
[7] *Salvifici Doloris*, 3
[8] *Christifideles Laici*, 53.
[9] *Ibid*., 53
[10] *Ibid*., 54.
[11] *Ibid*., 54.
[12] *Ibid*., 54
[13] *Ibid*., 54.
[14] *Ibid*., 41.
[15] *Ibid*., 41.
[16] *Ibid*., 41
[17] *Ibid*., 44.
[18] *Ibid*., 44.
[19] John Paul II, *Teachings*, VII, 1 (1984), p. 744.
[20] *Christifideles Laici*, 54.
[21] Mt 25:31-46
[22] Jn 10:10.

In the Service of Humanity: Humanizing Health Care

The first hospital in this city, founded by pilgrims returning from the Holy Land, was established over eight hundred years ago. The Hospital of Saint John in Thomas Street bore little resemblance to a modern health care institution. Its concerns were rather different. In many cases, curing the patient was hardly on the agenda at all. It was a case of caring for those who were beyond curing — what we today would call a hospice.

It is one of the great achievements of our time that health care can so often do more than care; it can restore health. The skills and the diagnostic tools, the new treatments and the high technology equipment mean that conditions which even a generation ago would have given little ground for hope can now be routinely treated and cured.

It would be a tragedy if the marvellous benefits which have been brought by new knowledge and skill were to obscure and impede the personal relationship of caring. When one reflects on the real meaning of health care, it is not to be found in complex equipment and in vast resources; it is to be found in the comforting presence of a professional who is not first of all a scientist or a technician but a *carer*. Health care nowadays, more often than in the past, is about restoration to health. That is very good — provided that it continues to be first, last and always about *care*.

Illness and suffering raise the deepest questions about human life and human destiny. There is, perhaps, no setting in which these fundamental question are so consistently and inescapably present as in health care. Here human beings meet one another "in depth" — the vulnerability of one calling forth the personal care of the other. In many ways it is the nurse above all who bears the responsibility, who has the vocation, of making that personal response. It is the nurse, in the day to day life of a health care institution, who allows the patient to know that he or she is not seen as a mere case, a collection of symptoms, an object of treatment. The patient is a person who has placed him — or herself vulnerable, anxious, trusting, into the hands of those whose vocation is to care.

Ailred the Palmer and his wife, who established Saint John's Hospital eight hundred years ago would be astonished if they could see the possibilities for curing disease which are now available. One fears they might also be a little unhappy when they compared the efficient but impersonal atmosphere of a modern hospital with the crude but, I would imagine, homely atmosphere of their foundation.

The personal dimension of health care is something which has, I know, been of

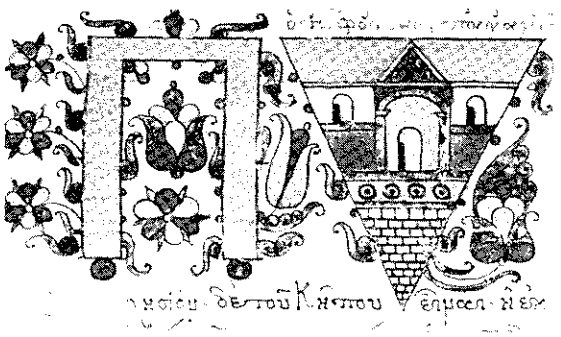
great concern to the nursing profession in recent years. The increasing specialization and the growth in technology, on the one hand, and the very great pressure introduced by the demand for financial stringency, on the other, have worked against the provision of genuinely personal care.

The concept of market forces seems to be all-pervasive in our society. It is, for many reasons, quite inappropriate in the field of health care. The picture of a patient seeking personal care in his or her illness cannot be properly transformed into the image of the consumer, assessing the quality of a product and seeking to get the best value from among competing suppliers. The two images are at work, but we simply have to say that the second

is a betrayal of the traditions of the health care professions.

A similar sort of tension exists with regard to the notion of health which underlies much of our thinking. On the one hand, we have the broad definition of health as proposed by the World Health Organization in 1958, which sees health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." On the other hand, we have the idea of health which underlies the drive for efficiency and the quickest possible turnover of hospital beds. Where does "complete social well-being" fit in there?

What I wish to suggest in this paper is that all of this is part of a much bigger problem which we have to face. It has



ramifications in the quality of health care, in the equity with which health care is available and in the area of bio-ethics. The problem can, I think, be summed up in the idea of *the humanization (or re-humanization) of health care*.

The personal quality of health care

This is the most obvious area in which the tension between impersonal efficiency and the service of the person makes itself felt.

There has been, in recent years a welcome growth in the recognition of the value of pastoral care and the importance of having competent and qualified pastoral care teams. At the same time, however, there has been a diminishment in the possibilities for every member of the health care team to make this an integral element of his or her work. The first phenomenon is greatly to be welcomed; the second is most regrettable. The provision of a pastoral team is not intended to be, and cannot be, a substitute for this central dimension of the work of every member of the team. There can be no genuine health care without *care*! And it is not just care for health, considered as the absence of disease; it is care for the person.

In his Apostolic Letter on Suffering (*Salvifici Doloris* 1984) Pope John Paul compares nurses and doctors to the Good Samaritan. The Good Samaritan is anybody who stops beside the suffering of another in a spirit of availability:

> "It is like the opening of a certain interior disposition of the heart, which has an emotional expression of its own. The name 'Good Samaritan' fits every individual who is sensitive to the suffering of others, who is 'moved' by the misfortune of another ... Nevertheless, the Good Samaritan of Christ's parable does not stop at sympathy and compassion alone. They become for him an incentive to actions aimed at bringing help to the injured man" (*Salvifici Doloris* 28).

The dilemma that faces us today is that the provision of the most effective help, with all the expense and technology which that involves, seems to make that personal sympathy and compassion more difficult to express. This is especially true since the meeting of minds and hearts requires a particular depth and an enormous availablity if it is really to touch the patient in his or her time of anxiety and suffering.

As the Pope put it:

> "Illness and suffering are phenomena which, if examined in depth, always pose questions which go beyond medicine itself to touch the essence of the human condition in this world" (*Dolentium Hominum* 3).

The root of the problem, it seems to me, is that the more complex the procedures which a patient undergoes, the more easy it is to see him or her as an object which is being treated. If Ailred the Palmer was ever able to do anything in the way of curing people in his hospital, it was, I presume, largely a matter of wrapping them up warmly, giving them good food and lots of sleep and allowing their bodies to heal themselves. Indeed, that may still be the case more often that we might like to admit!

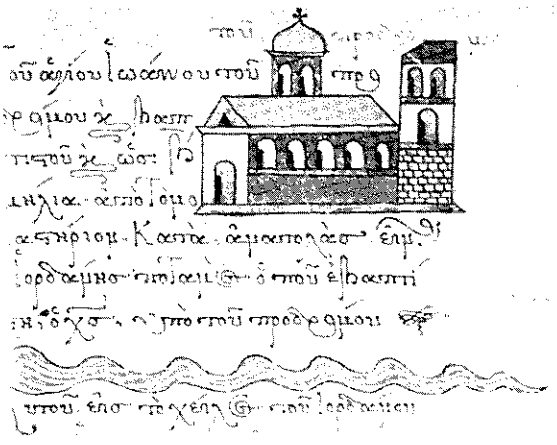
Because we find it harder to see the patient as an active participant in the process of healing, we find it easier to see

him or her as a passive cog which can move only when the machine makes it turn.

Health care is, rather, a partnership in which there is a giving of oneself to the patient who has entrusted him or herself to the carer. A Good Samaritan is a person who is capable of a gift of self (cf. *Salvifici Doloris* 28).

Pierluigi Marchesi, the Prior General of the St. John of God Brothers, asks: "Why do we not experience the therapeutic and health care relationship as the gift of ourselves?" He replies that we need to humanize the hospital, and this means:

> "that all health care professionals must seek continual improvement, a kind of leap, beyond the arrogance of power and so-called scientific knowledge, to plunge into a process of identification with the suffering individual, a process which enables us to comprehend before acting and gives rise to hope, trust and a therapeutic partnership"
> (Address to the International Conference on the Humanization of Medicine, November 1987, published in the review *Dolentium Hominum*, no. 7).



There is an instructive parallel in the sphere of industrial relations. In the early days of industrialization, the worker was seen as a machine. Efficiency dictated increasing specialization to get the most out of this machine. You got assembly lines in which the worker performed simple and repetitive mechanical operations. This would correspond to the notion of the patient as a cog whose role it was to fit as inconspicuously as possible into the smooth running of the hospital. This seemed very logical and efficient, but only because it forgot what people are like. A person who is bored and constricted does not in fact perform very efficiently.

The second stage was for the management to become more involved with the workers, showing an interest in their families, giving them increased responsibility. This was a step forward, but it was still being done for the sake of productivity rather than for the sake of the people who were workers. This would correspond to an attempt to give more personal attention to patients because it will produce more effective results for the hospital.

The third step is participation. Pope John XXIII said that he was:

> "in no two minds as to the need for giving workers an active share in the business of the company for which they work..... Every effort must be made to ensure that the company is a true community of persons"
> (*Mater et Magistra* 91 CTS)

This would be no more than a recognition of the truth. We may call it the placebo effect or spontaneous remission or any other name we like. The fact is that the patient is an active partner in the process of healing.

As Pierluigi Marchesi puts it:

> "... No physician has the power to heal another person. The bodily, instinctual, psychological and spiritual ego of the patient is an active part of the reconstruction of the lost well being"
> ("The Medical World in Suspense" in the review *Dolentium Hominum*, no. 1)

This is the kind of "leap" to which he refers, to see the health care team as helping the patient to bring about healing rather than seeing the patient as merely a passive recipient of professional ministrations.

Equity in health provision

The most obvious instance of the tension between the personal caring and the impersonal market forces is in the area of equity. There has been a great deal of discussion in recent years about the dangers of a two-tiered health system.

Obviously there can be no moral objection to the idea that people who can pay should pay. The question as to whether all health care should be free — or, more accurately, paid for through taxes — is an ideological one. Clearly, those who can

afford more should subsidize the others and those who cannot afford health care should not be denied it. There can be many views as to the best way to fund health care.

Nor can there be any serious objection to the idea that the people should be free to pay, either directly or through insurance, for luxury accomodation with various frills like an individual television set, a private room and a more sophisticated type of cuisine.

Very serious moral problems arise, however, when what is involved is the possibility of buying *better health care.* It is one of the glories of the medical and nursing professions that they are committed to refusing "to allow considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient" (*Declaration of Geneva*), and that care "is unrestricted by considerations of nationality, race, creed, colour, age, sex, politics or social status" (*International Ethical Code for Nurses* 1973).

It is said, and I am certain that it is true, that public patients receive the highest standards of medical care. It is said that in the case of emergency, or "non-elective" procedures, there is no delay in treating a public patient. But this is not enough. With regard to so-called elective procedures, of which hip replacement always seems to be the example, there is, at least in the public perception, an entirely unacceptable level of discrepancy in terms of the time people have to wait.

The distinction of elective and non-elective, especially when the former can include extremely painful and disabling conditions, is not to be found in the Declaration of Geneva or in any of the great statements of Medical Ethics. These proclaim very clearly that the criterion for access to medical services is to be need.

There can surely be no doubt that in such cases, delayed care is by its very definition inferior care.

In 1975, a working party of the Irish Medical Association went further. It reported that public patients:

> "are less likely to have an operation performed by a consultant surgeon. They are more likely to receive their day to day attention from resident staff. Patients attending outpatients' departments are treated less well, first because of long waiting and poor physical conditions and secondly because they are often seen by residents who, in our opinion, may not be competent to deal with their problems"
> (Quoted in *Submission to Commission on Health Funding*, Council for Social Welfare 1987).

As the Council for Social Welfare put it,

> "Certainly public perception increasingly is that if people wish to have the best quality, as and when required, they have no option but to seek this in the private sector"
> (loc. cit.).

The question at issue here is not that more and more money must be poured into health care. There are obviously always more things that could conceivably be done than can actually be delivered. There are obviously questions about the need to minimize waste, to discuss the relative claims of treatment, on the one hand, and education and prevention, on the other. When all of that has been said, the challenge remains as to whether care is related primarily to need or to some other factor, whether scarce resources are disproportionately available to those with the money to pay for them.

In fact, if anything, it should be the other way around. Scarce resources should flow disproportionately towards the most vulnerable and to the poorest. In the Pastoral Letter *The Work of Justice*, the Irish Bishops said,

> "If we are to assure basic human rights to everyone, it will not be enough to cease discriminating against the poor. It will be necessary to begin quite deliberately to discriminate in favor of the poor"
> (*The Work of Justice*, 1977, par. 109).

This is necessary for two reasons. In the first place, poor people lack clout; they will not be able to acquire health care and services for themselves as effectively as others. To put it at its lowest, people of a high social standing would not tolerate in silence the kind of waiting for treatment which is endured by those who are without economic resources and influential friends.

In fact, of course, what happens is that, to a considerable extent, the poor subsidize the rich. Even apart from the apparent subsidizing of the VHI Plans D and E by the others, VHI member, in 1986 received £ 97.3 million pounds for a net investment of £ 68.3 million. The difference is largely accounted for by a tax relief which disproportionately benefits the rich.

The other reason why the poor should receive positive discrimination is that they are disadvantaged in the area of health. Research in this area is notoriously difficult. One can find correlations between, for instance, unemployment and illness; it is not so easy to determine how much unemployment is a result of illness rather than the other way around. In any case, unemployment hits social classes which are already more liable to ill health. What does seem clear is that poverty, which is one of the prime results of unemployment, does adversely affect the health of all of the members of the family, particularly the younger members (Cf. Breen, R., "The Costs of Unemployment" in *Unemployment, The Need for Change*, ed. Kerins, A., Dublin College of Catering 1988).

As the so-called Prayer of Maimonides puts it, "O Lord, help me to see in the patient only suffering humanity."

Equity in the social distribution of medical care is demanded by the idea of health care in the service of humanity. As Pope John Paul expressed it,

> " .... the need for humanization is translated into the direct effort of all health-care workers, each in his or her own sphere of competence, to promote suitable conditions for health, to improve inadequate structures, to eliminate the causes of so many illnesses, to foster the just distribution of health-care resources, to see to it that health-care programs throughout the world have only the good of the human person as their aim.....

Equity is not a question of the overall expenditure on health. This is an area where the rising tide certainly does not raise all ships. The amount spent per capita on health care by the American government is greater than that in the United Kingdom. The OECD would put the figure at about 674 dollars in the US and 640 dollars in the UK. The overall health expenditure is almost three times as high in the States, but this does not result in "freeing" services for the poor, who, it would be generally accepted, are less well catered for in the States than in Britain (The Jesuit Centre for Faith and Justice, the "Nation's Health," in *Doctrine and Life*, February 1989).

These facts have their own importance as symptoms. The real issue is whether health care is operating in the service of humanity. That is what is at stake in the great ethical codes — is the service of the person the first and, indeed, the only aim?

> To humanize medicine is to accept this challenge and to work generously for the construction of a world in which every human being is guaranteed the means necessary for the full appreciation and use of the fundamental gift of life, which has its origin and its ultimate end in God, who loves the living"
> (Address to the International Conference on the Humanization of Medicine, November 1987, published in the review *Dolentium Hominum* no. 7).

The ethics of health care

Side by side with all of these questions and at first glance quite unrelated are the many controversies that rage nowadays in the field of bio-ethics. We are surrounded by debates about abortion and steriliz-

ation and euthanasia and genetic engineering.

The first thing that one notices about these debates is that they so rarely seem to lead to agreement. If one looks a little more closely, one can see why this is so. The participants are not speaking the same language, nor are they using the same criteria.

There is, for instance, the "How would you feel ...?" kind of argument: This woman has ten children already, her housing situation is awful, her income is meagre, her husband drinks. ... If you were in her shoes, how would you feel about a sterilization?

Then there is the "Look at all the suffering that can be avoided" argument. This is rather similar, but tries to be more objective, not looking to feeling but to

measurable consequence. This infant cannot look forward to any decent quality of life; how can the parents even think of coping when he grows to full strength! Better to let him die.

Ranged on the other side is the person for whom the rules are clear. We might call this the "There is no point in discussing it" kind of argument: There is no point in discussing it; that is how it has always been done in this hospital; or There is no point in discussing it; you cannot question the consultant's decision; or even There is no point in discussing it; since the Bible says, "Thou shalt not kill," it could never be right to switch off a ventilator.

One could go through these various approaches and give them their proper names in moral philosophy. The "How would you feel...?" argument is Emotivist; the "Look at how much suffering could be avoided" argument is Utilitarian; the "No use in talking about it" argument is Legalist, and, because it appeals to a sense of duty which is beyond discussion or explanation, might be called Kantian.

These various approaches are "in the air" of contemporary culture. It is important to recognize them and to realize that they are not capable of effective dialogue with one another. One has only to hear an Emotivist argument meeting a Legalist argument over a decision to discontinue treatment to know that, however long the discussion, there will be no meeting of minds. There are different and irreconcilable perspectives at work. Unless that is recognized, a great deal of heat and aggression will build up, but nothing will be achieved.

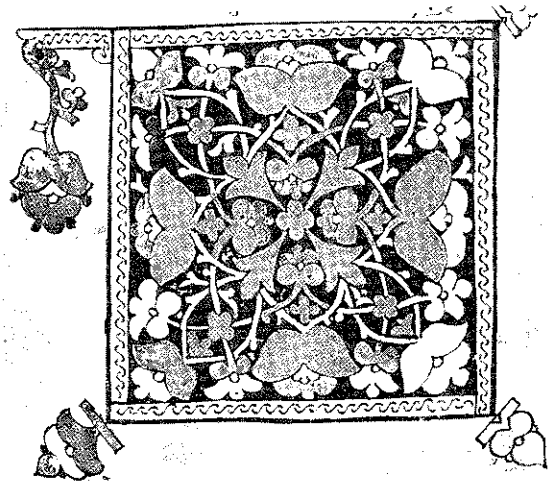
What I want to suggest is that we are here face to face with the same issue that we have been discussing — that of health care in the service of humanity. The quality of care and the equity of its distribution can only be adequately considered if one begins from the dignity of the human person who is served by health care.

The moral disputes which are so widespread today also require that we start from the same point. The dignity of the human person is the starting point from which we can begin our moral reflections. When one loses sight of that starting point, moral reflection loses direction. At the same time, and for the same reason, the quality of care and the just distribution of health care resources begin to suffer.

The dignity of the human person is a starting point which is in harmony with the great codes of health care ethics. The

Declaration of Geneva speaks of the doctor as being at the "service of humanity". This, of course, means being at the service of suffering humanity, *seen in the patient*; it is a matter of being at the service of *persons*, not just at the service of some abstract ideal. The International Ethical Code for Nurses (1973) says that "The nurse's primary responsibility is to those people who require nursing care."

A real discussion of moral issues can only begin from a vision of what the human person is and can become and, thus, from an understanding of the purpose of human choice and action. Human life and activity and personhood are sold short by all of the ethical approaches we have looked at in just the same way as they are sold short by impersonal treatment and inequitable systems.



The purpose of human life and activity is not to feel good, nor is it to maximize the pleasant and minimize the painful. The purpose of human life is not to conform to unintelligible laws and rules. The purpose of human life and activity is to be true to oneself, to others, to the world and to God, in order to move towards the destiny that God offers. Morality, for the Christian, arises out of what Pope John Paul calls "that deep amazement at human worth and dignity which is called the Gospel" (*Redemptor Hominis* 10).

That starting point enables us to see what is of value in the other approaches to morality; it also enables us to see how they sell the dignity of the human person short.

a) Utilitiarianism is not enough. You cannot judge a person's actions simply by looking at the results the actions produce. We are not machines to be measured by our productivity. We act in an interpersonal context: other people's actions, reactions, interpretations and unpredictable behaviour can completely alter the consequences that we had expected and intended.

More importantly, human actions are not just mechanisms, they are a *language*. Quite apart from what they *do*, we have to ask what they *mean*, what they *say* to the other people involved, what they *say* about ourselves and our attitudes.

This is partly, but by no means entirely, connected with the person's intention. Actions can have a human meaning that persists even if the person seeks to deny it. The act of sexual union, for instance, means personal sharing, intimacy and commitment. Even if one or both parties protest that this is not what they intend, a falsehood remains: "The body is saying one thing, while the mind is meaning another" (Irish Bishops, *Love is for Life*, 10).

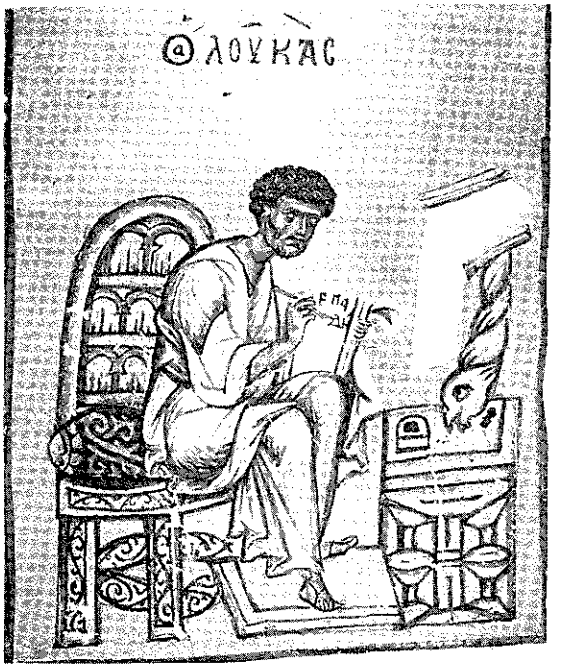
Without that dimension of action as language, some moral discussions will seem unintelligible. What could it matter, for instance, *how* an infertile couple conceive or *how* the life of a hopelessly handicapped newborn baby comes to an end? The couple is just as happy and the infant is just as dead. But if the action has *said* that a medical technique is a fitting context for the mystery of procreation or if it has *said* that this little life is not supremely precious, then the action has *said* a falsehood.

The whole ethos of modern health care may well tend to point us in a Utilitarian direction. The stress is on results and measurable effects rather than on an interpersonal dialogue and partnership. This is the stress which raises so many concerns among health care workers about the quality of care. It is the same stress which makes it difficult to get a hearing for such moral issues as I have been indicating. The fact that there is a deeply human truth involved in the idea that a child is to be the fruit of the loving union of man and wife can be lost sight of by all concerned. Medical research and development sets off along paths which have been chosen with no reference to that kind of human reality. The fact that a childless couple are so focused on the desire to have a child is not an excuse for the carers' failing to ensure that this can be done in the most human and personal way possible.

It is significant that the struggle to rehumanize health care is so close to the struggle to reestablish a morality based on

personal dignity. It is, I believe, the same struggle, which requires the overthrowing of the tyranny of results in favour of a more human relationship and partnership.

b) Emotivism is not enough. It is not the purpose of human choice and action to make oneself and others feel good and avoid pain. It is the purpose of human choice and action to make the world and oneself more fully human — more just, more honest, more loving or, as our religious tradition would put it, more Christlike. This may often involve doing things which are by no means pleasant. It would often be much easier all round to pretend to a patient that he or she will get



better. To sit and listen, to hold the hand and to share the anger and the pain of someone who is dying, to break the news of a pessimistic prognosis to a patient and to a patient's family is not easy. Silence is the more pleasant option, perhaps even for the patient — that does not make it the right option.

The point is that the choices we make and the actions we perform do something to us. They affect us not just on the level of emotion and instinct but on the level of our humanity. Our actions shape us and mould us, for good or for evil: by behaving justly, I become a just person; by behaving selfishly I become a selfish person.

As the Second Vatican Council expressed it,

> "When a person acts, he or she not only transforms matter and society, but fulfils him or herself..... Rightly understood, this kind of growth is more precious than any kind of wealth that can be amassed. It is what a person is rather than what a person possesses that counts"
> (*Gaudium et Spes* 35).

Feeling can make us more sensitive to other people; they can help us to act with enthusiasm; they can sometimes force us to reconsider our position when we say, "That cannot be right! It feels all wrong!" But morality does not, in the end, depend on how one feels; it depends on what it means to be human, what are the qualities that make life more human, that are the demands made on me by other persons if I am to respect their humanity. That is why doing the right thing is not the same as doing the least painful thing.

Once again, the challenge to bio-ethics and the challenge to modern health care are one and the same. One of the dangers in health care today lies in a failure to consider the whole person. It is not enough to think in terms of symptoms and tests and procedures. In the same way, it is not enough to think in terms of pleasure or absence of pain. In both intances, what is required is an understanding of the whole person in all of his or her richness and potential. What is at stake is to be at service of growth in "what the person is."

c) Legalism is not enough. If morality is seen as being simply about the rules,

that is, about a formula of words, then one is gravely at a loss when brought face to face with a situation which the rules were never designed to meet. This can happen in two ways.

First of all, words which seemed perfectly clear in their meaning can become problematic. "Thou shalt not kill" seems eminently clear until someone begins to raise questions about the definition of death. The rule remains perfectly correct, but if someone claims that a particular person is already dead and someone else denies it, the rule will not solve their dilemma. Nor will the rule solve the difficulty for people who argue whether the discontinuation of treatment in certain circumstances should be seen as killing.

Moral rules are necessary — otherwise moral concern would evaporate into a vague good will. On the other hand, moral rules are not enough. The Legalist allows morality to become "an algebra" of rules. Because the rules are not understood, they are incapable of being intelligently explained or intelligently applied. The real disservice that the Legalist does to morality is to suggest that it is not capable of rational explanation.

A morality which stops short at the rules does not focus on persons and thus misses the point. Moral rules grow out of personal relationships — to express them, to enable them to grow, to protect them. Morality is about our relationship to one another — and to God. "In Christian morality," the Irish Bishops said some years ago, "the prohibition, 'Thou shalt not', is always a consequence of the positive command, 'Thou shalt love'" (*Human Life is Sacred* par. 80).

Here again, the moral challenge mirrors the health care challenge. Moral rules are like efficient structures and proven procedures. If they grow out of and serve an attitude of care for people, then they are good and necessary. If they become ends in themselves, they lose their soul.

The second thing that can make the algebra of the legalists' rules unable to meet a new situation is if the whole situation changes: the words that are used have substantially changed their meaning.

This has happened with regard to the word "health." The WHO definition of health as "a state of complete physical,

mental and social well-being and not merely the absence of disease or infirmity" is a welcome advance. It is a clear statement that what is at stake is the whole person. Not just a list of symptoms to be diagnosed and treated.

But this carries with it the need for profound changes in health care ethics. It changes the way in which health care professionals must view their own role and the way in which they must relate to other areas of expertise.

Using the broader definition means that medical and health care professionals may no longer regard themselves in any full or exclusive sense as "the experts on health." "Social well-being" and such factors are part of what the health care team has to deal with, but these are things about which the doctor, and indeed the nurse, are in many respects amateurs.

The ethical issues which face health care workers today are, therefore, broader and, one might say, more humbling than in the past. The care of the whole person involves family relationships, economic factors, living conditions and the political priorites of society. The care of the whole person involves having time to listen and to be with the patient. The care of the whole person involves a philosophy, indeed theology, which appreciates the dignity and worth of the individual.

If the doctor sees "complete physical, mental and social well-being" as his or her exclusive field, then the idea that social workers, marriage counsellors, housing authorities and chaplains might have a professional imput to make will seem as unlikely as that they would be able to propose an alternative way of dealing with a cardiac arrest.

That is one very important reason why the introduction of an Ethics Committee in a modern hospital is by no means an intrusion on the competence of the doctor. It is, rather, a recognition that medicine has, for excellent reasons, felt it necessary to take account of areas which are not within its own field of expertise. It follows that people of experience and knowledge in these areas have a contribution to make in arriving at wise decisions.

The broad definition of health and morality that is based on the dignity of the person are allies. They are part of an approach that sees health care as being in the service of humanity, in the service of the human person. This is particularly important at a time when the drive for efficiency and for a fast turnover of beds, for increasing specialization and ever more sophisticated technology are all tending to push health care in the direction of a narrower definition of health and a more limited view of the patient.

There are many factors that push us in the direction of impersonality. It nevertheless remains true, in the words of Brother Pierluigi Marchesi:

> "The barrier to humanization is not outside of us; it is not in the sciences and their deficiencies, but inside of us. It is a barrier maintained by our mental indolence, by a pronounced cultural limit, and by a lack of maturity of and in our personhood.....
> Beyond all expressions of faith or political conviction, the hospital can become the laboratory generating the spiritual community of people dedicated to actively building human solidarity within and beyond illness. (We will do so) in the certainty that our way of providing care and practicing medicine will enable us, in the person who suffers, to preserve what is human and to evoke the divine."
> ("To Effect Change ..." in the review *Dolentium Hominum*, no. 7).

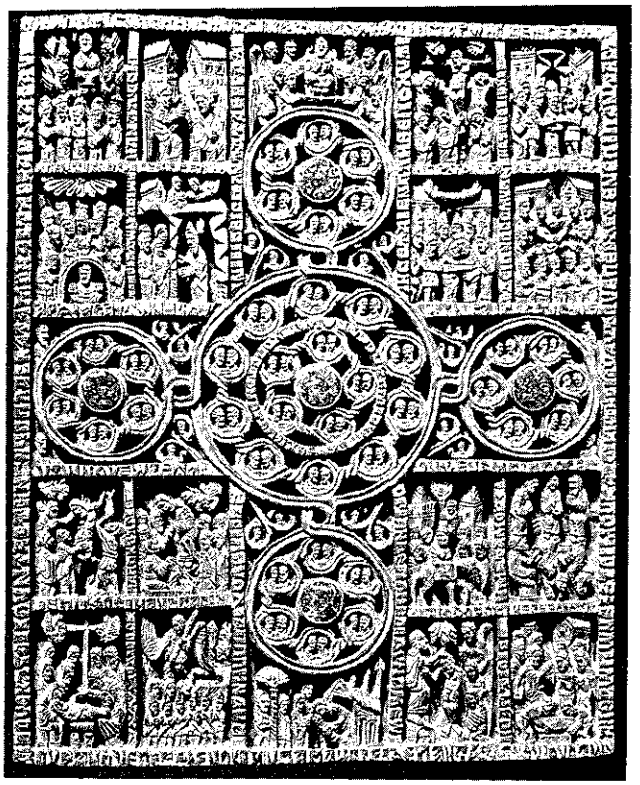
Ailred the Palmer and his wife would not have understood the language; but they would have recognized in the idea of so treating the sufferer as "to preserve what is human and evoke the divine" the ideal which motivated themselves.

It is the ideal that inspires the long tradition of Christian health care. That ideal was expressed, in this century, by Saint Giuseppe Moscati, an Italian physician, who stated it like this:

> "Blessed are we doctors, so often unable to heal an illness, blessed are we if we remember that besides bodies we have before us immortal souls, for whom we must feel the urgency of the Gospel precept of loving them as ourselves."
>
> "It is not science," he said, "but love which transforms the world."

✠ DONAL MURRAY
Auxiliary Bishop of Dublin

Magisterium of the Church



Excerpts from
the Holy Father's Addresses

Letter from Cardinal Casaroli

Urgent: A "New Evangelization" Which Proclaims the Right to Life

(To participants in the Congress on Life, sponsored by the Italian Bishops' Conference, held in Paul VI Hall, on April 16, 1989)

Jesus shared human suffering. By accepting life, he made its conditions his own: he knew the fatigue of work, the humiliation of exile; he experienced hunger, thirst, fear, weeping and, above all, pain. "And being in agony he prayed more earnestly; and his sweat became like great drops of blood falling down upon the ground," the Evangelist Luke notes (22:24).

Precisely because he knew human suffering, both physical and moral, through an absolutely unique personal experience, he had immense pity for human pain. His compassion, as he performed miracles to heal bodies, restored souls to spiritual health and revealed God's merciful love. He is the Good Samaritan spoken of in the Gospel parable. "But a Samaritan traveller who came upon him was moved with compassion when he saw him. He went up and bandaged his wounds, pouring oil and wine on them ... and looked after him" (Lk 10:33-34).

Jesus also shared human death. In absolute freedom he faced death and experienced the drama of feeling far away from God, a drama that moved him in the depths of his soul and made him cry out: "My God, my God, why have you abandoned me?" (Mt 27:46), but is calmed in filial abandonment into the hands of the Father.

His dying is a gift of total and perennial love which, in a mysterious but real way, continues in the Eucharist through the sacrifice of his "body given up" and his "blood poured out" "for the life of the world" (Jn 6:51).

Therefore, by virtue of his death and resurrection, every death becomes a "pasch," a passage from mortal to immortal life.

In this light every human life, even the most disregarded, marginalized and rejected, has infinite value because it is the expression of God's immense love. Therefore, the life of the unborn, of children, the sick and suffering, the elderly, the dying, as well as that of young and healthy persons, is equally sacred and absolutely inviolable, from the moment of conception until its natural end.

The Church, from her very origins in a social context of disdain and rejection of human life expressed in terms of abortion and infanticide, of slavery and inhuman working conditions, decisively introduced a new mentality and a new order with regard to life.

In the Didaché, an ancient Christian writing, it is clearly stated: "You shall not kill the fruit of the womb through abortion and you shall not harm the child already born" (Didaché V, 2).

Athenagoras recalls in his Apologia for Christians that Christians regard as murderers women who take medicines to abort. He condemns the assassins of children, even of those still living in their mother's womb, "where they are already," he writes, "the object of the care of Divine Providence" (no. 35).

A comparison spontaneously arises between the early period of the Church and the present time. Undoubtedly humanity today shows a love and concern for human life that is notably wide in scope and meaning. The general increase of the sense of the dignity of the person and the value of human life is comforting. Noteworthy also is the social sensitivity that is manifested in numerous and specialized services on behalf of disabled, elderly, poor and abandoned persons.

At the same time, however, no one can deny that there are still many forms of contempt and maltreatment and rejection of life. It is not only a question of personal selfishness, but also of a social conscience which, by not believing in the inviolable value of life, claims to be its absolute master and unquestionable arbiter. Frequently civil law itself is the first to violate or, at any rate, not to protect adequately the inviolable right to life. Nor has the growth of what has been called the "culture of death" been arrested. All of this requires an urgent and prompt "new evangelization" that provides ample space for the proclamation of the right to life.

The Health World Demands Global Commitment by All Sectors Devoted to Care

(To participants in the General Chapter of the Camillians, Saturday, May 20, 1989, Audience in the Consistory Hall)

According to a criterion which is becoming customary, your general chapter, having fulfilled its constitutional tasks, decided to make a special study of the theme: "Towards the Poor and the Third World." The Order prepared for the chapter reflection by seeking the contribution of all the members of the various provinces throughout the world. These have voiced the expectations of justice and love coming from the poor and from those countries which experience the painful consequences of poverty.

You have always been sensitive to this serious problem, which I have amply treated in the Encyclical Sollicitudo Rei Socialis. *Therefore, in a spirit of strict fidelity to the Founder, your revised Constitutions state: "In its ministry, our Order shows a preference for the poorest and most forsaken of the sick, and is solicitous in responding to their needs in developing nations and mission lands" (art. 51).*

*The Second Vatican Council recalls that "The appropriate renewal of religious life involves ... a continuous return to the sources of all Christian life and to the original inspiration behind a given community, and an adjustment of the community to the changed conditions of the times" (*Perfectae Caritatis, *2).*

The charism of every religious institute approved by the Church has lasting relevance, notwithstanding the changed conditions of the times to which religious life has to adjust while fully safeguarding its original inspiration. The more the dimensions of suffering acquire new aspects today, the more necessary and urgent it is that your response be generous, consistent and unified, after the example of St Camillus de Lellis. Your Founder was close to the poor and the sick in order to ease their state of mind and free them from spiritual and material anguish.

*If man is "the way for the Church" (*Redemptor Hominis, *14), "in a special fashion [he] becomes the way for the Church when suffering enters his life" (*Salvifici Doloris, *3). From the beginning your main apostolate has been in the field of health care. Poverty finds its fullest and most painful expression in physical and mental suffering, since it affects the very foundations of human life and dignity. However, your service to others will be truly evangelic and in conformity with the Camillian charism, if in the service of the poor you give witness to a life of poverty, a credible example of sharing and participation, in accordance with the spiritual testament of St Camillus on his deathbed.*

Your Constitutions reaffirm that "The Order is keenly sensitive to the pastoral care of ecclesiastical and civil institutions involved in the care of the sick and the poor and is dedicated to animating the greatest possible number of lay people in loving and serving the sick" (art. 54).

*Today this requires more and more coordination, designed first of all "to promote and spread an ever better ethical religious formation of Christian health care workers in the world, keeping in mind the different situations and problems which they must face ..." (*Dolentium Hominum, *5). Besides other initiatives of your worthy Order, the recent establishment in Rome of the International Institute for the Health Care Apostolate, the Camillianum, is a significant response to the need for the specialization in health care required by the Christian concept of service to our neighbour.*

The health area, threatened by new illnesses brought on by a crisis of values, by the contamination of the environment, by growing social ills, demands a global commitment by all sections of the Church so that assistance to those who suffer can transform them into active subjects of evangelization (cf. Christifideles Laici, *54). This fitting goal can be achieved if all — priests, religious and laity, and especially those who by an institutional and specific charism have dedicated themselves to the health-care apostolate — work with a commitment inspired by Gospel principles.*

You Have a Special Apostolate: To Be United with Christ and To Pray for Those Who Do Not Yet Know Him

(St. Henrik's Catholic Cathedral in Helsinki, June 6,1989, meeting with the sick, elderly, and religious)

For the first time in history the Bishop of Rome is setting foot in this Cathedral, dedicated to Saint Henrik, the holy Patron of Finland. My heart rejoices that I can do so with you: the elderly and the sick *as well as the* priests and the religious sisters and brothers of Finland. *It is a privilege for me to speak to you,* to be with you, *because you are all special in the eyes of the Lord.*

We have just heard the extraordinary words of the Beatitudes: "Blessed are the poor." These words are addressed to all of us but especially to those who have the heavy cross of pain or sickness *to bear. The Lord says to you this morning: "Blessed are you." In your* weakness and dependence *you often realize better than others that we are all poor, weak and ultimately dependent on Christ, who says: "I am the vine, you are the branches. He who abides in me, and I in him, he it is that bears much fruit, for apart from me you can do nothing" (Jn 15:5).*

How can I be blessed, you ask yourself? For the most part, modern society idolizes health, youth, power and beauty. The sick and the old seem to lack precisely those things that the world so much admires. But there is a higher wisdom: *a wisdom that reveals the true meaning of our human weakness and our pain. That wisdom is* revealed in Christ. *He knows what it is to suffer: he experienced it on the road to Calvary. He was scourged and crowned with thorns, he had to carry the cross and was crucified.*

Christ associates with himself — *in the closest possible way all those who suffer. If any of your relatives, neighbours and those looking after you do not fully understand how much you suffer, be assured that Christ the Lord does. Not only does the Lord understand our suffering but he teaches us that suffering, pain, growing old, and death itself — all these things have* an immense value when they are united with his own Passion and Death. *In fact, Jesus says that no one can claim to follow him without taking up his cross.*

In the Gospel of Saint John we read: "God so loved the world that he gave his only Son, that whoever believes him should not perish but have eternal life" (3:16). Jesus Christ is God's definitive word about the human condition, and therefore also about suffering. In the plan of God all life has value, *because from the moment of conception onwards there is a meeting, a dialogue between the Creator and the creature, between the divine and human. That dialogue takes its highest form in prayer and worship, and it reaches special intensity in our loving obedience to God's will, when we accept life, with all its difficulties and sufferings, as a sharing in the work of redemption.*

All of you therefore have a special apostolate: *it is to be united with Christ and to pray for those who do not know him. I ask you to pray for me as well and for the Catholic Church throughout the world. I ask you to pray for those who cannot pray and who do not know how to pray, and for all who have lost faith in God and in his mercy. Allow the light and the healing presence of Christ to shine through your lives so that all who come into contact with you will discover the loving kindness of God.*

Society Exists to Promote the Security and the Dignity of the Person

(Uppsala University, Sweden, June 9, 1989)

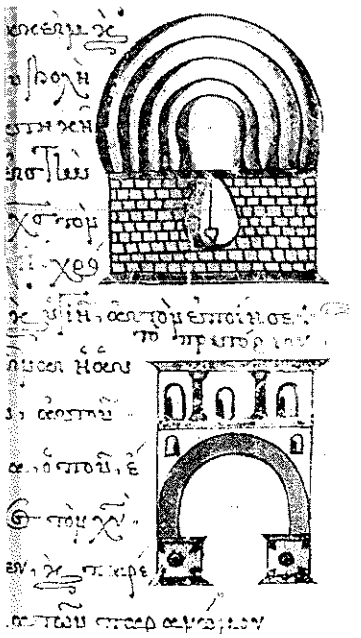
The dignity of the person can be protected only if the person is considered as inviolable *from the moment of conception until natural death. A person cannot be reduced to the status of a means or a tool of others. Society exists to promote the security and dignity of the person, Therefore, the primary right which society must defend is the* right to life. *Whether in the womb or in the final phase of life, a person may never be disposed of in order to make life easier for others.* Every person must be treated as an end in himself or herself. *This is a fundamental principle for all human activity: in health care, in the upbringing of children, in education, in the media. The attitudes of individuals or societies in this regard can be measured by the treatment given to those who for various reasons cannot compete in society — the handicapped, the sick, the aged and the dying. Unless a society treats the human person as inviolable, the formulation of consistent ethical principles becomes impossible, as does the creation of a moral climate which fosters the protection of the weakest members of the human family.*

As I had the occasion to state last year, on the ninth centenary of the University of Bologna, one of the richest legacies of the Western university tradition is precisely the concept that a civilized society rests on the primacy of reason and law.

As Bishop of Rome, a son of Poland and once a member of the Polish academic community, I wholeheartedly encourage all the representatives of intellectual and cultural life who are engaged in revitalizing the classical and Christian heritage of the university institution. Not all teachers, not all students are equally involved in the study of theology and the liberal arts, but all can benefit from the transmission of a culture enriched by that great common tradition.

Your university system has kept alive the teaching of theology, and this offers an open forum for studying the word of God and its meaning for the men and women of today. Our times are in great need of interdisciplinary research in meeting the complex challenges brought by progress. *These problems bear on the meaning of life and death, the threats involved in genetic manipulation, the scope of education and the transmission of knowledge and wisdom to the younger generation. We certainly have to admire the marvellous discoveries of science, but we are also aware of the devastating power of modern technology, capable of destroying the earth and all it contains. A mobilization of minds and consciences therefore is urgently needed.*

It is vital for the future of our civilization that questions such as these should be jointly examined by scientific experts as well as by expert theologians, so that all aspects of technical and moral issues may be carefully considered. Speaking to UNESCO in Paris on 2 June 1980, I made a special appeal to the moral potential of all men and women of culture. I said then and repeat before this distinguished assembly today: "All together you are an enormous power: the power of intelligences and consciences! Show yourselves to be more powerful than the most powerful in our modern world! Make up your mind to give proof of the most noble solidarity with mankind: the solidarity founded on the dignity of the human person." In this great task you will find an ally in the Catholic Church, *an ally willing to cooperate fully with her Christian brothers and sisters and with all people of good will.*



Union with Christ Makes One a Source of Grace, Peace, and Joy

(To the sick during the visit to the Marian Shrine of Civita d'Itri, Latina, Sunday, June 25, 1989)

I have come to this holy mountain to venerate Our Lady in her Shrine, so famous and so important for you who seek comfort for your physical and moral suffering in the motherly glance and countenance of Mary.

Following the footsteps of my predecessor, Pius IX, 140 years after his visit, I too wished to come up here at the start of the day entirely devoted to the Archdiocese of Gaeta, precisely to you, suffering members of the Mystical Body, the Church. Here I am, then, at the feet of Mary, health of the sick, and Help of all Christians.

I offer a special greeting to those responsible for health care: administrators, doctors, nurses, auxiliaries, Sisters, and voluntary workers, and also to the families of the sick.

I express my appreciation of the dedication with which you endeavour to create a friendly, welcoming, and relaxed atmosphere for the sick, who are living images of the suffering Christ. You feel obliged to bring human warmth into your work, performing it as a real mission, as by one brother for another. Indeed, you realize that the person who suffers does not merely seek the specialist capable of healing his illnesses, but also a human being capable of understanding *his states of mind and of supporting his daily struggle towards recovery.*

In your task you are greatly helped by your faith, which allows you to see in the sick person the outlines of Christ's countenance. *In fact, has he himself not said: "I was sick and you visited me" (Mt 25:36)? These words continually resound within you. He who sees in secret will repay you.*

Indeed, is there not already a valuable reward in the appreciation of your patients, who always carry in their hearts the memory of your dedication, serenity, and sensitiveness, apart from your competence and the effectiveness of your therapeutic treatment? Your work, often long and exhausting, has an inestimable value in the eyes of society, and above all, before God.

Dear sick people, I would like especially to thank you for your presence. I am grateful for the words of your representative, who made a profound analysis of what it means for a Christian to be sick, to be sick in the contemporary situation. I am grateful for these words, for this analysis, which expresses also the feelings, attitudes, and hopes of all of you.

I have come here, not to bring you merely human encouragement, but also and especially the comfort of the Christian faith. I have come to say to you that your infirmities are part of the plan of God's fatherly and demanding love. *Do not regard them as blind fate, but as an ever providential test, even if hidden and incomprehensible from a purely human point of view.*

Raise your eyes to Christ, *who accepted the trial of his Passion. Look at him, the Innocent One, Who unreservedly offered his life to save all mankind, look at him who entrused himself with complete abandonment to God, his Father. As you know, at first he asked that the bitter chalice might be removed from him, but immediately he added: "Not my will, but thine, be done" (Lk 22:42). His suffering has become a cause of salvation, pardon, and life for us.*

Your generous union with Christ's suffering forms the summit *of your belief. Those who are called to suffer with Christ do not undergo a punishment, but are set aside for a demanding and fruitful task. indeed, if accepted and offered with love, their suffering becomes a source of grace, peace, and joy. It becomes the narrow way; as we know, this is the way which leads to Paradise.*

Dear sick friends, I wish you a speedy return to health, *so you can leave hospital and return home. Your usual family and social duties await you; through them you will be able to do so much good, thanks to your renewed energy. I pray for your speedy recovery.*

Now, however, since in the book of your life the chapter on illness is not yet finished, I recommend you to make the most of it in all its aspects. In fact, suffering purifies self and others; it is a source of glorification, a gift offered to complete in one's own flesh "what is lacking in Christ's afflictions, for the sake of his body, that is, the Church" (Col 1:24).

Therefore, let your suffering be a gift to Church, *so that she may go more speedily along the roads of the world.*

Accepting the mystery of pain in one's life means recognizing that salvation blossoms from Christ's Cross, and Christ's Cross is the true tree of life.

However, the Cross is not an end in itself. Good Friday is followed by Easter Sunday. Man's suffering is illumined in the perspective of Christ's Pasch. In the midst of the pitch-darkness of humiliations, doubts and discouragement which sickness brings with it, the believer finds comfort in the light shining from the countenance of the risen Christ.

Therefore the Apostle writes also in the Second Letter to the Corinthians: "For as we share abundantly in Christ's suffering, so through Christ we share abundantly in comfort too" (2 Cor 1:5).

You Are the First to Arrive at the Mountain of Joy

(To young sick and disabled people at the Major Seminary of Santiago de Compostela, on August 19, 1989)

Beloved Brothers and Sisters,

1. On this significant day on which so many young men and women of the entire world, gathered together in Santiago de Compostela or in the most remote parts of the earth, join with the Pope to celebrate Christ the Redeemer, *you constitute the center of attention of the Church, because suffering places you especially* close to Christ, *furthermore, it makes you* living Christ *in the midst of the world, since* the suffering individual is the way of the Church *because that person is, first of all, the way of Christ himself, who is the Good Samaritan who "did not pass by" but who "had compassion and went to him and bound up his wounds... and took care of him" (Lk 10:32-34) (*Christifideles Laici, *53).*

For this reason I feel a special pastoral satisfaction in coming here to greet you — I would like to greet each one of you personally — to speak about your situation, to encourage you, to bless you and to let all other men and women see what you are and what you mean *for the whole of humanity.*

I appreciate the expressive way in which your representative has pointed out your desires and indeed your acceptance of God's will, expressions and testimonies which are summarized in the book which you have just given me.

I would also like to show my appreciacion for the sentiments of closeness and solidarity with those who are sick or disabled expressed by a young person of your own age.

In your sickness not only are you privileged in the sight of God but, by means of it, it is you who can ask and help the youth of the world to find Jesus Christ, the Way, the Truth, and the Life. At a time when the Cross is hidden away, your acceptance of it makes you witnesses of the fact that Jesus Christ wanted to embrace it for our salvation.

2. Young sick and disabled people! *Precisely in the most beautiful period of life, characterized in man by a particular vigor and dynamism, you find yourselves weak and without the strength necessary to carry out so many activities which the other boys and girls of your own age can do.*

In effect, many people of your age have come on foot today to Monte del Gozo — the Mount of Joy — where we will meet this evening. You are not in a position to walk, but — we could say it in a paradox — you have arrived before anyone else at the "mount of joy." *Yes, because Calvary, where Jesus died and rose again and where you are with him, is,* looked at with the eyes of faith, the mount of joy, the hill of perfect happiness, the summit of hope.

3. *Because I have personally experienced it, I also know the suffering which physical incapacity causes, the weakness that comes with sickness, the lack of energy for work, the feeling of being unable to lead a normal life. However, I also know — and I wish that you also may see it — that* this suffering has another sublime characteristic: *it gives a great spiritual capacity, because suffering is a purification both for oneself and for others. If it is lived with a Christian outlook it can become a gift offered so as to complete in one's own flesh "what is lacking in Christ's afflictions for the sake of his body, that is, the Church" (Col 1:24).*

Thus, suffering makes sanctity possible, since it offers great apostolic opportunities and it has an exceptional salvific value when it is united with the sufferings of Christ.

The evangelizing strength which suffering has *cannot be measured. So when I call all the Christian faithful to the great missionary task of carrying out a new evangelization, I have in mind that in the front line will be, as exceptional spreaders of the Gospel, the sick,* young sick people. "The sick are sent as laborers into the Lord's vineyard." *This is because "the weight that wearies the body's members and dissipates the soul's serenity is far from dispensing a person from working in the vineyard. Instead, the sick are called to live their human and Christian vocation and to participate in the growth of the Kingdom of God in a new and even more valuable manner"* (Christifideles Laici, *53*).

4. *In the Apostolic Letter* Salvifici Doloris *I have spoken at length of the* Christian meaning of suffering *and I have referred to some of the ideas already expressed. I would like this Letter to be a* guide *for your life, so that you would always contemplate your situation in the light of the Gospel, fixing your gaze on* Christ crucified, *who is Lord of life, the Lord of our health and our sicknesses and Master of our destinies.*

In offering to Our Lord your limited strength, you are the treasure of the Church, the energy reserve for its task of evangelization. *You are the expression of an ineffable wisdom, which can only be learned through suffering. "It is good for me that I was afflicted, that I might learn your statutes" (Ps 118:71). Through suffering life becomes deeper, more understanding, more humble, more sincere, more united, more generous. In sickness we better understand that our existence is gratuitous and that health is an immense gift of God.*

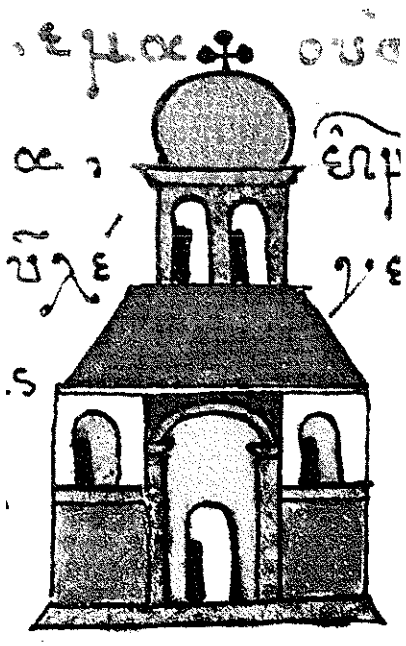
My beloved friends in suffering, through pain you will discover more easily, and you will teach other people to discover Jesus Christ, "Way, Truth and Life." *Look at Our Lord, the Man of Sorrows. Center your attention on* Jesus, *who,* young like you, *by his death on the Cross, helped man see the inestimable value of life, which necessarily brings with it the acceptance of the will of God the Father.*

5. Before ending this meeting, I wish now to address all those people who, through family ties or their professional work in the area of health or human and social care, are in continuous contact with our beloved young sick people.

I appreciate the generosity, and at times abnegation, with which you try to create a welcoming, peaceful family environment around these people, who are living images of the suffering Christ. You feel the obligation to carry out your work as a true service, of brother to brother. You know well that a sick person does not only seek relief in his suffering or limitations, but also the help of a brother or sister, who is capable of understanding his state of soul and of helping him to accept himself as he is and to better himself in his daily life.

To achieve this faith is fundamental, a faith which permits you to see in the sick person the friendly face of Christ. Did he not say: "I was sick and you visited me" (Mt 25:36)? In this Christian framework your service, at times long and tiresome, has an inestimable value before society and, above all, before the Lord.

I bless you, beloved sick and disabled people, with my greatest affection. This Blessing I joyfully extend to your loved ones, and to all those who look after you and accompany you, whether spiritually, humanly or medically.



The Church's Special Concern for Health Questions

A letter from Cardinal Casaroli, Secretary of State, to Archbishop Fiorenzo Angelini which our Pontifical Council made public at the Meeting on the Church and Health in Latin America

Dear Archbishop Angelini:

The Holy Father, having been informed of the Meeting on the Church and Health in Latin America, to be held in Bogota, October 2-6, 1989, entrusted me with the task of conveying his message of encouragement together with his affectionate greeting to the organizers, guests, and all the participants in these sessions. In particular, he greets Monsignor Dario Castrillon Hoyos, President of CELAM, the brother bishops present, the priests, men and women religious, and all those working in Catholic associations in the health field.

The world of health has certainly been the object of special attention on the part of the Church over the centuries. In following the teachings and example of Jesus, she has always shown her closeness to the sick, like the Good Samaritan of the Gospel. On many occasions and in many places she has been and continues to be a pioneer and promoter of health, whether by supplementary activity and collaboration or in fulfillment of her pastoral mission.

In recent times we have been witnessing new social and pastoral initiatives aimed at the defense and promotion of health and in favor of the sick and health personnel. His Holiness John Paul II is today a concrete testimony of welcome and love in this field of health. His gestures towards sick in his encounters during all the apostolic journeys are a significant fact. He is the Pope who has bequeathed to us a beautiful Apostolic Letter on the Christian Meaning of Human Suffering *(*Salvifici Doloris, *February 11, 1984). His particular concern for this sector of the apostolate has led him to institute a new Office in the Church to stimulate and coordinate everything relating to this field: The Pontifical Council for Pastoral Assistance to Health Care Workers (*Dolentium Hominum, *February 11, 1985).*

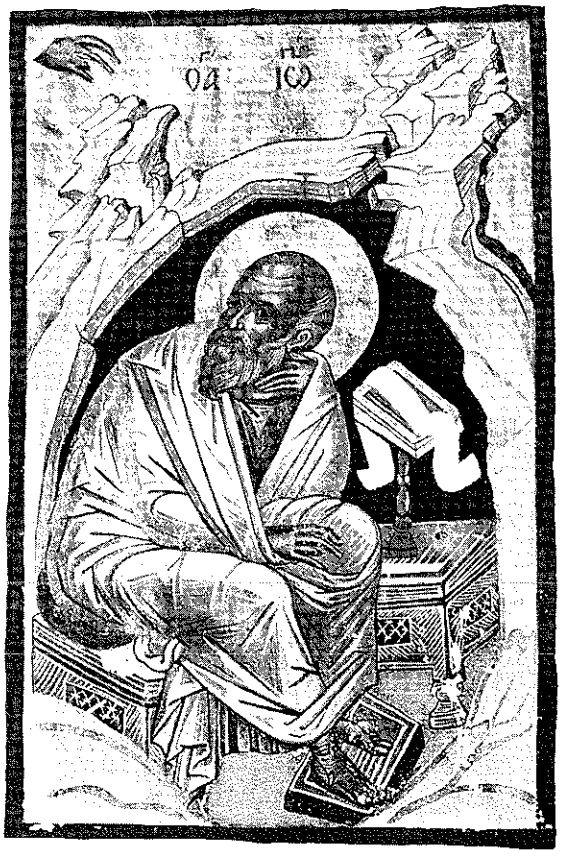
The Holy Father, in his pastoral concern for the Church in Latin America, encourages all those who, with generosity not free from sacrifices, contribute to making the Church's presence and action more intense in hospitals and other health facilities and promote conditions of health and hygiene in the neediest populations.

Access to better health conditions is a basic right repeatedly proclaimed by the Church and by international organisms. The difficulties of every kind causing large segments of the population to suffer health deficiencies reflected in high infant mortality rates or low average life expectancy cannot, however, be passed over.

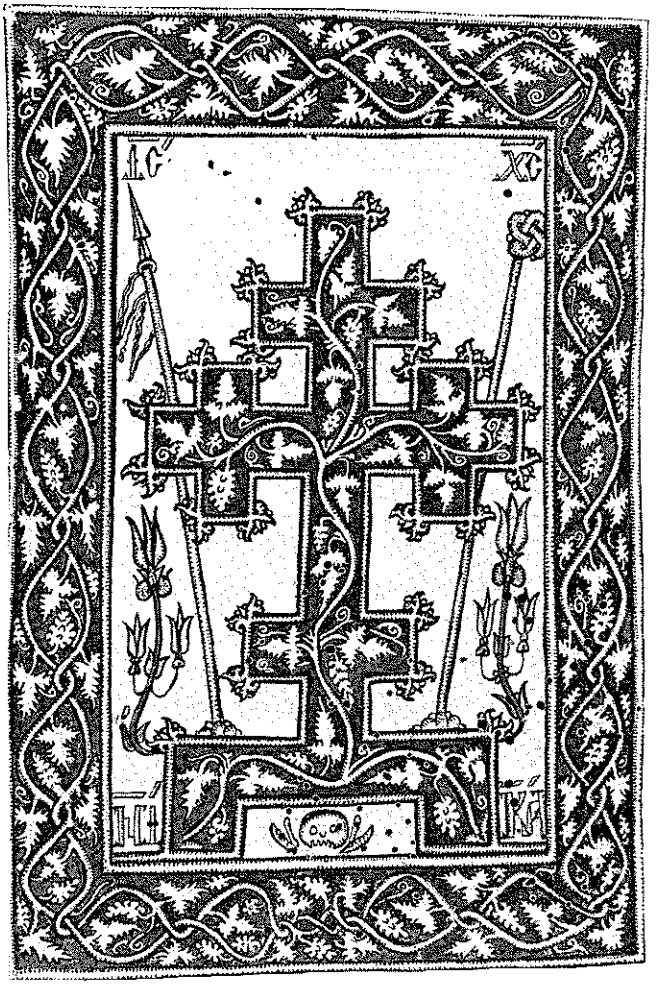
There is, therefore, a need for renewed efforts by those participating in these days of study and reflection to give a greater stimulus to pastoral action in health care while also paying special attention to the organizations of Christian professionals working in the field of health. In this regard, the Pope encourages the work of this meeting and with renewed vigor calls for active solidarity on the part af all who, with generous toil, professional knowledge, and means, can collaborate towards the improvement and promotion of the health conditions of so many of our sisters and brothers, without forgetting, either, what is related to health education on an individual and family level.

While expressing his deep appreciation for those devoting their lives to alleviating the sufferings of their sick brothers and sisters, the Holy Father with great pleasure gives his assurance that he will ask the Lord to grant abundant fruit to the Bogota meeting and, as a token of his benevolence, imparts his hoped-for Apostolic Blessing upon the organizers and all participants.

I take this opportunity to assure you once again, Archbishop Angelini, of my consideration and esteem in Christ.



Topics



Economically Conditioned and Responsible Parenthood

Care of the Dying and Therapeutical Obstinacy

Report on Psychiatric Patients

Christian Health Professionals of Spain and the Patient's Family

Economically Conditioned and Responsible Parenthood

A paper presented by John and Elaisa Varela, of Montevideo, Uruguay, at the Plenary Assembly of the Pontifical Council for the Family in Rome, June 13-16, 1989.

One of the difficulties frequently encountered by those of us working in the field of Family Guidance and related areas is economic conditioning when it comes to deciding whether or not another child should arrive.

Such difficulties are connected with a rise in the cost of living, the problem of gaining access to decent housing for a numerous family, the considerable expense of nonpublic education (which terribly conditions parents' freedom and right to choose for their children the best education in accordance with their convictions and is partly due to a lack of proportional distribution of tax revenues used for schooling), and the minimal support for mothers by public institutions, if not resolute, shameless opposition to maternity.

And, along with these motives, a hedonistic, consumer society leading people to place material comfort and pleasure before any other value, a rarefied atmosphere regarding numerous families as socially irresponsible, the pressure exerted by powerful international political and economic organizations fostering birth control policies, and perceiving work in the home as an anti-value, which prompts women to flee from their homes in search of a job providing them with personal, economic, and professional realization, turning their backs on their responsibilities as mothers and wives.[1]

"At the root of these negative phenomena, there is often a corruption of the idea and experience of freedom, conceived not as the capacity to carry out the truth of God's project for marriage and the family, but as an autonomous force of self- assertion, not infrequently against others, with respect to one's selfish well-being."[2]

It has become necessary for everyone to recover awareness of the primacy of moral values of the human person as such. To comprehend once again the ultimate meaning of life and its fundamental values is the great and important task becoming inevitable nowadays for the renewal of society.[3]

In 1985 the Holy Father told the Uruguayan Bishops gathered in Rome, "I know that you are often concerned about the break-up of the family and the lack of clear criteria in this field. Therefore ..., open to lay people the human and Christian greatness of their mission; remind them of their duty to be faithful to the Magisterium of the Church in the domain of responsible parenthood and procreation, following the norms contained in the Encyclical *Humanae Vitae*. Help Christian spouses in their difficulties and problems so that they may always feel encouraged towards the merciful love of Jesus and the integrity of Christian life. In this way they can be centers spurring a full experience of the Christian ideal and a solid contribution to the good of society, which, in Uruguay, so deeply needs families that are united, morally healthy, open to others, creative as regards morality at every level, educators in faith, and respectful of the rights of each person, beginning with respect for the life of each creature from the moment of conception."[4]

Authentic Love

The signs of authenticity in conjugal love are faithfulness and fertility. Conjugal fidelity is seen to be an exigency of man's dignity: "The definitive character of faithfulness in marriage, which many seem not to understand today, is an expression of the unconditional dignity of man. One cannot live just on a trial basis, nor can one die that way; and, by the same token, there is no place for living on a trial basis, accepting a person only for a certain time."[5]

And faithfulness is accompanied by fertility, "which is the fruit and sign of conjugal love, the living testimany of the spouses' full mutual donation."[6] True love is thus inseparable from openness to the gift of life: "In his eternal design, God has united the fundamental duty of the family — which is the gift of life offered by the parents, man and woman, to their children, to each new child — to the vocation to love, to sharing

in that Love which proceeds from God, for He Himself is Love."[7]

Responsible Parenthood

Responsible parenthood is in essence the conduct whereby spouses respond to God's design for them as such in regard to the full realization of the ends of marriage through the transmission of life and the upbringing of children, conduct which, familiar with the biological foundations of procreation, will also comprehend a responsible decision regarding the number of children, but without this latter aspect's necessarily involving a restrictive sense either.

The fact that we have come to know the intimate biological machanism by which life is transmitted has posed and made possible rational action on points which previously were veiled. Nevertheless, if unreflecting spontaneity in the transmission of life should not be taken, with no further ado, for a lofty degree of virtue and love for one's children, a merely rational posture does not always display loving responsibility either, for it may only be the result of selfish utilitarianism; in fact, for many people responsible parenthood amounts to the same thing as birth control, and such is not the case.[8]

Spouses ought to behave with human and Christian responsibility in their role of transmitting life, for only in this way — with a generous, human, and Christian sense of their responsibility — do they glorify the Creator and walk towards Christian perfection.[9]

Human and Christian Responsibility

To comply properly with the responsibilities of marriage, "outstanding virtue is required; spouses, prepared by the grace of a holy life, should thus cultivate and obtain by their prayer steadfastness in love, greatness of soul, and the spirit of sacrifice."[10]

If there is no fullness of Christian life, it is virtually impossible for the decision on the number of children to be objective and truly responsible; if a couple is not habitually faithful to its Christian vocation in regard to charity, a concern about cultivating its interior life or faith, and obedience to the laws of the Church, for example, we may conclude that it will ordinarily not be faithful to its vocation in fulfilling its role in parenthood either.

Simply to state that responsible parenthood consists of having as many children as can be raised is an ambiguous as well as partial way of speaking. A person's not being in a position to raise offspring is not resolved by numerically restricting children. If someone does not know how to raise four children, it will be quite probable that he will not know to educate just one either; the problem should be traced back to the period prior to marriage.[11]

In conclusion, the authentic meaning of responsible parenthood cannot be separated from the practice of virtue or from the light cast by the call to holiness of the spouses.[12]

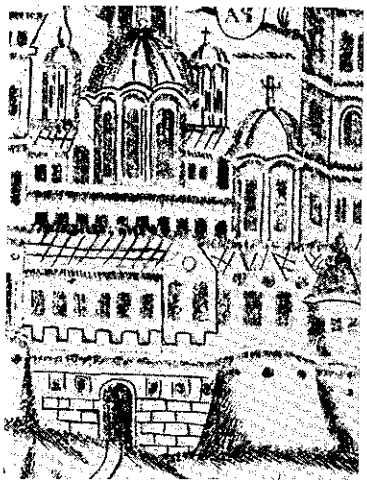
In a 1979 address, the Holy Father pointed out that there are many elements for reflection in the natural order itself which can help spouses to obey joyfully: "Do we not see the need for human nature to be subordinated to morality? Have we thought about the importance of the influence which a rejection of children, when progressively accentuated, can exert upon the psychology of parents, whose nature is inscribed with the desire for a child? And what can we think of education of young people in sexuality which does not warn them about the immediate, selfish search for pleasure when dissociated from the responsibilities of conjugal love and procreation?"[13]

In short, proper understanding of responsible parenthood brings into play the defense of life in the most radical way. "The generalization of contraceptive practices leads to abortion, since the two, on different levels, certainly go in the direction of fear of the child, rejection of life, lack of respect for the act and fruit of the union between man and woman, as the Creator of nature has wanted them."[14]

Formation of Conscience

Man is not a law unto himself; his conscience is not completely independent. The Holy Father has given us the principles according to which Catholics must form their conscience on this problem. A Catholic's obligation to accept the Church's teaching on every moral problem cannot reasonably be regarded as an offense against the freedom of individual conscience. In any case, even for non-Catholics, the basic principles providing norms for action in the moral field always remain valid. It is a contradiction to speak of "Catholic" methods of regulating births when the ethics of any method derive from the exigencies proper to the natural law, which equally affects all men, whatever their creed may be. The marriage act is essentially and totally subordinated and ordered to that great law of *generatio et educatio prolis* — i.e., the fulfillment of the primary end of marriage as the source and origin of life. It is, therefore, immoral to isolate the exercise of sexuality from procreation.

No matter how demanding the moral norm may seem in this field, it would be unjust and scarcely objective to forget that God, the author of nature, does not subject it to laws that are impossible to comply with, though the consequences of original sin make themselves felt in this area as in others. It is also frequently forgotten that all, in any state (and, therefore, spouses as well), are called to sanctity, and that Christian spouses, to live out their marriage correctly, are provided with the specific grace of the sacrament and the other means of grace God has placed within their reach. To see only difficulties without at the same time noticing the means God offers to overcome them and reach the supernatural end is directly opposed to a Christian vision of life.



A Prudent and Christian Decision

The judgement which a husband and wife should form should not be purely arithmetical, for the prudence with which it must be made does not consent to it.

The Church is not probirth on an extremist basis and is aware of the difficulties encountered by many of her children in making ends meet for the family, but it is not licit to go to the opposite extreme. If a call is needed, it is precisely to avoid a partial, selfish interpretation of responsible parenthood; indeed, what prevails among Western families is definitely not the large family. For this reason we must insist that responsible parenthood is parenthood which cannot dispense with sacrifice; it must be prudent, but with the prudence of the spirit , which is quite different from that of the flesh.[15]

"It is important for spouses to acquire a clear sense of the dignity of their vocation and know that they have been called by God to reach divine love, through human love as well, and have been chosen from eternity to cooperate with the creative power of God in the procreation and, later on, education of children; the Lord asks them to make their home and their whole family life a witness to all the Christian virtues. Marriage ... is a divine, grand, and wonderful way, and, like everything divine in us, it has concrete manifestations of response to grace, generosity, dedication, and service."[16]

[1] Cf. P. Richards, *Digesto Familiar* (Montevideo, 1988)

[2] John Paul II, *Familiaris Consortio*, no. 6.

[3] *Ibid.*, no. 8.

[4] John Paul II, "Discurso a los obispos uruguayos," January 14, 1985, quoted in J. Fuentes, *Católicos en Uruguay* (Montevideo, 1985), p. 111

[5] John Paul II, *Insegnamenti*, III, 2, p. 1192

[6] *Familiari Consortio*, no. 28

[7] *Insegnamenti*, III, 2, p. 844.

[8] Cf. P. Richards, *Digesto Familiar* (Montevideo, 1989).

[9] Vatican II, *Gaudium et Spes*, no. 50.

[10] *Ibid.*, no. 49.

[11] Cf. *Gran Enciclopedia Rialp*, vol. 18, pp. 41-44

[12] Cf. R. García de Haro, *Líneas básicas del Magisterio de Juan Pablo II sobre el matrimonio y la familia*, in *ASD Prensa* (Buenos Aires, 1985), no. 13.

[13] *Insegnamenti*, II, 2, p. 1032

[14] *Ibid.*, pp. 1033-1035.

[15] Cf. Rm 8:6-8

[16] J. Escrivá de Balaguer, *Conversaciones* (Madrid, 1988), no. 93.

Care of the Dying and Therapeutical Obstinacy

To care for the dying means to help them to die with human and Christian dignity. To die *with human dignity* means to face death with serenity and courage, to be able to integrate death into life as its concluding and perfecting part. To die *with Christian dignity* means to manage to discover in one's death participation in the Paschal mystery of Jesus Christ crucified and risen, the passage from earthly to eternal life, moving from the house of men to the house of the Father.

The well-known document on euthanasia by the Congregation for the Doctrine of the Faith (May 5, 1980) places itself precisely in this perspective: "It is very important today," we read, "at the moment of death to protect the dignity of the human person and the Christian conception of life against a technicalism which threatens to become abusive. In fact, some speak of the 'right to death', an expression which does not designate the right to procure death or have it provided as one wishes, but the right to die in all serenity, with human and Christian dignity."[1]

From such concepts it is easy to deduce the need for care of the dying which involves the requirement of favoring the specifically human and Christian dimension of man's death; but they also relate to affiliated moral problems: I am referring to the use of analgesics to relieve the suffering of the seriously ill or dying, even with the risk of shortening their lives, and so-called therapeutical obstinacy or abandonment. The document contains a very clear reference: "Everyone," it states, "has the duty to care for himself and have himself cared for. Those caring for the sick must lend their services with all diligence and administer those remedies which they deem necessary and useful. In all circumstances, however, should we have recourse to every possible remedy?"

This way of concluding the period with a question interpellates and, at the same time, awaits a moral-existential reply by all those caring for the sick.

In these pages we intend to deal precisely with these two moral problems for the purpose of insisting, above all, on the need to favor the human and Christian dimension of man's dying. For this reason, the setting forth of the two moral problems will be preceded by some reflections on the value of bodily life in the perspective of salvation.

1. Value of Bodily Life and Salvation in Jesus Christ

In the context of the secularized mentality of our day, man tends to conceive of himself as an absolute to which he is willing to sacrifice every other value. Science and technology can then become a form of idolatry which, before dishonoring God, wounds man himself in his real, full humanity.

In the theistic mentality, on the other hand, life is first of all a prerogative of God, who "lives eternally" (*Dt* 32:40) and has life in himself (*Jn* 5:26). All the creatures receive existence from the creative breath of God (*Jn* 2:7). Man, too, of course, but he, unlike every other creature, participates in the prerogative of life in a wholly singular manner: he has been created as the "image of the living God" (*Gn* 1:27); he is destined to share in the nature of his Creator. Consequently, the life man bears in himself is not comprehensible in its totality if not related to God and to the position God has assigned to it in the world above other creatures.

In this context, the design of God the Creator becomes a criterion of evaluation for man's life and tasks in history. In the same framework, science and technology — excluding every form of absolutizing — must also find their meaning as instruments of humanization and for the glorification of God, discovered, admired, and loved as well through their achievements (cf. *GS* 34).

In the New Testament human life is placed in relation to the life of the Lord Jesus, dying and rising again. In him we find the true dimension of human life, understood as its perfect realization and as life destined never to perish. Jesus is in fact the Lord of life: he has overcome death and made life and immortality shine forth (2 *Tm* 1:10). Since life is in him (1 *Jn* 5:11), he is the guide to life (*Ac* 3:15), and as the

new man, he bears man to full understanding of his own humanity.

Man's life is then conceived as a sharing in the life of the Risen One. What the Word carried out in the humanity assumed in his Incarnation is now effected by him in the Mystical Body through the Spirit, and man is rendered "a new creation" (*Rm* 5:18). "According to the divine plan, indeed, the Spirit completes the creation of man not only by making use of the life led by Christ, but also by introducing every person into participation in the same Paschal mystery as lived out by Jesus" (*SC* 6). And this is because God has destined us to share the greatness of the Risen Christ, to become members of his glorious body (*LG* 9, *GS* 32)."[2]

From this standpoint, bodily life should be conceived as a coessential component of the human person. It is the latter's first incarnation, the foundation upon which and through which the person realizes itself. By way of it the person enters into time and space and can express and manifest the values constituting it in its totality and fulfill its own life project.

Nevertheless, the wealth of the person, which is also and first of all spirit, as such transcends the body itself and temporality. Above this fundamental value is the spiritual and moral good of the person. This good might require the sacrifice of bodily life when it could not otherwise be reached. In such a case, however, the sacrifice must be carried out as a free gift.

2. Treatment of Pain and Analgesics

In view of the foregoing considerations, we shall now deal with the first of the problems raised in the introduction: that of treating suffering in the seriously ill or dying patient, including the use of analgesics.

In this regard, in the declaration on euthanasia cited above we further read: "In modern human society, in which the fundamental values of human life themselves are rather often questioned, the modification of culture influences the way suffering and death are regarded.... Consequently, the men living in such a climate anxiously ask themselves about the meaning of advanced old age and death, wondering, as a result, if they have the right to procure for themselves and their fellows 'the sweet death' which would shorten pain and be, in their eyes, more in keeping with human dignity."

After having specified that euthanasia, in a strict sense,is understood to be "an action or omission which, by its nature, or from the standpoint of intention, procures death for the purpose of elminating all pain," the authoritative document, in line with the constant tradition of Catholic morality, repeats the condemnation of interventions of this kind: "Nothing and no one can authorize the killing of an innocent human being, whether fetus or embryo, child or adult, elderly, or an incurable, agonizing patient.... It in fact involves a violation of the divine law, an offense against the dignity of the human person, a crime against life, an attempt on humanity."

Nevertheless, although some people are capable of bearing suffering without any therapeutic means of relief and generous souls may be advised to accept suffering to achieve greater conformity with the suffering Christ, for most pain can constitute a spiritual obstacle. In these situations under certain conditions it is licit to have recourse to use of analgesic substances.

The moral doctrine against euthanasia in fact does not signify abandoning the patient to his pain. Christianity, though evaluating pain anew and announcing the redemptive aspect contained therein, has at the same time foretold its being definitively overcome in the fullness of existence to be achieved in the future Kingdom of God, where, according to the description in Revelation, there will no longer be mourning or pain.

If illness and death are consequences of sin and we are obliged to oppose sin and its consequences, we are also called to fight against pain.

In this respect, "the medical practice of repeated and even massive administration of sedatives and narcotics to the seriously ill overwhelmed by pain

should be regarded as good Christian sense (knowing how to accept and control suffering in proper measure): for the purpose of avoiding the onset of conditions of intolerance, despair, or pessimism.

"But what should be borne in mind in such cases is that the patient's right-duty to think with sufficient awareness and responsibility about his final tasks never ought to be compromised: last will, secrets to pass on, duties related to his own salvation. The values at stake are too great and decisive to risk compromising them with a prolonged, irreversible sopor. In those extreme moments, above all, in which the eternal destiny of an existence is decided, it should be recalled that the real object of therapy is not the malady as a detached entity, but the subject who is struck by the malady, who entrusts himself to treatment in his entirety."[3]

This behavior does not mean renouncing efforts at fighting for life and against death proper to the medical art; it means that in this struggle there exists and is acknowledged a limit imposed by the main person concerned, the patient, who must add to the duty of surviving the need to safeguard his most precious values as a man who suffers and awaits another life.

The solution to the second problem is more delicate — i.e., the one involving therapeutical obstinacy or abandonment.

3. Care and Valid Therapeutic Means

Resorting to a doctor to prolong life is in the nature of things. Today, in addition to visiting the doctor, people go to clinics or hospitals, where the equipment for diagnosis and treatment, as in the case of intensive care and resuscitation facilities, may offer services which were impossible in other times and places. At such centers patients are frequently caught between life and death for long months, sometimes with their vitality reduced to mere vegetative reflexes.

These cases raise undeniably distressing questions, for while, on the one hand, every new therapeutic initiative seems only to prolong the suffering of a poor man, on the other, there are abundant exceptional successes due almost exclusively to the professional insistence of the health team.

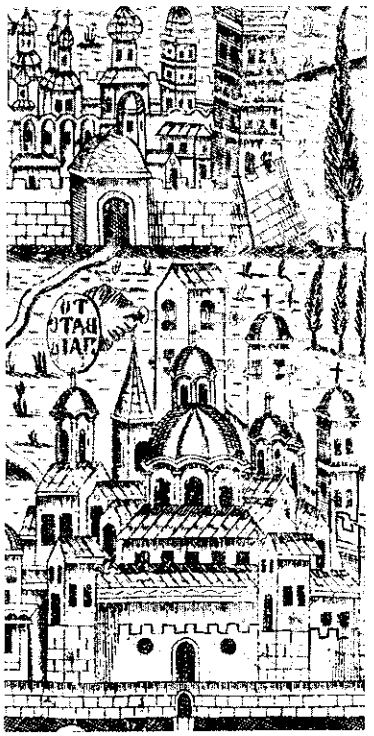
The greatest uncertainty is that of the doctor who must decide whether to stop or continue resuscitative treatment, for in those circumstances the patient is generally unconscious, and the relatives faced by the dilemma rely on his decision.

One criterion which has been traditionally followed by Catholic morality in such instances is to distinguish between ordinary and extraordinary means. According to this criterion, which maintains the doctor's obligation to use all available means in a concrete situation, only the use of ordinary means is deemed obligatory. A therapeutic means involving significant risk, pain, or expense is termed extraordinary.

This doctrine was authoritatively upheld by Pius XII in his address of September 24, 1957 dealing with the problems linked to the suspension of resuscitation: "If the attempt at resuscitation," the Pope states, "constitutes for the family a serious burden which in conscience cannot be imposed, the family may licitly insist on the physician's interrupting his attempts, and the physician may licitly consent thereto."[4]

The same orientation is expressed by the Congregation for the Doctrine of the Faith in its statement on euthanasia referred to above. Nevertheless, in updating its language, the statement prefers to speak of proportionate and therapeutically valid means rather than ordinary and extraordinary ones. This new language seems more appropriate for the plurality of situations which present the problem in highly varied ways in different times and places.

The basic criteria outlined by that document are contained in the following points: "If there are no other sufficient remedies, it is permitted, with the patient's agreement, to have recourse to means supplied by the most advanced medical techniques, even if these means are still at an



experimental stage and not devoid of risks. The patient, in accepting them, could also evidence generosity at the service of mankind; " — it is also permitted to interrupt these treatments when they do not succeed in obtaining the hoped-for results. For such a decision, however, the reasonable desires of the patient and the family must be taken into consideration, along with the wishes of competent physicians, who will undoubtedly be able to judge better than anyone else whether the investment of instruments and personnel is disproportionate to the results foreseeable and whether the techniques used impose on the patient suffering and discomforts which are greater than the benefits that may be derived from them.

"It is also licit to rest content with the normal methods medicine can offer. No one may, then, impose on another the obligation to resort to a technique which, though already in use, is not yet free from risks and is excessively burdensome.

"When an inevitable death is imminent in spite of the means used, it is permitted in conscience to make the decision to refuse forms of treatment which would ensure only a precarious and painful prolongation of life, without, however, interrupting normal care due the patient in such cases. The physician thus has no reason to be distressed, as if he had virtually failed to assist a person in danger."

In order to summarize the criteria provided, we might say that a therapy is not valid or respectful of human dignity: 1) when it is ineffective from a therapeutic standpoint; 2) when it threatens to subject the patient to further grave sufferings without concrete prospects of improvement; 3) finally, when it is exceptional from the standpoint of risks and cost. It is a question of those therapies which past moralists called extraordinary means and which are preferentially called disproportionate means today.

Removing life support in these instances, which leads to a swifter death, may seem like a way of provoking death, but it is instead the suspension of a treatment which is no longer beneficial, the removal of an artificial obstacle impeding the natural process of death. To rest content with the normal means offered by medicine and reject extraordinary ones thus means accepting the human condition by avoiding means disproportionate to the results which may be hoped for. This is possible because bodily life is not an absolute good to be defended at all costs and at any price. "A more severe obligation would be too burdensome for most men and would make it too hard to attain higher, more important goods. Life, health, and all temporal activity are, in fact, subordinate to spiritual ends."[5]

In concrete cases the task of applying the criteria to which we have referred is not easy. In spite of this weight of uncertainty, however, we cannot fail to say to the physician that in such circumstances he must bear in mind the prevailing interest of the sick person above the emotivity of pity among family members and scientific concerns themselves. "When we speak of the doctor's duty to protect life," writes the theologian Thielike, "we understand not biological life as such, but human life, and to characterize human life other criteria beyond those of the electrocardiogram and the electroencephalogram are needed."

4. Death and the Liberation of Man

Man dies in conformity with his nature only when he lives out his death. The dignity of man requires that death be the culmination of personal and human evolution, the final effort, the last act recapituling all the preceding acts, the coronation of life.

A human life should not simply fade away; it must be be "surrendered" with freedom and love. And if it is true that it is hard for such a "surrender" to be effected at the very moment of death, it is also true that it will always be valid if it has been fulfilled previously on a spiritual level.

In this context, "death is the last test of courage which is asked of us to ascend, through Christ, towards the great promise. In all the anxieties and torments, in all the abandonment and pain which death may involve, the dying of Christ is contained, but this is only the reverse side facing us of that whole whose law is called resurrection."[6]

FR. RENATO DI MENNA, M.I.

[1] Cf. *Déclaration sur l'euthanasie*, in "La Documentation Catholique," no. 1790 (1980), p. 699.

[2] I. Goffi, "Uomo spirituale" in *Nuovo Dizionario di Spiritualità*, Ed. Paoline (Rome, 1979), p. 1638.

[3] G. Perico, "Diritto di vivere o di morire?" in *Anime e Corpi*, no. 64 (1976), pp. 151-152. Cf. R. Di Menna, "Il problema della morte nella dimensione ospedaliera," in *Medicina e Morale*, vol. IX (Rome: Ed. O.M., 1976), pp. 115-137.

[4] Pius XII, *Discorsi ai medici* (Rome: Ed. O.M., 1960), p. 615.

[5] *Ibid*, p. 612.

[6] R. Guardini, *I Nuovissimi* (Milan: Vita e Pensiero), pp. 18-19.

Report on Psychiatric Patients

This study deals with the suffering of the "mentally ill," which is often unknown to society, to the family, and to the environment itself in which they live. These patients suffer morally much more than those who suffer only physically. "It is terrible to understand that intelligence is slipping away," says one of them. "Being sick for weeks and years without having done anything wrong. Can you understand what I feel?"

This report concerns the sick in Europe. In certain countries the situation is no doubt even more serious. If the Holy Father could speak in favor of them on an apostolic trip, that would be a great consolation for both them and their families.

Number of Patients

In this article we shall not distinguish the different categories of the mentally ill, though for the treatment needed such differences are important.

Psychotics, whose deep personality is ill, need very constant care and quite often are forced to remain at a psychiatric hospital for brief periods, and sometimes even on a long-term basis. A rather significant number of the chronic patients are obliged to remain hospitalized throughout their lives.

Neurotics, whose deep personality is not completely compromised, are followed up in their families as outpatients. There is a considerable number of such patients in all countries. In the Diocese of Strasbourg as well there are four psychiatric hospitals officially classified as COS (Specialized Hospital Center) and many clinics. In all, about 2,000 beds. This report is accompanied by a statistical table with data furnished by a Norwegian study.

Senile Dementia

At present the number of victims of senile dementia is sharply on the rise. Doctors now call this malady "Alzheimer's disease." The pathology results from medical progress and consumer society. The patient slowly degenerates and loses his mental faculties (memory, place perception, etc.). It is irreversible.

From the early manifestations on they should be prepared psychologically for death. When the degeneration is too far advanced, they are not capable of acting with full awareness. In the developed countries of Europe different clinics are being built to look after this type of patient.

The Criminally Ill

To the sick about whom we have spoken there is added a category of psychiatric patients even more to be pitied, the most unfortunate, completely rejected by society: the criminally ill. They are looked after at the so-called "security" facilities. In France there are about 700 beds for these patients at four hospitals. The other European countries possess similar structures. Stays are generally very long.

The causes of this situation are extremely complex: heredity, absence of parents, parental separation, a lack of education, consumer society.

Treatment Applied to These Patients

Science has unquestionably made great progress in therapy for such persons. A great many of the depressed, affected by episodic crises, are cured, but others improve without fully recovering. Since 1952, the year the first specific therapy was discovered — and with the aid of progress in psychology due to psychoanalysis — the treatment of patients, psychotherapy, and organization have advanced considerably.

The Suffering of These Patients

"Mental" illness is, above all, an illness affecting the communication relationship. From this we can deduce the suffering of such people as well as that of the environment surrounding them. The patient is characterized by disconnected statements, delirium, abnormal behavior, muteness, depression, and so on. Hence the reciprocal incomprehension between the patient and his environment.

Such situations often lead to hospitalization,

which is sadly described as "internment."

The point is reached of having to use force to hospitalize them. The moral sufferings of these patients increase more and more. The "mentally ill" are frequently accused of violence. Statistics now demonstrate that there is a ratio of 1 to 20 for cases of violence between mental and normal patients.

Marginalization of the "Mentally Ill"

One aspect of their suffering is due to rejection by society. There is a very serious phenomenon which is gradually diminishing but still exists and has inconceivable manifestations: Those dying at psychiatric hospitals were rarely buried in the family tomb at their place of origin and were not pointed out to the parish priest who regularly visited the hospitalized in his parish.

Today the situation is improving, but the marginalization of the sick continues. Families often reject the patient — visits are rare if the stay is prolonged. A good many are utterly abandoned.

When one of these patients commits a crime, the news media furiously attack, damaging their reputation. This enables us to grasp the degree of suffering at which they may arrive.

Society generally accepts the mentally ill with difficulty. One patient told me, "I don't like to go to Mass alone — they avoid me." They are disliked in the towns. People are afraid of them, but they have never harmed anyone. In the localities where there are psychiatric hospitals there have never been cases of violence. Even if they are in contact with people, they are still regarded as marginalized *qua* mental patients.

They themselves are often terrified of their first entry into a psychiatric hospital : "I am going to be considered a lunatic for the rest of my life."

Doctors and Nurses

In the mental patients' environment, the life of the doctors and nurses is particularly demanding and hard. They need solid training. The physician is prepared for about six years, the nurse, for three. To be accepted at the Specialized Professional School a secondary school diploma is required.

Moral gifts and psychic equilibrium are basic conditions. These patients need continuous, delicate care. There are people from all walks of life. They need not only medical care, but moral support, often re-education so they can return to their cultural and family framework to cheer up again.

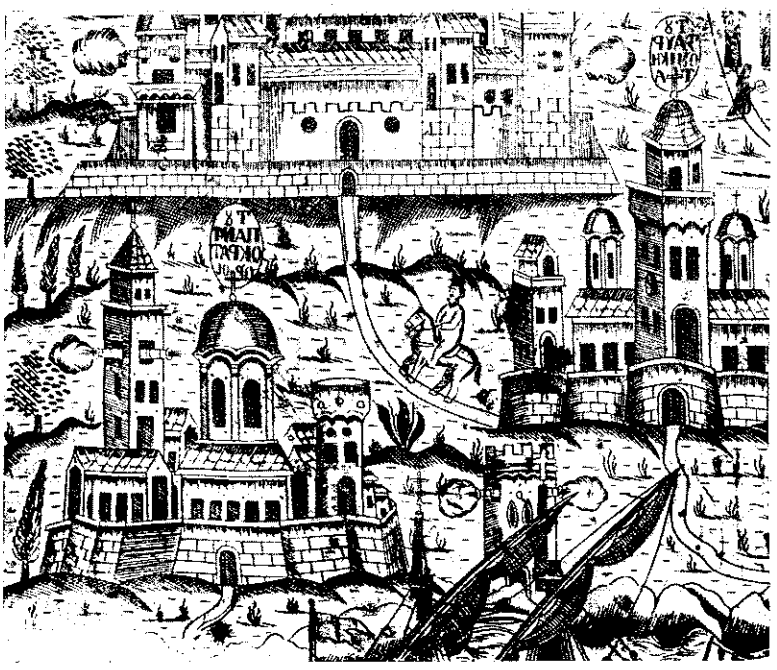
Those caring for them must thus have significant psychological, professional, and moral qualities.

Pastoral Care of the Mentally Ill

The pastoral care of the mentally ill is ensured, in the countries where there are psychiatric hospitals, through full-time chaplains, if there is a sufficient number of patients. The number of priests has diminished in recent years, and there are lay teams helping the priests.

In many European countries chaplains' associations have been founded to prepare people for this task, which requires specific training in psychology and psychiatry.[1] The first association of the kind was founded in Germany. The chaplains meet every year for three days of study and prayer. Friburg CARITAS is responsible for organizing these sessions.[2]

In France an association was founded in 1947 by August Bernard, chaplain at the psychiatric hospital at Rennes, assisted by Dr. Suzy Rousset. The association groups together chaplains, nursing sisters, and Christian nurses at psychiatric hospitals. Every two years a study session attracts the association members. There are periodic



orientation days for new chaplains. The association also publishes the journal *Mental Health Presence and Prospects*.[3]

Italy has also founded an association, and it is very active in Lombardy and Tuscany.[4]

Finally, since 1967 these associations have been holding an international meeting in Strasbourg every four years.[5] Lasting four days, it deals with a major topic on each occasion. On the average, two to three hundred chaplains, doctors, and nurses participate in these sessions.

Along general lines, this is the situation as a whole in Europe as regards psychiatric patients.

FR ALBIN GEBUS
Chaplain

[1] A Gebus, Training of the chaplains in the psychiatric hospitals (Supplement 1967).

[2] Currently run by Fr. Antoine Szekely, a Camillian.

[3] Editor of the Journal: Abbe Froc, 15, rue Saint-Georges, 35000 Reunes.

[4] Directed by the chaplain at Antonini Hospital in Milan, Fr Francesco Casiraghi. I have frequently spoken in Florence and Milan to help the chaplains to found this association.

[5] The fifth gathering took place in 1986 in Strasbourg: the topic was depression. These meetings have been organized by A. Gebus, chaplain at C H S in Brummath (F 67170).

MENTAL HEALTH STATISTICS IN EUROPE (DATA FROM PSYCHIATRIC HOSPITALS)

Countries	Inhabitants	Psychiatric hospital beds	Psychiatrists	Nurses and psychiatric personnel	Patients hospitalized in 1982	Per 100,000 inhabitants
Algeria	18 336 732	6 480	52	4,361	18,500	101
Austria	7,503,300	12,498	430	6 592	45 177	602
Belgium	9,859 000	24 900	985	1 278	45 839	465
Bulgaria	8 861 000	7 405	373	6 426	40,148	453
Czechoslovakia	15 369,271	19,548	929	6,867	46,715	304
Denmark	5 093 000	10 528	430	—	22 330	439
Finland	4 765 000	19 095	—	53 450	36 576	767
France	53 900 000	122 050	1 965	—	183,643	352
East Germany	16,740,000	31,626	1 250	14 312	49 302	295
West Germany	61 500 000	119 750	—	2 587	257 933	449
Greece	9 600 000	14 831	786	3 251	24,268	253
Hungary	10 709,539	12 768	480	311	—	—
Iceland	229 327	194	29	7 052	850	371
Ireland	3 443 405	13 461	231	—	22 404	665
Italy	57 200 000	83 220	2 518	—	94 473	165
Luxemburg	400 000	1 131	31	263	1,235	309
Malta	300,000	926	8	1,055	729	243
Marocco	21 800 000	3 410	32	—	12 196	56
Holland	14 149 000	26 753	329	10 215	20,926	148
Norway	4 079,498	7,107	318	8,640	10,835	264
Poland	35,735,000	39 490	1 691	5 542	125 832	354
Portugal	9 867 000	10 607	—	—	12 888	131
Romania	22 400 000	22 802	—	—	—	
Spain	37 563 898	46,483	1 476	8,091	67,312	179
Sweden	8,284,437	20,800	800	30 000	58 000	697
Switzerland	4 346 000	12 011	—	—	18 742	295
Turkey	44 000 000	6 617	751	686	10 312	23
USSR	268 000 000	—	—	—	—	—
England and Wales	49,001,000	91,952	1,176	54 260	130,540	643
Scotland	5 116 000	17 661	238	10 548	21 974	426
Northern Ireland	1 543 000	4 933	61	2 823	6 674	433
Yugoslavia	22,107,000	11,068	—	—	31,200	141
Totals	833,811,407	822,105	17,369	238,610	435,553	10,023

The number of outpatients should be added to these figures. In the developed countries they are more numerous than the hospitalized patients The number of cases of depression, above all, is constantly on the rise In France there are 5 000 psychiatrists; of these only 2 000 work at psychiatric hospitals.

Christian Health Professionals of Spain and the Patient's Family

Introductory Remarks by Jesús Conde, Diocesan Delegate for the Health Care Apostolate in Madrid

The third National Meeting of Christian Health Professionals was held in Malaga, March 10-12, 1989, to reflect on the assistance role performed by the patient's family. The conclusions reached were felt to be of interest to the readers of *Dolentium Hominum* by its editors, who, in addition to publishing them, have asked me for a brief introduction which would situate them in their context.

Though health professionals are forced to deal with patients' relatives on a daily basis, they do not usually stop to think about the latter's importance in the process of care or the assistance they require, in turn, in order to provide effective help to the sick members of their family. CHPS' desire to deal with this topic is attributable to various motives which at the same time are those which have played a decisive role in the creation and development of this association and which I would like to discuss at the outset.

The subject of the "patient's family" was chosen by CHPS for its Meeting because the members themselves had contributed, together with the other Christians involved in the health apostolate in Spain, to selecting it as the leitmotiv of the campaign for Patient's Day 1989, an initiative organized by the Health Care Ministry Department of the Spanish Bishops' Conference since 1985.

CHPS forms part of this Department by constituting a Commission — together with those of Hospital Ministry, Parish Ministry, Mental Health, and Formation Ministry — charged with stimulating the pastoral action of the Spanish Church as a whole in the health field, in a coordinated manner and with a deep sense of community impregnating both the Bishops' Conference and the local churches.

This formulation of the Health Care Apostolate as a joint effort of the entire Church community in which each of the Christian ministries must contribute its specific charism while remaining in constant relationship with the others has made it possible year after year for the problems most seriously affecting the world of health and pastoral attention to it to be detected and analyzed in an overall health care and Church perspective and for carefully pondered and realistic solutions to them to be proposed. This focus also decisively influenced the profoundly "ecclesial" way in which CHPS has joined in the pastoral tasks proper to the world of health.

For over ten years CHPS has been stimulating the development of the health care ministry in the dioceses, as some members have been appointed diocesan delegates for this pastoral work by their bishops. For its part, the Health Care Ministry Department has sought to create adequate channels to include lay health professionals in its pastoral activity. In 1986, on a provisional basis, the CHPS Commission was set up, composed of eight health professionals and the Director of the Department. Less than two years later the bishop in charge of the Health Care Ministry named the Coordinator of this Commission, which was recognized as an organism of the Spanish Bishops' Conference.

Three distinctive traits characterize CHPS. Firstly, an awareness of being baptized and forming part of the Church. The members are not divided according to professional categories on a national, regional, interdiocesan, or diocesan level. It does not harbor branches, sections, or Catholic associations of doctors, nurses, auxiliary or administrative personnel, and so on, but rather groups made up of professionals on different levels who are united by their common dignity as Christians.

The theology underlying this organization is that of the Pauline "Body," the living stones, and the common priesthood of the faithful cited in the First Letter of Peter. Members feel that in a world like that of health care, where a class struggle has emerged among the various professional categories, what is needed, above all, is to contribute a deep sense of community for better service to the patient and those caring for him. And they consider

that to achieve this it is indispensable that they themselves first feel like a community and act in community fashion, beyond differences in standing. From this point of view, the Christian dimension is prior to the professional one. This does not prevent each from speaking and acting in his own personal and professional perspective.

Secondly, CHPS' decidedly pastoral commitment must be stressed. Without overlooking technical, scientific, or work-related problems, they seek to live in communion and act together with all those in the Church who want to be the emissaries of the Good Shepherd to the world of health. They feel called to evangelize, to participate in the saving offer of the Church through the sacraments of illness, to humanize medical facilities and the caring relationship, and to collaborate in the clarification and solution of bioethical problems in the light of the message of Christ and the Church.

Finally, a third characteristic trait should be mentioned which is very much in keeping with current trends in health care. Many CHPS members work at hospitals and in their training received a markedly hospital-oriented view of the caring function and medical organization. But their membership in the health care ministry as a whole has led them to collaborate not only with Catholic religious assistance services at hospitals, but also in parish communities, in training people to visit and look after the sick at home, and in other initiatives outside the hospital. They thus contribute their experience while receiving a broader vision of the human and Christian ministry of healing.

The Health Care Ministry is, then, serving as a concrete channel for a renewed interest on the part of CHPS members in the patient's family. The Christian community has provided them with numerous opportunities to meet with relatives of elderly, chronic, terminal, psychiatric, drug-addicted, and AIDS patients, among others. And in these encounters, taking place in a climate free from the hierarchical connotations existing in relationships among professionals, patients, and their families at medical facilities, they have been able to hear a detailed account of these families' human and social situation, along with an enumeration of their multiple and serious problems. And they have also been able to perceive the enormous therapeutic potential which the patient's family possesses when it knows to be just that.

All of this, plus the results of reflection by CHPS members, is clearly reflected in the conclusions offered below. I invite the reader to consider them carefully, and add no other comment, except, if anything, to provide a last piece of information. These conclusions, joined to the reflection and work of other Christians devoted to the health care apostolate, have contributed to the publication of the *Charter of the Rights of the Patient's Family*, prepared by the health ministry teams of the dioceses grouped together in the Ecclesiastical Province of Oviedo (cf. the journal *Labor Hospitalaria*, no. 212, 1989, pp. 161 seq.).

In this way, what John Paul II requested in the Encyclical *Familiaris Consortio* is gradually being carried out:

"An even more generous, intelligent, and prudent pastoral commitment, after the example of the Good Shepherd, is needed in regard to families that are going through difficult situations. In this respect, attention must be called especially to some with greater need not only of assistance, but of more incisive action affecting public opinion and, above all, cultural structures. These are, for instance, the families with handicapped or drug-addicted children, the families of alcoholics, the elderly, forced not infrequently to live in solitude or without adequate means of subsistence, the painful experience of widowhood, of the death of a relative deeply mutilating and transforming the family's original nucleus.... Lay specialists (doctors, social workers...) can offer no small help to families..." (*Familiaris Consortio*, 77, 75).

Summary of Work by the Groups

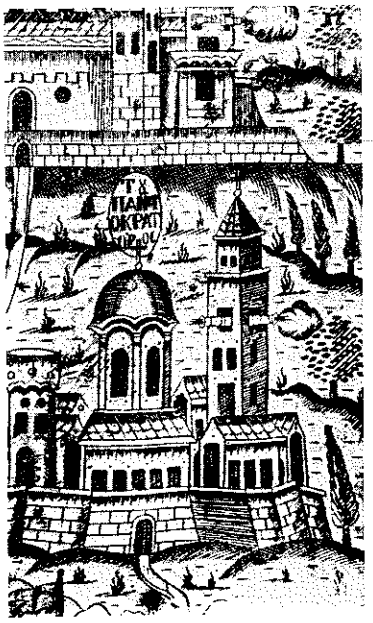
The Family of the Sick Child

1. *Behavior Generally Adopted by the Sick Child's Family.*

* We detect certain general tendencies in behavior classifiable in two mutually exclusive categories: 1) relatives who trust the health professional and 2) relatives who do not trust him, make unreasonable demands, or try to bargain with him for better care.

* There may also be differing attitudes if the patient's family contains nonbelievers or practicing believers.

* Other behavior patterns (such as anxiety, impatience, abandonment, collaboration) may depend on the greater or lesser clash between the family's values and those of the Christian professional.



2. *The Role the Sick Child's Family Can and Should Play.*

* The family has the responsibility or role of accompanying its sick member — it is a right and a moral obligation. The family must avoid the transferral of its responsibility.

* The family must realize that the primordial place where certain illnesses should be treated is the home, one's habitual environment.

* The family must behave in such a way as to avoid increasing the child's anguish and fear by manifesting its own anguish.

3. *Action by CHPS Members to Promote Recognition of the Family's Role and to Help to Carry It Out.*

* Teamwork is fundamental.

* Require authorities to recognize the family's role in the process of illness and make decisions in this regard.

* Detect whether there is excessive transferral of responsibility by the family to the health professional and set up mechanisms to correct deviations.

* Make the family aware of its rights and duties, stressing its rights.

4. *CHPS Action Towards Integral Attention to the Sick Child's Family.*

* Continuing education of the health professional (including the physician) is needed on the sociology, psychology, ethics, and values of illness to augment the control of human quality.

* The model of Jesus must be put into practice as regards families and other health professionals.

* We must remember that the initial contacts among the patient, his family, and the health professional are essential for the smooth functioning of further relations among them. The health professional should be considerate and respectful.

* Criticism and differing views should not be feared if the Christian health professional defends a Christian or medical position regarding any problem presenting itself before an equal or a superior. We must trust Jesus in adversity.

* Visit the patient's family at home to detect possible deficiencies or medical, psychological, social, and spiritual needs, or simply to say, "Hello, friend! How are you?"

The Family of the Elderly Patient

1. *The Behavior Generally Adopted by the Family of the Elderly Patient.*

* We see two types of families: those where the elderly draw together all the members and those where the elderly are ignored. In reaching this conclusion the following factors are taken into account:

— The family's social situation — its social commitments, for instance.

— The economic situation of the elderly and their families.

— The way families view the elderly — they are not usually regarded as active members.

— The acceptance or rejection of illness by the elderly and their families.

— The loss of moral values and of the patriarchal conception.

— The area where the elderly and their families reside, be it rural or urban.

— The forms of dependence the elderly patient occasions in the family.

— Women's entry into the work force and consequent absence from the home for many hours each day.

— The family's ignorance of health care.

* The problematic of the elderly without a family must be considered apart. They are usually abandoned, particularly if preferring to remain at home.

2. *The Role the Elderly Patient's Family Can and Should Play.*

* Welcome the elderly patient and grant him full participation in the family.

* Its role is very important, for it knows the patient best.

* The health team, in collaboration with the family, should be helped to integrate the elderly into their surroundings, and the elderly should be helped to accept the assistance offered.

* Families should become aware, program, meet, and reach common criteria, adapting to the stage they must live through with the elderly and avoid the "itinerant elderly."

* Medical facilities should be used only in extreme cases.

* One should act on the basis of one's own experience and orient the family regarding the patient.

3. *Action by CHPS Members to Promote Recognition of the Family's Role and to Help to Carry It Out.*

* Draft a *Charter* of the rights and duties of the family of the elderly patient.

* Educate families in health care so they will be able to look after their sick elderly, facilitating the attention these require.

* Help family members to reinforce a sense of their obligation to care for the sick elderly.

* Help them to experience the closeness of God in pain and illness. Such help ranges from giving meaning to the patient's life and providing him with needed attention to comforting him in his moments of pain, along with giving Christian meaning to the family's situation as well.

* Impede a sense of resignation in the family. Our Christian charism must be present in our availability.

* Teach people to live out old age and live with the elderly.

* Always avoid paternalism.

4. *Action by CHPS Members Towards Integral Attention to the Elderly Patient's Family.*

* Theological, moral, ethical, human, and professional training.

* Possess and cultivate the virtues of availability, generosity, hospitality, welcoming, service, attention, humility, and concern for others.

* Coordinated work through a multidisciplinary team on which the chaplain, catechist, and others should be included.

* Integral attention to the family should be prolonged until after the death of the elderly patient.

Families of the Chronically Ill

1. *Behavior Generally Adopted by Families of the Chronically Ill.*

* There is an escapist approach wherein the family is afraid to face reality.

* There is a progressive abandonment of the patient which eventually becomes complete as a result of psychological exhaustion.

* Attitude of overprotectiveness and paternalism leading to a rejection of the patient and indifference.

* A lack of information and formation leading to a situation of rebelliousness and aggressiveness in regard to health personnel.

* Depression in the family, especially among the younger members, over illness.

* Rebelliousness or nonacceptance of illness on the part of the patient making the family's accompaniment difficult.

* Dehumanization and consumer values make the family-patient relationship difficult.

* Abandonment is less frequent when there is a mother-child relationship.

* Family members' self-pity relegates the patient to the background.

* As an exception we observe the help and support received by some patients, such as those who have had laryngectomies.

* Impotence and/or resignation, with variations depending on culture and religiosity.

* The patient's problems are solved if human values are not overlooked. We see that in rural environments acceptance of the patient is greater since there is a different conception of the family unit.

2. *The Role Families of the Chronically Ill Can and Should Play.*

* Organize themselves so as not to overburden a single family member, such as a sister or an unmarried daughter.

* Psychological education of both the patient and the family to accept illness.

* Economic aid when needed.

* Attention to limitations, providing support and protection, but augmenting the patient's possibilities and avoiding pity.

* Keeping informed and in contact with the health team; mutual collaboration should be authentic.

* The patient should develop awareness of the fact that he is ill and be helped to relate to other patients with similar characteristics.

3. *Actions by CHPS Members to Promote Recognition of the Family's Role and to Help to Carry It Out.*

* We professionals should be aware of the family's needs regarding medical therapy.

* We should join forces by forming a health team with other professionals.

* Health education at school should be augmented so that as children grow, their acceptance of pain and suffering will grow as well.

* There should be medical and psychological education of the family group to accept illness.

* There should be information on the rights and duties of the patient and the family.

* Talks and courses for the family should be organized.

* Economic, religious, and environmental aid in the tasks involved after discharge from the hospital.

* Reconciling overselves with the families of these patients.

4. *Action by CHPS Members Towards Integral Attention to Families of the Chronically Ill.*

* MEDICAL: adequate technical and human training; teamwork with our colleagues; motivation by way of our example.

* SOCIAL: participation by health personnel in medical education groups outside the hospital; there can be no integral care unless the way things are done in the outpatients' clinics is changed.

* PSYCHOLOGICAL: a capacity for listening; stimulation to overcome the barrier of an illness.

* SPIRITUAL: evangelize not only by word, but also, and above all, by deed; availability to help; teamwork with the hospital chaplains.

The Families of the Terminally Ill

1. *Behavior Generally Adopted by Families of the Terminally Ill.*

* Behavior depends on the type of illness leading to the terminal phase:

— If the patient is connected to a life support system, the family seeks a liberation.

— If the cause is acute — as with a heart attack, a traffic accident, or a cerebral hemorrhage — the family usually does not accept the situation.

— If it is a chronic or cancer patient, the family may have "adjusted."

* Depending on the information it receives, the family may be disoriented or afraid.

* The family's attitudes are generally:

— A lack of acceptance of the patient's reaching the end, as a result of insufficient information.

— Anguish, flight, and rejection manifested in the family's absence. In such cases death is seen as a liberation.

— Extreme overprotection and dedication.

— A conspiracy of silence which denies the patient information and even religious assistance.

— The family arrogates to itself such rights as calling the notary and asking for voluntary discharge.

2. *The Role Families of the Terminally Ill Can and Should Play*

* The family's role is irreplaceable. The family should participate more and be more active by:

— Accompanying, keeping pace with the patient.

— Helping the patient to assume death by his own act.

— Trying to discern and interpret the patient's wishes.

— Listening and establishing good "communication."

— Providing support, aid, and responsible love while respecting the right of the terminally ill.

— Getting full information on the state of one's relative.

— Being an integral part of the health team.

— Paying attention to all the patient's needs: hydration, hygiene, pain relief — in a word, offering quality of life by helping him to live, not to die, for the terminal patient is someone who goes on living.

— If the patient is a believer, by being a pastoral worker and sharing a common faith with him.

3. *Action by CHPS Members to Promote Recognition of the Family's Role and to Help to Carry It Out.*

* Personally recognizing the relative's role.

* Disseminating among health professionals the conclusions of the Meeting.

* Informing public opinion.

* Starting accreditation, quality control, and ethics committees at hospitals.

* Promoting the Charter on the rights and duties of the family.

* Helping the family to play its role.

* Providing the family with formation and information so that it can offer care contributing to a better quality of life for the patient.

* Favoring communication with the family.

* Providing psychological support.

* Being aware of the history of the patient's family environment and orienting the family to fulfill its mission.

* Letting the relative remain in the room when the doctor visits or nursing care is provided.

4. *Action by CHPS Members Towards Integral Attention to the Terminally Ill.*

* Home care:

— Medical: Coordination between the hospital and the primary care facility; a daily visit, or when needed, by the doctor and paramedic; palliative care should be offered; depending on the illness and the quality of life, it is sometimes better to hospitalize the patient.

— Psychological: Information on care, training, listening, and communication.

— Social: Get help on a full-time basis (by obtaining a work leave for a family member, for example), secure laundry and food services.

— Spiritual: Show respect and solidarity; if the family is Christian, it should feel accompanied by the parish community.

* Outpatient clinics: Health education of the population on the care and needs of the individual and the family when faced by terminal illness.

* Hospital care:

— Medical: An adequate environment, a single room for the patient and his family, the creation of units for the terminally ill.

— Psychological: Understand and accept the family's reactions, communicate, provide psychological attention to the family and the team.

— Social: Feel ourselves to be part of the family, promote volunteer work because the family needs a breather.

— Spiritual: Become aware of the fact that spiritual accompanying is the mission not only of the priest, but of all Christians; the religious assistance service should be present, along with attention respecting the patient's creed.

* Final conclusion: Christian professionals must be involved in creating groups to promote greater humanity.

The Family of the Psychiatric Patient

1. *Behavior Generally Adopted by the Family of the Psychiatric Patient.*

* A reaction of rejection in the face of the anguish caused by madness. This reaction is manifested in different attitudes: negation, minimizing or blaming the patient, and fear, which magnifies the importance of symptoms. A lack of interest, particularly with chronic cases, which is justified by family problems: "He's better off at the hospital." Overprotectiveness, especially with depressions and children.

* This negative attitude is improving, but much remains to be done. The family's shame over these patients has decreased more than its fear. Both attitudes depend greatly on the degree of training and information regarding these illnesses.

2. *The Role the Family of the Psychiatric Patient Can and Should Play.*

* The family has a very important role as a collaborator in both treatment and social rehabilitation. But in order for this role to be performed, it is indispensable to help and prepare the family, inform it so it can know and understand what is happening and take it on, and remove fears.

3. *Action by CHPS Members to Promote Recognition of the Family's Role and to Help to Carry It Out.*

* Make the family aware of its role in the illness and life of the patient. To this end family awareness groups can be created with families of psychiatric patients to provide information and exchange experiences.

* Foster family associations to inform other families — not just those affected — and press for the creation of needed resources, such as day hospitals, protected workshops, and intermediate care facilities.

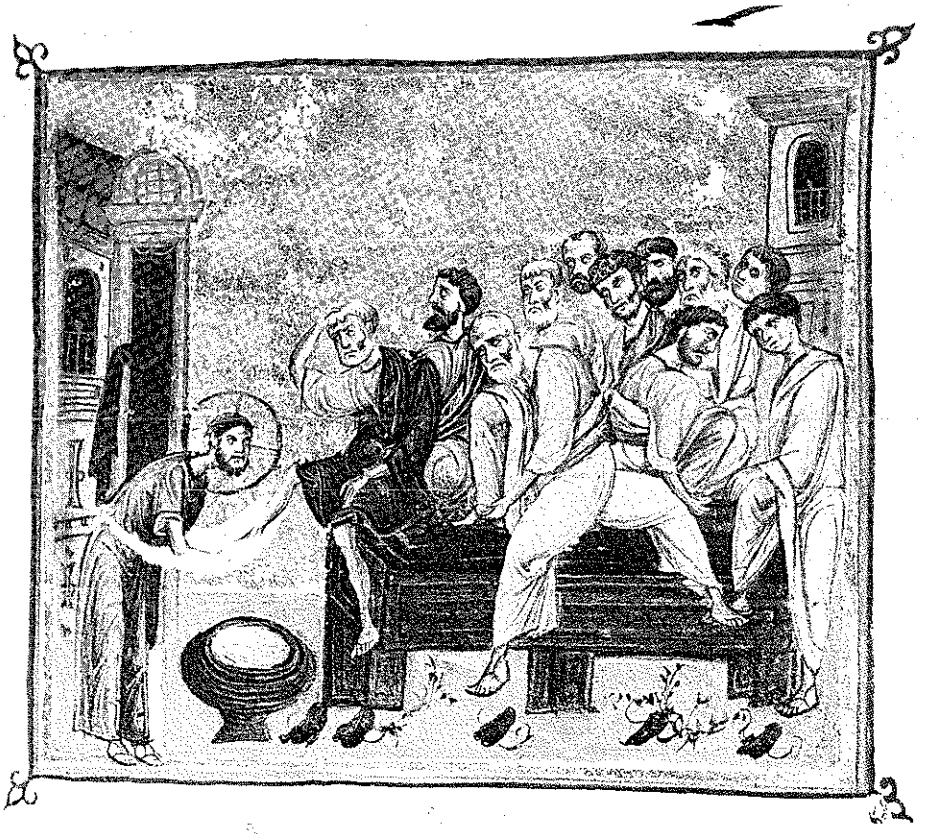
* Public campaigns with a twofold purpose: prevention, since any family may come to have a patient in its midst, and support for families affected.

4. *Action by CHPS Members Towards Integral Attention to the Family of the Psychiatric Patient.*

* The group observes two premises to be taken into account for all levels of assistance: 1) always regard the family as a subject of medical attention; 2) each professional should offer integral care.

* Home care: Make integral care a reality, for it is virtually nonexistent today.

* Outpatient clinics: Attention should not be limited to a "technical" examination of the patient, but should also include the family; interest should be



shown in the family and the way it is coping with the illness and collaborating.

* Hospital care: There must be greater cooperation within the entire health team: orderlies, nurses, doctors, chplains, and others.

— Health professionals should be trained for humanity in medical care at hospitals and clinics through seminars and talks.

— In this regard we take as our starting point the reflections by our first national Meeting, held at Espinar, which have been published.

The Family of the Drug Addict

1. *Behavior Generally Adopted by the Family of the Drug Addict.*

* Negation, fear, and concealment, especially with alcoholics.
* Rejection, feelings of shame and guilt.
* A readiness to punish.
* A lack of awareness of the illness.
* Impotence in the face of the problem and few solutions.
* Not realizing that the family is of capital importance for rehabilitation.

2. *The Role the Family of the Drug Addict Can and Should Play.*

* The family's role is basic. When the family is stable, there is a better chance the problem will be eradicated.
* When the family is characterized by economic problems, a lack of communication, neurosis, conflicts in the couple, and so on, family therapy is needed — awareness of the problem and analysis of the family situation.
* We observe the need for the family to be educated by both health professionals and other families with the same problem.
* There must be increased communication, motivation, and stimuli in the family. Abandonment must be replaced by love.

3. *Action by CHPS Members to Promote Recognition of the Family's Role and to Help to Carry It Out.*

* Make people aware of the problem.
* Maintain a broader dialogue with the addicts' families.
* Carry out health training and education.
* Be familiar with the different care facilities to inform relatives and send them to the right place.
* Increase family awareness in order to form family groups and demand from the authorities mutually coordinated facilities, relating a hospital's emergency units to its outpatient clinics, for instance.
* Volunteer dedication outside of working hours is needed to provide unselfish assistance.

4. *Action by CHPS Members Towards Integral Attention to the Family of the Drug Addict.*

* Medical care: Be receptive and create a climate of cordiality and confidence. Seek to make relatives comfortable with the means available to assist them. Look after the cleanliness and comfort of the facility, providing for an adequate waiting room.
* Spiritual assistance: Attend even those who are not Christians with charity. Bear witness. Unite as a human and Christian team to give our best to the family. A "utopia" would be to succeed in forming a Christian community.

People must be made aware of the need for volunteers to help families in their homes through the creation of teams at clinics and hospitals.

The Family of the AIDS Victim

1. *Behavior Generally Adopted by the Family of the AIDS Victim.*

* We observe abandonment by the families of infected children, especially if the mother is a prostitute or drug addict.
* Two positions appear in regard to the acceptance of these patients: 1) Family members closely observe the reactions to these victims by health professionals (a fact to be remembered is that relatives do not take the precautionary measures professionals do); rejection, concealment, and ignorance on the part of the relatives, who demand that all the patients' primary needs be taken care of by health personnel, not by themselves.

2. *The Role the Family of the AIDS Victim Can and Should Play.*

* Acquire more information and knowledge concerning the illness.

* Acceptance, affection, and complete support of the patient.

* Require government bodies, the Church, and society to provide resources for AIDS victims.

* Require health organisms to use the mass media to demythicize the taboo surrounding the illness.

* Collaboration among all health professionals.

3. *Action by CHPS Members to Promote Recognition of the Family's Role and to Help to Carry It Out.*

* A premise to be taken into account is that it is very hard to work with the AIDS victim because he has lost

confidence in the family and society.

* When admission takes place, family members should be given the charter of family rights and duties and be told about supporting the Barcelona proposal.

* A basic dialogue should be established with relatives to initiate a climate of trust when the patient is admitted.

* The family should be formed and informed. It does not matter who performs this task, but it must be performed.

* The family's irreplaceable role ought to be acknowledged at all times, twenty-four hours a day, not only when we need it for some assistance to the patient, but also when they "bother" us by asking questions.

* In some cases the AIDS victim rejects the family and we have to act as a bridge between them.

4. *Action by CHPS Members Towards Integral Attention to the Family of the AIDS Victim.*

* Love and accept them as they are and act towards them as we do with the relatives of other patients.

* Treat the family in an integral way — psychologically, economically, emotionally, and so on. Become members of the family.

* Formation and information: demythicization of the term AIDS.

* Proposal for next year's Meeting: create in all dioceses a detection and follow-up group for AIDS victims.

The Families of the Handicapped

1. *Conduct Generally Adopted by Families of the Handicapped.*

* Behavior usually involves rejection, pain, pity, and overprotectiveness.

2. *The Role Families of the Handicapped Can and Should Play.*

* Strengthen human values.

* Let the handicapped develop as persons.

* Let the handicapped do everything they can by themselves, acting to complement, not supplant.

* Counsel them to get in touch with other families with the same problem, create associations, or join those already existing to pressure the Administration for cultural, economic, and social aid.

3. *Action by CHPS Members to Promote Recognition of the Family's Role and to Help to Carry It Out.*

* Personnel should become aware of the family's importance.

* The family's rights and duties should be recalled and pointed out.

* Prevailing norms on the concrete needs of each patient should be softened.

* Form and inform relatives concerning the illness, its consequences, and types of assistance.

4. *Action by CHPS Members Towards Integral Attention to Families of the Handicapped.*

* A visit, a call, or a moment spent listening are very readily accepted by the patient and the family.

* Demonstrate by our attitude that they can count on our support.

* Tie in with multidisciplinary teams to achieve integral attention.

Testimony

Riccardo Pampuri

CICIAMS

Italian National Mercy Confederation and Fratres Blood Donor Groups

Camillianum

Riccardo Pampuri: A Doctor, an Apostle, a Saint for Our Day

"The holiness our time needs is simplicity and humility"

A. Meersch

1. Biographical Notes

* Riccardo Pampuri was born on August 2, 1897 in Trivolzio, Pavia. His baptismal name was Erminio Filippo.

* His mother died when he was three, and his father, when he was ten.

* In Pavia he completed studies in medicine and surgery

* In Pavia he was a member of the Catholic university circle and attended the St. Vincent de Paul lectures. In 1921 he joined the Franciscan Third Order

* In Moromondo he practiced medicine from 1922 to 1927, offering a brilliant example of charity and Christian life.

* On June 22, 1927 he entered the Order of St. John of God as a postulant at the house in Milan On October 21 he entered the novitiate, and on October 24, 1928 made his temporary vows

* He died in a holy way on May 1, 1930 at the Order's St Joseph's Hospital in Milan.

* He was beatified by Pope John Paul II on October 4, 1981 and canonized on November 1, 1989

2. The Forging of an Apostle

Pampuri's life, marked by great spirit and apostolic zeal, was forged in his home, where he observed the examples offered by his family:

* his mother, named Angela, was truly angelic in conduct and prompted respect;

* Carolina Bersan, the servant, greatly influenced Riccardo's life;

* his aunt Mary was a woman of immense faith and uncommon virtue;

* his uncle Carlo played a key role in building his character.

His uncle Carlo was decisive in forging Riccardo's hard-working nature, manners, bearing, and spiritual thrust — he served as a living example.

After these first steps in the home, living out virtue each day, little Riccardo started school. Nothing extraordinary was noted in him, except for the fact that he was a punctual, modest, collected, and respected boy.

At age nineteen, when in the second year of medicine, he was called to military service and assigned to the 86th Medical Section in a war zone His biographer, Giuseppe Gornatti, tells us that at this time "his comrades in arms at the field hospitals recalled him as constant in service, devotion, and especially attendance at Holy Masses, which were sometimes numerous, depending on the greater or lesser number of soldier priests."

His biographer describes the influence of his uncle Carlo in these terms: "Pampuri as a student, possessing before his eyes a pure heart and a constant example of great moral value in the person of his uncle, kept the fruits acquired during the years at secondary school and the university."

After finishing military service, he continued study at the University of Pavia, taking advantage of this time to earn a degree in medicine and exercise virtue as well. Effort, overcoming obstacles, and the aspiration to greater perfection were the constant orientation reflected, above all, in the letters he sent to his sister,who was a nun (Sister Longina Maria). Let us examine some passages

"I am in the final hours of this year, and in going back over this fading year, to the others which passed, I feel overwhelmed by much — too much — remorse over the inadequacy of my response to the unlimited graces Divine Mercy has granted me and on account of the many — too many — acts of ingratitude I have met them with.

"And yet how much indifference and coldness there are on the path of goodness! I feel the emptiness of many things, grasp the evil of many others, but in practice the slightest sacrifice becomes burdensome to me, fulfilling my duty becomes oppressive, and will power does not always suffice to carry it out. I pray, and in prayer and the Holy Sacraments I find great consolation and true peace, but shortly afterwards strength abandons me and the painful struggle returns between awareness of duty to be done and remorse over not having done it until, when the latter prevails, I put all my good will into it and recover lost peace. How I envy you, dearest sister, in your serene peace! Pray, pray always for me, who so trust in your prayers to obtain from Divine Providence and infinite Goodness a holy peace in His holy grace for the new year and all the remaining ones of my life" (December 31, 1918).

"I hope Divine Mercy will want to grant me a bit more strength, especially in constancy, so that I can continue along the good path, and you will surely not refuse me your good prayers to obtain such a necessary grace for me" (March 29, 1920.

"And you, dearest sister, who always recall me with such affection, pray a lot so that this year, which should be the last of my

studies and the first in my professional life, I may attain such strength in our faith — so lovely and so holy — that I may finally be able to emerge from a life of sterile desires and vain aspirations to initiate another truly fruitful in works which, in rendering proper praise and thanksgiving to God, will make me more joyful and happy in the serene peace of his holy friendship" (December 31, 1920).

"Now I am also your brother a bit in the spiritual order, for, though unworthy, in the hope of becoming somewhat better, I have placed myself as well under the protection of the Seraphic Father St. Francis, enrolling in his Third Order" (August 5, 1921).

"Unfortunately, I am always inconstant and easily let myself be overcome by a wretched inertia which frequently makes me neglect good and waste a lot of time which could be employed in such a valuable way. So pray always that I may reach perfection once and for all, especially by the constant, active fulfillment of my daily duties, in an increasingly profound spirit of piety, with ever more ardent love for Jesus Crucified, to bear patiently and joyfully the little, continuous crosses of each day accustoming us to greater mastery over our passions and preparing us for greater sacrifices.

"Also pray for my patients, so that with the help of God I may provide them with true relief" (April 20, 1922)

"You show great confidence in my work of religious propaganda alongside my patients, but unfortunately the flame of my charity is too weak to be able to communicate its own warmth to others; I always feel very weak and overly attracted by material concerns, in spite of the fact that I understand their useless vanity; only with an effort and very slowly do I think of those supreme spiritual goods to which I should aspire as the only necessari ones, with invincible ardor.

"Love for God and one's neighbor is so beautiful, and the reward following upon the exercise of the Christian virtues, so great, here below as well, with peace of soul and spiritual consolations! But our corrupted nature, which makes itself felt so, and the continual obstacles of the devil and the world render me too insensitive to such inestimable treasures, too inactive in obtaining them" (April 28, 1923).

In all his letters there is a passionate display of tenderness, simplicity, and memory. They are like a mirror reflecting his spiritual bearing, progress, and constant aspiration to virtue That was his sign and expression, as his teachers and classmates grasped, for his figure stood out among them. Their recollections include the following:

* he was pure and was widely recognized as such;

* he was also reserved in his external appearance; his companions recall his clean gaze, his modest face, and his unaltered voice;

* he was extremely diligent and serene and never lost his temper; this quality gave him notable moral authority over others;

* he was pious, orderly, and unostentatious;

* he always made himself respected without being dominating, and since he was seen to be sincere in religious life, his prestige was immense;

* he was convinced about working for the sake of duty (that is why he studied) and also about the obligation to pray (he was thus decidedly Christian in his life);

* when word spread among his medical colleagues that he had entered religion with the St. John of God Brothers, the news caused no surprise: "We all commented that he had to end that way."

3. An Apostle for Our Day

Riccardo, having been forged in such a lofty school and having gained exercise in such basic virtues, was better prepared now for dedication and an apostolate among his own people, a subject appearing very concretely and consistently in connection with his medical practice in Morimondo for some six years.

"In caring for the sick he was an exemplary model," one of his biographers says. He was always well disposed and responded to calls, no matter how untimely they were; he took no note of the hour and visited the most seriously ill more frequently, up to three times a day.

Another index of the appreciation and esteem the young people of Morimondo had for him is found in their repeating, when they heard abaut his entry into religious life, "We'll find other doctors, but we'll never again have a brother like Dr Pampuri."

To his apostolate as a physician we must add his apostolate in the parish and among young people and his love for the missions.

He always demonstrated a great spirit of service and was a good organizer. When adoration of the Eucharist was introduced in the parish, there was Riccardo organizing and helping the young to participate, with himself at the forefront, for he was never absent from the ceremonies held

He devoted time to young people when visiting patients at their homes, since, though healthy, they nonetheless needed some counsel. For this reason they talked a lot about the doctor in their homes — he practiced what he preached.

He also oriented many of the young towards a spititual renewal of their lives, leading them to make the Spiritual Exercises; and when he felt there were difficulties on the part of parents or on account of work, he himself did his best, visited the parents, took on responsibility for the families' needs; in short, he went out of his way to have the young people of Morimondo go to a set of Exercises

His love for the missions was also concrete and practical; he devoted himself to mission action, not only dedicating part of his earnings from his work, but offering his personal efforts for mission organization in the parish.

Another example of his apostolic style is manifested by a certificate conserved in the Postulation Records coming from the international Franciscan organization to benefit lepers in which he is thanked for his sympathy and valuable cooperation and is thus granted a diploma as a founding member.

In addition, he felt great joy when participating in the Genoa Eucharistic Congress, which he describes in one of his letters to his sister Longina; on the back of one he wrote,

"My Jesus, You called me to Genoa as a believer.

"Make me return as an apostle To love You and make You be loved."

A piece of testimony clearly displaying the apostolic character of Pampuri was sent to the Postulation by Fr. Cherubino Facchinetti, O F.M., who states,

"I am pleased to be able to affirm that I always esteemed it as a special grace of the Lord to have met the young Erminio Pampuri, surgeon, and to have enjoyed his kind, edifying conversation He always talked about spiritual things. He often spoke to me about his religious vocation and wished to realize it as soon as circumstances permitted

"In practicing his profession, the great charity burning in his virginal heart appeared luminously; it made him solicitous in assisting, lovingly caring for the sick, around whom with exemplary prudence and delicacy he conducted a true religious apostolate

"The benefits he received from the medical profession were shared by him with poor patients. He had often secretly given me sums of money to be kept for him which he later devoted to the Catholic Missions among non-Christians.

"I cannot pass over his deep faith and very profound love for the Sacrament of the Altar. Several times I had to shake and call him to separate him from his prolonged visits and adoration before the Holy Tabernacle, and he would apologize for having kept me waiting."

4. Until the End (with the St. John of God Brothers)

Pampuri could have stayed in his little town of Morimondo, with his people, his parish, the young, acting as a rural doctor close to families and children — a doctor of bodies and souls

But the Lord's call to a religious Institute pursued him. In several letters to his sister Longina he manifests this desire, stating the following in the one written to her on September 5, 1923: "At the close of last month, after a week of Spiritual Exercises, I made the decision to enter the Order of the Jesuit Fathers, but the unfavorable medical opinion closed the way for me, just as I had already suspected."

He would try again four years later, specifically at the Hospitaller Order of St. John of God, on June 6, 1927. In a letter addressed to Fr. Zaccaria Castelletti, Provincial of Milan, he requested acceptance in these terms: "Following your advice and trusting completely in the help of Divine Providence, I write you to ask to form part of the Order of St. John of God"

The decision must not have been to the liking of his family, as we gather from another letter he wrote the same day to his next-of-kin: "I must apologize most sincerely for the serious disorder occasioned by my decision. As for me, I hope, by the Lord's grace, I have made this decision with purity of intention"

After entering, he wrote to his sister: "The Lord, who is granting me such a grand and beautiful grace in calling me to religion, where the rain of His graces and blessing is so abundant, will not fail to complete His work and lead me in such a way that I shall come to be a good brother and the joy and peace I so desire will shine in me"

After a year of novitiate he made his temporary vows in Brescia, on October 24, 1928. His life continued to be simple, but made an impact on account of his humility and charity. His prayer and union with God were constant, and his activity in the dental service at Brescia was exemplary; he did all he could for the poor, above all. His charity was tireless, and the esteem of the inhabitants, immense. He died a holy death in Milan on May 1, 1930, fragile in body, but great in spirit

The extraordinary and surprising was surely not to be found in Riccardo Pampuri; his life was made up of the simple, the everyday, and the consistent, but lived out in depth, in faith, and in mystery. That is why he came to be extraordinary, sublime, striking, holy.

Pope John Paul II, in the address delivered on the day of Pampuri's Beatification, October 4, 1981, said,

"The figure of Blessed Riccardo Pampuri, at age twenty-four a municipal doctor and at thirty a religious of the meritorious Hospitaller Order of St. John of God, is extraordinary, close to us in time, but closer still to our problems and our sensibility.

"The short, but intense life of Brother Riccardo Pampuri is a stimulus for the whole People of God, but especially for the young, for physicians, and for religious.

"To today's young people he addresses an invitation to live out Christian faith joyfully and valiantly, constantly listening to the Word of God, generously consistent with the demands of Christ's message, in giving oneself to one's sisters and brothers.

"He calls physicians, his colleagues, to develop their delicate art with dedication, animating it with Christian, human, and professional ideals so that it will be an authentic mission of social service, fraternal charity, and true human promotion.

"Brother Riccardo recommends to men and women religious — especially those who carry out their consecration in humility and hiddenness in hospital wards and long-term facilities — that they live out the original spirit of their Institute, in love for God and for their sisters and brothers in need."

Fr. JOSÉ L. REDRADO, O.H.
Secretary of the Pontifical Council for Pastoral Assistance to Health Care Workers

CICIAMS, an Association Active in the Church and the World

The problems posed by health, illness, suffering, and the very meaning of life touch man and the family in their totality in every country in the world.

In the Church's millenary tradition, interest in and understanding for the sick and suffering have been constantly present, witnessed to by the history of the great hospital institutions of the religious orders consecrated to the care of the sick and by missionary activity contributing to health in developing countries.

John Paul II, in his Encyclical *Salvifici Doloris*, recently gave us a precise teaching so that in the world of health, today markedly secularized, Christians may continue to maintain the concepts of charity and compassion which have been proper to the Church through a meaningful presence in action and thought.

The pastoral function for health care problems and persons threatened or stricken by illness and suffering is clearly present in the local Churches. The Bishops' Conferences in a growing number of countries have constituted Commissions or specialized sections for pastoral care in health.

CICIAMS, the Catholic International Committee of Nurses and Sociomedical Workers, founded in 1933, is a federation of Catholic professional associations grouping together on a national level the personnel engaged in care (nurses, sociomedical workers, midwives, and so on), both religious and lay. The CICIAMS Statute (1972), approved by the Holy See, describes the goals of its action as follows:

* to encourage in all countries the creation and development of Catholic professional associations with a view towards ensuring moral and spiritual support of Catholic nurses and social-medical workers while promoting the improvement of their technical competence;

* to coordinate, with respect for the autonomy of each, the efforts of the Catholic professional associations, for the purpose of studying and representing Christian thought in the professional domain of nurses and social workers;

* to cooperate towards the general development of this profession and promote health and social action in keeping with technical progress and Christian principles, thereby ensuring a dignity and a level of health to which every human being has a right, with respect for his convinctions.

Today CICIAMS groups together about seventy national associations. It has instituted five regional secretariats, for which international vice presidents are responsible. The international president, elected every four years, is currently Richard Lai Pong Chong, a Malay, who previously served two terms as Vice President for the Asian Region.

Since 1978 the General Secretariat, like those of other Catholic international organizations, has been located at the Vatican (Palazzo di San Callisto); the Secretary General is an Italian woman, Liliana Fiori. According to the statutory protocol, CICIAMS has an Ecclesiastical Advisor, Fr. Joseph Joblin, S.J., named by the Holy See in 1982.

The President of CICIAMS is a member of the Pontifical Council for Pastoral Assistance to Health Care Workers and the Ecclesiastical Advisor is a Consultor.

Since 1947 CICIAMS has been a member of the Conference of Catholic International Organizations. But after a few years, grasping the importance of being close to the international agencies concerned with health-social action, it requested and received consultant status from WHO. It was thus registered with the Economic and Social Council of the United Nations and entered the UNICEF Advisory Committee; finally, in 1957, it initiated official relations with the International Work Organization.

CICIAMS' Commitment Today

In a message sent to our member associations on the eve of the Synod on the Laity, our Ecclesiastical Advisor invited them to return to the orientations adopted at CICIAMS' international meetings in recent years.

* Our associations group together health care workers concerned about fulfilling their responsibilities as Christians better in professional life.

* For a Catholic professional activity is the preferred means of participating in the work of evangelization.

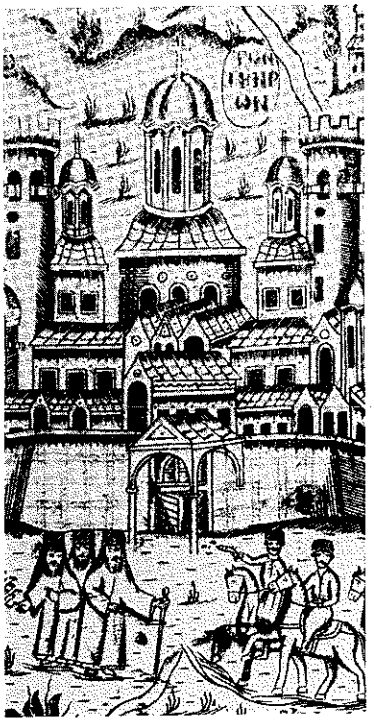
* The professional associations, grouped together in CICIAMS, ensure an organic presence of the Church in society.

* The existence of associations of Christians in the professional field should enable them to act responsibly in the structures guiding development.

These orientations and lines of conduct must be situated in the reality of culture, society, and, particularly, the health care world of today. The technological era no doubt offers enormous possibilities, but it threatens to take from man the savor and joy of existence, gratitude, and respect for life.

There is a change in mentality regarding illness, suffering, and death. The tendency to negate the sacred right to life finds support in the mass media. Man, like things, becomes manipulatable, an instrument of production and consumption.

The "bitter fruits" of such thinking — the Holy Father observed in October 1987 before the Association of Italian Catholic Health Care Workers — are already present: legalized abortion, euthanasia, genetic manipulation, experiments on human embryos, in vitro fertilization, psychic violence, and so on.



Health personnel finds itself in the heart of the problem and decisions characterizing our time and the development of medical care. CICIAMS wishes to encourage and sustain Catholic personnel so that it will fully assume its responsibilities as laity in the Church and the world today through:

* ethical training which is continually stressed and remains faithful to the Magisterium of the Church (the text entitled *Ethical References and Principles for Action for Catholic Nursing and Obstetric Personnel* was adopted in June 1988);

* solid Christian formation based on listening to the Word of God and sacramental life to be capable of remaining faithful to Baptistm and available for service to priests and religious in bearing witness to our Faith in varied and often difficult existential situations.

* promotion of a health policy which is positively respectful of life, defending and exercising the right of our associations to be represented locally, nationally, and internationally.

Italian National Mercy Confederation and Fratres Blood Donor Groups

The voluntary association I am honored to preside over and direct, the Italian National Mercy Confederation, appeared in Pistoia on August 23, 1899. It appealed for unity and took as its motto "United in Charity." The Mercy members assembled in Pistoia desirous of getting to know one another and seeking coordination so as to work together more effectively and spread the Gospel message.

Since that day, ninety years ago, the Confederation has continued on its way amidst varied difficulties, promoting and protecting the rights of the Mercy members throughout the country.

On June 14, 1986 the Holy Father granted us an audience, where we were guided and introduced on behalf of the Italian Bishops by the Most Reverend Giuliano Agresti, Archbishop of Lucca, and on that occasion John Paul II traced out our new face specifically in his address while giving us concrete tasks, to which we want to be and to remain faithful.

We have called this turning-point a "new course." We wanted this new course and this new task to be sanctioned in the preamble to the new confederal statute, unanimously approved by the Mercy National Assembly on June 3, 1989.

"The Confederation intends to make its own the message which the Supreme Pontiff John Paul II entrusted to it at the audience of June 14, 1986, marking a new historic course for the Italian Mercy members on the eve of the third millennium. The Confederation also intends to act through studies, meetings, and training schools to achieve the 'Civilization of Love' which the Pope has entrusted to its members."

Operative Situation

The Confederation gathers together over 450 Confraternities and 360 Fratres Blood Donor Groups in 60 Dioceses.

All told, about 600,000 members work with over 1,500 motor vehicles.

Services are the most highly varied and arise from the different needs emerging. The main ones are:

* medical and social transportation;
* blood and organ donation;
* civil defense;
* administration of specialized clinics;
* administration of rest homes;
* administration of dialysis facilities;
* home care;
* care for the elderly;
* care for hospital patients;
* care for prisoners;
* care for drug addicts;
* care for the handicapped;
* family consulting;
* crisis center.

Mercy Members in Other Countries

This large charitable movement, which appeared in Florence in 1244 on the initiative of St Peter the Martyr of the Dominican Order, first spread through Tuscany and then into other Italian regions and abroad.

Mercy Members in Russia

Last year we got in touch with the Soviet members.

The promoter and animating force is the writer and member of parliament Daniel Granin, who states, "In recent times we have received visits from the representatives of charitable organizations in the United States, Japan, and Poland. We are very interested in foreign experiences. We are, however, convinced that the Italian members are really closer to us on account of our spiritual ideals, the concrete affirmation of love for man, and their activity based on the humane, unselfish principles of Mercy."

The writer Granin was our guest in Italy, and last year at Palazzo Vecchio in Florence an embrace of peace took place with the President of the Fatima Mercy branch and of those in Portugal.

Contact in person and by letter is constant, and the Russians themselves asked for close cooperation in terms of training as well through the sending of our experts to the USSR and visits by their young people to our headquarters.

At present Russian Mercy branches exist in 85 cities, ranging from Leningrad to Moscow, from Samarkand to Alma Ata on the Chinese border. Members work at hospitals and in care of the aged.

Mercy Activities in the Rest of the World

As regards Europe, in Portugal alone 388 are functioning. From Lisbon they have spread to all Portuguese-speaking countries in Africa, Asia, and Latin America. In Brazil alone there are more than 1,000. Mercy activities are also known to exist in Spain and the Principality of Monaco.

In view of the foregoing, it is clear that both national and international problems are multiple, complex, and rather significant,

If we wish to follow the new course recharted by John Paul II, we need help and deem it necessary to request the following.

1) That the action of our association, both nationally and internationally, should be carried out in collaboration with and with the approval of the Pontifical Council for Pastoral Assistance to Health Care Workers.

2) Article 33 of the new confederal statute states, "The confederation has its own Spiritual Advisor or Corrector. He is appointed by the ecclesiastical authority having jurisdiction."

We feel it is necessary for a Bishop to be named Advisor so that he can deal with relations on all levels and provide precise orientations in particular.

3) Assistance in ascertaining whether there are movements similar to ours in different countries in order to be able to organize an international meeting on our problems as soon as possible and seek joint solutions to them (especially as regards the Eastern European countries), and to provide an occasion for encounter.

4) The journal *Civilization of Love* is meeting with success on account of its content and direction giving an exact "image" of our movement, also engaged in involving the Confraternities for worship in the social sphere. The journal's efforts center on causing society to be seen through new eyes and summoning men of culture by this means to construct together the "civilization of love" which the Holy Father has entrusted to us that we may promote and build it.

Economic problems are a source of concern, as we lack advertisements, but they have been promised for the near future.

These are our main immediate problems, renewed each day; in a certain sense, then, there is a constant flood of needs and ideas. Continual contacts with the Pontifical Council for Health Workers would be a valuable reference point for us.

FRANCESCO GIANNELLI

CAMILLIANUM

International Institute for the Pastoral Theology of Health Care

This report is divided into three parts: a brief historical account, an evaluation after two years, and prospects and commitments for the future

1. Brief Historical Account

The creation of the Camillianum has a precedent which to some degree has given it grounding and support: the existence of Camillian centers devoted to this field in different provinces of the Order. In all instances, such experiences display the Order's sensitivity to culture and provide encouragement for even more incisive choices.

These were local experiences, however, at times arising on the initiative of an individual. The first attempt at constituting an institute for the pastoral theology of health care on an interprovincial level goes back to 1976.

Among other factors, the following ones have played a specific role in the process of bringing the idea to maturity: the publication of *Salvifici Doloris*, the creation of the Pontifical Council for Pastoral Assistance to Health Care Workers, whose President, Archbishop Angelini, has always encouraged us, and, closer to us, the existence of the Monte Mario Institute, created by the Roman Province, on the basis of which the Camillianum appeared.

The Camillianum was approved and academically erected by the Holy See on April 28, 1987, and its statutes received *ad experimentum* approval for a five-year period.

* August 17, 1987: Fr. Domenico Casera was named Dean of the Camillianum for a two-year term by the Congregation for Catholic Education.

* August 31, 1987: The religious Emidio Spogli, Francisco Alvarez, and Gianni Dalla Rizza were appointed, respectively, Assistant Dean, Secretary, and Administrator of the Camillianum by Superior General Calisto Vendrame.

* October 19, 1987: In the students' church of the Roman Province the solemn concelebration to inaugurate the academic year took place, presided over by Fr. Domenico Casera. On October 21 classes began for the two-year program.

* November 7, 1987: The official inauguration of the Camillianum took place. In attendance were the Superior General, Fr. Calisto Vendrame; the Prefect of the Congregation for Catholic Education, Cardinal W. Baum; the Cardinal Vicar Ugo Poletti; Cardinal Paul Zoungrana; Archbishop Fiorenzo Angelini; the Dean of the Teresianum Pontifical Theological Faculty, Fr. Federico Ruz; the Prior General of the St. John of God Brothers, Fra Pierluigi Marchesi; and the Superior General of the Sisters of the Sacred Heart, P. Menni. The inaugural address was delivered by Dean Casera.

2. Evaluation after Two Years

Still in an experimental phase, the Camillianum has obviously not yet reached cruising speed. Evaluation is thus utterly necessary. The indications and suggestions emerging from the six faculty meetings which have been held until now have been quite useful. Representatives of the students also participated in three of them.

In the expectation that the evaluation programed for the end of the academic year can be effected, I here offer some elements for discernment and comparison.

1) *Physical plant*

There is general agreement, on the part of students as well, in acknowledging the suitability of the premises and the beauty of the place where the Institute is located. The whole physical plant (furniture, classrooms, library, office equipment, etc.) also warrants a favorable judgment. For current needs, the capacity of the premises is sufficient.

2) *Curriculum*

The life, development, and future of an institute depend in large measure on its curriculum. This was, in fact, the topic occupying most of the attention and discernment of the commission created to initiate the Camillianum. The curriculum is always the reference point for discussion and exchanging views when it comes to examining and further specifying the Institute's global orientation. It was approved, along with the statute, by the Holy See.

The study plan seeks to implement and disseminate the Institute's aims. To reach goals, the program has attempted to stress at the same time doctrinally forming and pastorally equipping the student, bringing theoretical and practical moments into harmony, integrating the different sections (without losing an interdisciplinary character) into a unitary plan, and the student's specializing in a discipline which has still to be invented and delved into on a concrete level — the *Pastoral Theology of Health Care*.

3 *Faculty*

The make-up of the faculty can be seen through the following data, which include both the two-year academic program and the two-year updating program.

* Total number of professors 44
* Those who have taught or will teach this year 41
* Camillians (belonging to seven provinces) 17
* Nationality of professors: Italy, 36; Spain 3; Austria, Brazil, Germany, France, and Israel, 1
* Religious (17 Camillians, 2 Carmelites, 1 domenican, 1 Jesuit, 1 St. John of God Brother) 22
* Diocesan priests 7
* Lay people (including two women) 13
* Ministers of Protestant denominations) 2
* Professors coming from the world of health or medical-social assistance 33

4. *Students*

The following data refer to the *two-year academic program* They were updated at the beginning of the second semester of this year.

— First-year students	
Ordinary	13
Special	14
Guests/auditors	10
	37
— Second-year students	
Ordinary	12
Special	9
Guests/auditors	2
	23
Total for the two-year academic program:	60
— Nationalities (Italy, 30; Spain, 8; Argentina, 4; Brazil, 3; India, 3; Colombia, 2; Austria, Australia, Chile, Germany, Malta, Peru, Poland, Portugal, Thailand, USA, 1)	16
— Religious Congregations	22
— Religious (including 13 Camillians)	40
— Diocesan Clergy	9
— Laity (including one Protestant)	8
— Members of Secular Institutes	3

Note: Between the first and the second year a dozen students discontinued their enrollment: some had received permission for a single year (or even for a semester); others were recalled by superiors for work reasons; others, for family reasons, and so on.

At the end of the academic year the Camillianum granted its first degrees in the Pastoral Theology of Health Care to nine students and diplomas to six others.

As regards the *two-year updating program*:

— First-year students	38
— Second-year students	36
	74

In addition to the language of data — at times quite eloquent — experience and discernment enable us to offer some elements for judgement:

* In general, the two-year academic students seem to be well motivated: class attendance is exemplary, and the commitment of many to going into the subject-matter and benefiting from practical training is praiseworthy.

* The international make-up of the student body results in cultural variety and heterogeneous levels of preparation. Average background appears to be rather solid, however, though in some cases there are deficiences (it should be recalled that the Camillianum offers its specialty in the second phase of theological studies): not all are equal to the Institute's specialized standards. The subjects presuppose common background in theology, Sacred Scripture, psychology, sociology, and so forth which not everyone possesses.

* Among students there is a growing desire to promote a sense of community and family spirit, with a presence at the Camillianum not limited exclusively to academic objectives.

* The opportuneness of following students' practical training more closely and promoting pastoral initiatives together with them is becoming increasingly clear

5. *Library*

As of March 31 the situation at the library was as follows:

* Books	3,408
* Division by subject-matter	
Biblical section	185
Theology section	462
Pastoral section	583
Psychology section	368
Sociology section	225
Moral section	372
History section	265
Spirituality section	216
Medicine section	202
Various (dictionaries, encyclopedias, etc)	165
Books from the Magdalene House	365
* Journals (titles)	82

Building up the library is one of the primary commitments of the Institute and one of the best services it can offer. It must thus be rendered truly international and endowed with the best specialized bibliography available in the major languages, a goal which for the time being is being attained for Italian and will soon be reached for Spanish, thanks to nearly three hundred volumes provided by the Spanish Province As for other languages, a good many works have arrived from the United States and some from Austria and Brazil, kindly sent by the respective Provinces. The library has also benefited from the books of the lamented Fr. Jean Jacques.

In regard to journals, we should stress the 22 titles in German from subscriptions offered by German and Austrian Provinces. Journals ara received free of charge as well from England, France, Spain, Brazil, Colombia, the Philippines, and Holland, paid for by these Provinces and Delegations

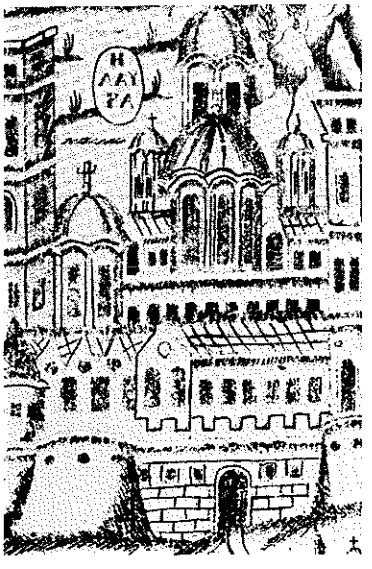
6. *Administrative team*

While waiting to constitute the organs provided for by the statute, the Camillianum is ordinarily governed by the administrative team made up of the dean, the assistant dean, the secretary, the treasurer, and the librarian.

In addition to the functions assigned to each by the statute, the administrative team has met on many occasions and at key moments for programing

Two members of the team have also taken on responsibility for editing the scientific journal (Fr. Casera) and organizing meetings/conferences during this academic year (Fr. Spogli), both assisted by a special commission. The first issue of the journal *Camillianum* will appear at the beginning of the next academic year; at the outset, one issue a year is planned on In regard to meetings, the first has been scheduled (May 26-27).

* Both the members of the administrative team and the Camillian professors have also honored their commitment to encourage the health care ministry, an important task of the Camillianum Clinical pastoral education weeks, lectures, teaching at other institutes or athenaeums, preparing the European Conference on Pastoral Care and Counseling (September 1989, Assisi), preparing the Symposium of European Bishops (October 1989, Rome) and the Diocesan Synod of Rome — these are some of the activities in which the Camillianum is directly or indirectly involved,



practically in every region of Italy

* The ordinary running of the Camillianum is quite demanding. The different areas of life and activity must be followed closely: only in this way can one intervene effectively therein, change course if necessary, discern adequately, expand projections, and promote initiatives.

7 *Publicizing*

Two years after the start of the publicity campaign, this is perhaps the field which most readily displays successes and deficiences.

The Camillianum is now known throughout the world, but by only a few Until the present there has been no skimping on publicity — on different occasions thousands of leaflets were distributed in seven languages; different Italian and foreign journals and newspapers have published reports; even Vatican Radio has often acted as its spokesman. From the indications supplied by students on the way they heard about the Camillianum, the means used seem to have been rather effective.

There are, however, some deficiences which must be stressed:

* certain personalized campaigns directed at the regional and national Bishops' Conferences have not yet been conducted (we hope to be able to do so in Latium, Italy, and perhaps Spain as well);

* there has not yet been a satisfactory response from the work environments where our people carry out their ministry;

* the publicity ensured by meetings and the scientific journal itself is still lacking

3. Prospects and Commitments for the Future

From this brief overview, and in the light of experience during these two years, certain guidelines and commitments emerge.

1. *The Camillianum belongs to the whole Order*. The Provinces' availability is, then, necessary.

2. The *Curriculum* should be revised in terms of the following criteria or needs:

* deepening and promoting the integration of theology and pastoral care, of doctrine and practice for adequate specialization;

* seeking greater balance among the different subject areas and sections of the program;

* making some disciplines cyclical so as to enable the Camillianum to enjoy the collaboration of Camillian professors who normally live in other countries;

* institute supplementary courses to be held in the morning to introduce students whose background is deficient to the basic concepts and language of certain subjects (Scripture, psychology, and sociology, for example).

3. *Cultural promotion*. The Camillianum is a challenge for the Order. The Church and society, in looking to the Camillianum, hope to find true specialists there. It is necessary, then, to create the means whereby professors may devote themselves to specialized research with professional rigor, each in his own subject, to publishing their writings, and to promoting culture in the world of health. The institution on the part of the Church of a *new academic degree* (the licentiate and the doctorate in the Pastoral Theology of Health Care) means granting recognition of the validity and academic status of the different subjects making up the curriculum.

4 *External projection*. In addition to becoming well known through regular classes and announcements, the Camillianum must create its own image for its contribution to promoting culture and evangelizing the world of health. Without neglecting the commitment to stimulate the health care ministry — as is now being done by the administrative team and Camillian professors on other levels — it is necessary to institutionalize as soon as possible:

* periodic meetings open to the local church, possibly in collaboration with other institutes or universities;

* periodic conferences and study days or weeks on a specialized level;

* reduced courses for lay professionals who cannot attend regular courses;

* short courses or study days outside Rome;

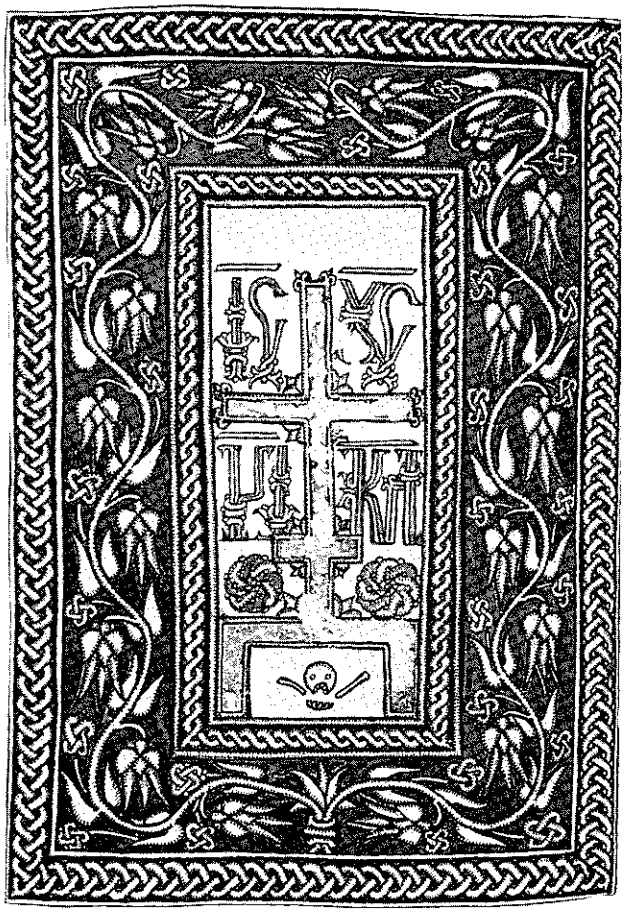
* publication of the scientific journal on a regular basis;

* preparation of audiovisual material and other pastoral aids.

5. *Students*. At the Camillianum all well-motivated students are highly esteemed. As for the two-year academic program, however, we must favor access by ordinary students and not lower admission requirements for special students. To this end it is indispensable to conduct publicity campaigns and send out leaflets from Rome.

Fr. FRANCISCO ALVAREZ, M.I.
Professor at the Camillianum

Activity of the Pontifical Council



Addresses Delivered

Chronicles and News from Meetings

The Second World Day Against Drug Abuse and Traffic June 26, 1989

On the occasion of the Second World Day Against Drug Abuse and Traffic proclaimed by the United Nations, the Pontifical Council for Pastoral Assistance to Health Care Workers, faithful to its aim of "stimulating and promoting the work of formation, study, and action carried out by the different Catholic international organizations in the health field, as well as other groups, associations, and forces which, at differing levels and in varied ways are active in this sector" (*Dolentium Hominum*, 6), is close to and supports all who, with exemplary generosity, devote themselves to the fight against drug abuse and traffic and to the recovery of their victims.

The rampant plague of drugs is most clearly manifested in a triple phenomenon: in the growing number of drug addicts, in the criminal narcotics trade, and in the serious lack of common commitment on the part of the community at all levels.

Drug abuse becomes a health problem only after traveling a long road — i.e., after having been a social problem amidst all others, under multiple aspects.

Our time, perhaps more than other periods in history, drives man to seek a modification of his own psyche which will enable him not to succumb in the face of fears, danger, insecurity, and the crisis in values.

In the fight against drug abuse and traffic, the moment of repression cannot hold priority or solve the problem by itself. Prevention, in turn, must become remote and rest on the unrenounceable principle of the supreme dignity of life and of the human person and then extended itself to defending the institution of the family, promoting adequate education and training in the home, at school, and in work environments. No prevention will be effective as long as the drug phenomenon is considered at the conclusive stage and not at the moment when it is originally, dangerously instigated. Alongside the most valuable effort to rehabilitate drug addicts, then, there must be widespread preventive action directed at individuals and institutions with a view to awareness of the phenomenon, operative intervention, and coordination of forces and initiatives.

Both positive laws and voluntary initiatives must be situated in this vast dimension. Furthermore, the institutions drawing inspiration from the Christian precept of love cannot ignore the fact that every illness in the physical order involves the psyche and the spiritual reality of man; every healing action must, therefore, rest on faith and the trusting remembrance of Christ, physician of bodies and souls.

The culture of death nourishing drug abuse and traffic must be replaced by a culture of life. Respect for the dignity of the human person becomes particular attention in the face of the person who suffers, who cannot and must not feel deprived of his basic human rights. Indeed, beyond the social, political, and economic parameters of the phenomenon of drug addiction, on a personal and collective level there is an existential crisis in ethical and spiritual values, the overcoming of which is the only real goal in the fight against drug abuse and even traffic. The essential question — as John Paul II states — remains that of "giving a meaning to man, his choices, his life, his history" (August 5, 1979). The Holy Father acknowledges, in turn, that "...drug dealing has been transformed into authentic traffic in freedom, inasmuch as it leads to a terrible form of slavery and sows corruption and death on earth" (May 13, 1988).

We cannot fail, then, to observe with admiring support the valiant efforts of the multiple association which, taking inspiration from love and manifesting the Gospel indication of the Good Samaritan in action and witness, work for the rehabilitation of drug victims according to a vision and project which, while seeking the positive side of suffering in a constructive way, look to the integral promotion of the human person, mobilizing increasingly vast energies and resources in the name of solidarity. Energies and resources which are not exhausted in the sphere of an exclusively earthly view of the human condition, but venture into the world of faith and transcendence.

The World Day against drug abuse and traffic for the Christian community is, first of all, a day of prayer to obtain from God, by the mediation of the Blessed Virgin, the strength for generous dedication which will make us effective promoters of preventive and curative action to deal with this dread plague of our time by way of concrete initiatives. Prayer, moreover, which will serve as a medicine and antidote for those experiencing the painful consequences of drugs, whom we seek to view as our brothers and sisters, children of the same Father and Lord of all mercy.

The World Day cannot and must not be exhausted in the course of its brief timespan, but should, rather, become a high point for continued bold action.

In this spirit of shared awareness and cooperation, the Pontifical Council for Pastoral Assistance to Health Care Workers wishes to celebrate together with all men of good will this World Day against drug abuse and traffic.

✠ FIORENZO ANGELINI
President of the Pontifical Council for Pastoral Assistance to Health Care Workers

Pharmaceuticals at the Service of Human Life

A talk by Archbishop Fiorenzo Angelini in Verona, Italy on September 25, 1989

Historians acknowledge that medicine is linked, in its origins, to both a magical-religious element and an empirical one. This ancestral conviction is bound up with primitive man's belief that the therapeutical virtues of certain herbs or drugs were gifts of the gods. Many ancient peoples had one or more divinities as protectors of medicines. Moreover, early medicine was precisely the art of discovering and preparing drugs. And since medicine and pharmacy on an etymological level reflect the instinctive need to conserve life, improve its quality, and prevent its decline as a result of illness, to speak of pharmaceuticals at the service of life is to assert an obvious truth, with the additional reason that there would have been and there is no medical progress without progress in pharmacology, i.e., the science concerned with the action of drugs on the healthy or sick organism, and pharmaceutics, concerned with producing them.

This first general principle on the relation between medicines and service to human life involves the recognition of certain other historically verified truths, such as the following: thanks to drugs, illnesses which at one time cut down entire populations have completely or partially disappeared; the use of pharmaceuticals has permitted enormous progress in surgery, contributing decisively to raising average life expectancy; people hopefully await treatments for still incurable diseases through the identification and preparation of new drugs. All of these observations serve to confirm the relation between pharmaceuticals and service to human life. However, this relation should itself be considered in the light of the complex problematics of our time in the field of medicine and health.

The underlying truths should be taken up, studied, and gone into more deeply in constant reference to the present moment. Indeed, if there is talk today of the need for a rigorous moral code for drug use and experimentation, along with production and distribution, it is because makind's state of health poses new problems calling for adequate and very frequently urgent solutions. This is why the permanent truth about drugs' being at the service of human life is today transformed into the following question: How do drug research, programing, experimentation, distribution, availability, and use respect the priority aim of service to life?

Personally, I have always regarded these questions as so important and urgent that when the Pontifical Council I am honored to represent and preside over organized its First International Conference, I felt it was appropiate to devote it to this subject, using the same title as that of my talk today.[1]

In addressing that International Conference, the Holy Father John Paul II spoke of the need to subject the elaboration, distribution, and use of pharmaceuticals to a particularly rigorous moral code "to be respected as the only means to keep the exigencies linked to the production and cost of drugs — in themselves legitimate and important for their dissemination — from diverting them from their meaning and end,"[2] which are precisely to be at the service of human life.

The relation between medicine and drugs is, then, one of cause and effect.

One can thus understand that the problems connected with pharmacology and pharmaceutics — especially the latter — go far beyond science alone and are situated on the level of an ethical vision of human life. An ethical vision which, while placing stress on the individual in the past, has immediate social implications today, since solidarity is the new name not only for constructive interdependence among peoples, but also for love for one's neighbor.[3]

It is commonly recognized today that the ethical problem relating to the use of discoveries is being posed with growing immediacy and urgency for every scientist and researcher. In the field of medicine and pharmacology, the morality of science is proportionate to its capacity to express itself in service to life and its dignity. Drugs, then, are such — that is, they represent a true *remedium* — only if produced and used to serve life. All life and the life of all.

The production and availability of pharmaceuticals in the world mirror the economic and social conditions of the different geographical areas. While rich consumer society is familar with the generalized use of drugs, the poorest countries and those which are developing daily experience an imbalance between the demand for medicines and their availability. The problem is not just economic and social, I wish to state that it is also a cultural and, consequently, ethical problem, since it collides with health education, the political sensitivity of public authorities to the priority demands of justice, and the scale of moral values.

The problem's ethical dimension, inherent in the very correlation between drugs and service to human life, is further illuminated if we consider certain current realities which the development of the media enables us to verify in their dramatic force.

In 1987, when invited to a meeting in Dallas in which 150 Bishops participated, not only from the United States and Canada, but also from some Central American countries, I was asked to open the Conference with reflections on "Preventive Medicine and High Technology in the First and Third World."[4] Now, if, when speaking of preventive medicine, mention is made of drugs, I feel it is worthwhile to reflect a moment on some contradictions deriving precisely from the insufficient and inadequate reference of pharmacology and, above all, of pharmaceutics to the primary value of life and its dignity. We

know that there are medicines which, particularly for commercial reasons, are not sufficiently studied. As a result, the treatment of certain rare diseases is dramatically delayed; in some areas — tropical zones, for instance — they attack masses of individuals. In my travels connected with the responsibilities of my post, I have often verified on a direct basis the existence and painful consequences of this situation. To the point that, in thinking of health conditions in not a few Third World countries, a bitter observation seems inevitable to me. Precisely from Third World countries afflicted with serious social diseases there arrive today in the First World illnesses such as drug addiction and AIDS which threaten to become social diseases here. This kind of mysterious genesis whereby the countries suffering the injustice of a lack of indispensable means of prevention and available therapies return the insult, so to speak, in First World lands by sending new illnesses whose origin is often linked to subhuman living conditions should favor the spread of a new sensibility leading towards greater international cooperation to reduce and eliminate these unjust differences.

The underlying problem thus reappears — the recovery and safeguarding of ethical and moral values (the first and foremost of which is service to life and its dignity) as the presupposition for organic development of science and health practice, particularly as regards pharmacology and pharmaceutics.

Pharmacology and pharmaceutics certainly cannot move from a utopian, unreal view of the human condition; they are called to deal with whatever concrete problems medicine may pose for them through research and development. However, in a world like the one in which we live, with a maximum degree of sharing, science and industry must also look to certain priorities, such as that of producing specific drugs aimed at combatting social diseases. "If men are the subject of development and the goal towards which it tends," the Pope writes in *Sollicitudo Rei Socialis*, "a broader sharing of progress and technological applications with the less technologically advanced countries becomes an ethical imperative of solidarity, as is the refusal to make such nations the proving ground for extremely doubtful experiments or a place to unload questionable products."[5]

Preventive, therapeutic, and rehabilitative medicine have received and continue to receive extraordinary aid from the contribution by pharmacology and pharmaceutics.

To the point that the perfection reached in dosages increasingly enables patients to become their own doctors. It is only to be hoped that greater health information and training — to which the pharmaceutical industry has contributed and continues to contribute in the part concerning it — will correspond in parallel fashion to the gradual disappearance of illiteracy and serious forms of generalized ignorance.

In any case, the problem of ensuring access by all to the most necessary drugs is an ethical imperative not only for public authorities, but also for programing by pharmaceutical manufacturers, which, though unable to dispense with economic considerations, must work at the service of life by respecting certain hierarchies of values in investment and in action to stimulate public authorities to support pharmacological research.

It is becoming increasingly common to speak of "humanity in medicine." I would say that such remarks are also valid for drugs, whose "humanization" is itself respect for service to life in everything concerning them.

I am not an expert in organizational psychology and thus cannot go into the merits of the possible approaches to analyzing the forms of organization structuring laboratory research and drug programing, production, and distribution. But we cannot overlook the fact that the organizational model of the drug industry — much more than that of industries producing other consumer goods — must not be Taylor's conception of efficiency concerned only with maximum profit, but, rather, the human model of service to health and life.[6]

From an ethical standpoint, this dimension brings out a series of problems which go beyond those strictly linked to science and research, since they require a philosiphical, political, and economic vision of society, with relative responsibilities regarding political power, economic forces, the use of resources, the destination of investment, and, for someone looking to the service of man from a Christian point of view, the very credibility of ethics and social morality. I want to state and stress that there are problems demanding that we recall ethical and moral principles enabling us to evaluate and formulate them properly in order to reach correct solutions. There are others requiring further reflection, deliberate expectation of the goals of research. For both types an ethical and also Christian vision does not represent an impediment or obstacle, but rather a stimulus and incentive to focus on the primary, priority aim of medicines with increased sensibility. This sensibility can neither halt not delay the progress of pharmacology in all its branches, but instead favors and accelerates it.

An initial problem of a clearly ethical nature is that of collaboration. In general, I feel it can be acknowledged that quite often medicines and effective biological preparations are not the best means in every sense. Hence the pharmaceutical industry's broad responsibility to devote part of its resources to discovering drugs and vaccines which will guarantee to the utmost preventive and therapeutic benefits in proportion to undesirable side-effects.[7] This goal can be reached much more easily through cooperation.

Without going into the technical aspects of the problem, I think we should seriously reflect on a rather singular fact, to say the least. It is asserted that "Europe not only was the cradle of modern pharmacy, but is still the most important pharmaceutical research and production center in the world."[8]

Well, up to and including today, "this industry is also the only scientifically advanced industry of strategic importance worldwide which has not benefited from the creation of the European Common Market," though the first norms in this regard go back to 1965. It is evident that this situation has had negative effects on the innovative potential of the European pharmaceutical manifacturers, for the additional reason that "the pharmaceutical industry represents an economic dimension and a source of wealth as well whose benefits for the Community are not limited to generating income directly. The drug industry in fact contributes to general well-being, too, through both its constant contribution to public health and stimulating effect on scientific and technological progress."[9]

The negative consequences — as regards respect for the principle of medicines at the service of human life — of this lack of interaction (not only operatively, but even normatively) are evident. It would suffice to recall the problem of ethics in drug expe-

rimentation. From the Nuremberg Code (1946) to the Geneva Declaration (1948), published by the World Medical Association; from the Helsinky Declaration (1964) to the Reccommendations, also by the World Medical Association, of Tokyo (1975) and Trieste (1983), there has been ongoing — and, I would say, exhaustive — development of the deontology of drug experimentation. In spite of this, "we are today witnessing a barbarous, unscrupulous resumption of experimentation in delicate fields such as that of human embryos and fetuses ...in a paradoxical situation from the standpoint of social ethics: the deontological norms exist, but the civil laws to guarantee their application are lacking, and there are human beings still exposed to illicit experimental procedures."[10] Not to mention the fact that, for her part, the Church some time ago clearly specified her doctrine on integral respect for human life in experimentation.[11]

Another very significant problem as regards cooperation is that of aid to developing countries, as we have already pointed out. But I shall not dwell upon it, since in this respect Italy is undoubtedly one of the countries wich have shown greatest sensitivity. The principle inspiring aid must be the one clearly enunciated by John Paul II: "The developed countries," the Pope states, "are duty-bound to make available to less developed countries their experience, their technology, and part of their economic wealth. But this cannot be done except with respect for the other's human dignity, never wishing to impose oneself. The protection of health is closely linked to different aspects of life, whether these be economic and social or have to do with the environment and culture."[12]

It is a not always a praiseworthy habit, especially when one is dealing with arduous and delicate problems from an ethical standpoint, to adopt attitudes which are so cautious that they even appear distrustful. But let me add that, in spite of the complexity of the subject of "pharmaceuticals at the service of life," one can only acknowledge and applaud the extraordinary contribution by pharmacology and pharmaceutics to improving mankind's health standards.

The magnificent progress in transplant surgery, immunology, the treatment of nervous illnesses, and longevity and the quality of life — to mention just a few examples — has been possible thanks to advances in drugs.

I have always felt the same sensation since my childhood days, when I would go into the fascinating pharmacies in that period, on seeing pharmaceuticals as the ABCs of science and medical practice. The ethical principles which should preside over drug research, programing, production, distribution, and availability do not represent a fence, but a guide, not a check, but a spur towards research and study of ever new products responding to a universal demand for health.

The science of drugs can do a great deal to erase the injustice whereby, even today, out of 100 persons born the same year, the same month, and the same day around the world, 70 are "forced" to die thirty years earlier than the others.

In Christian language, the term most frequently describing analogically the effects of salvation, spiritual healing, and the recovery of the state of friendship and communion with God is "medicine." A term which has become increasingly up-to-date, since psychosomatic medicine recognizes the part played by the psyche and the spirit in physical illness itself. And, though not wishing to force an analogy which is doubtless of interest, I feel one can assume in the at once instinctive and conscious reaction of shame which is recalled by the Bible a virtual prefiguration of the ancestral search, after sin, for an antidote, a drug, a medicine, a remedy.

The hope with which man has always looked to medical science has constantly been associated with hope and trust in drugs. It would not be difficult, from Hippocrates to the Schola Salernitana, from the early laboratories for medical preparations to the sophisticated pharmaceutical establishments of today, to discover in figurative arts, literature, and folklore a continual reflection of this ancient, deep-seated hope, which is also the truest, most objective, and thrilling praise of medicines, regarded by mankind as the first servants of life.

[1] Cf. *The Proceedings* of the First International Conference sponsored by the Pontifical Council for Pastoral Assistance to Health Care Workers, on "Pharmaceuticals at the Service of Human Life," Rome, October 23-25, 1986, in *Dolentium Hominum*, no. 4 1987), pp. 1-136.

[2] *Ibid.*, p. 6.

[3] John Paul II, Encyclical *Sollicitudo Rei Socialis*, 40

[4] F. Angelini, *Preventive Medicine and High Technology in the First and Third World* (in press).

[5] John Paul II, *Sollicitudo Rei Socialis*, 32

[6] Cf. E. Spaltro-M. Bruscaglioni, *Psicologia organizzativa* (Rome, Aureli, 1967).

[7] R F. Hirschmann, "Innovative Drug Invention," in *Dolentium Hominum*, no. 4 (*Proceedings* of the First International Conference)

[8] G. Battaglino, *Direttive e Raccomandazioni comunitarie in campo farmaceutico* (Milan: Organizzazione Editoriale Medico Farmaceutica, 1987), p. iii.

[9] *Ibid.*, p. iv.

[10] E. Sgreccia, *Bioetica Manuale per medici e biologi* (Milan: Vita e Pensiero, 1983), p. 318.

[11] John Paul II, *Insegnamenti di Giovanni Paolo II* (Libreria Editrice Vaticana, 1983), V/3, pp. 1609-1613.

[12] Cf. *Proceedings. Dolentium Hominum*, no. 4 (1987), p. 7.

Evangelization and the Health Care Ministry

A talk delivered by Fr José Luis Redrado in Bogota, Colombia during the Meeting on the Church and Health in Latin America, October 2-6, 1989, organized by CELAM-DEPAS and the International Federation of Catholic Physicians.

I. What is evangelization?

1. *To evangelize* is to *bear* the Gospel = Good News (*Evangelii Nuntiandi*, 18):

* "The time is fulfilled, and the kingdom of God is close at and Repent, and believe the Gospel" (Mk 1:15).

* The beatitudes (Mt 5): the poor, the meek, those who weep.

* Discourse in Nazareth (Lk 4): "The Spirit of the Lord is upon me, for he has anointed me to bring the good news to the afflicted"

2. *To evangelize* is to proclaim with one's *life* (*silent* proclamation) and one's *testimony* this saving presence of God (*EN*, 21).

* The living word of Christ must take shape in the lives of witnesses.

* It does not involve providing information-culture on Christ.

* It does not consist merely of sharing life with men (to be good professionals, solve problems)

* This testimony prompts certain questions in others:

3. *To evangelize* is to *make explicit* what is hidden, announce with the word, account for our hope (*EN*, 22)

— *There is no true evangelization unless the name, doctrine, life, and mystery of Christ are announced.* It is therefore not a matter of something implicit. Faith must be made explicit.

— The announcement also provokes conversion and adherence in the listener (EN, 24-24).

4. *To evangelize* is *to ensure witness and commitment in life. To celebrate* the Good News and share it (Faith is commitment and mission: it is lived out, celebrated, and given).

5. And one who has been evangelized at the same time evangelizes — he is an apostle and a witness.

The following stages, then, fulfill the objective of evangelization:

1. Testimony (silent announcement)
2. The word (explicit announcement)
3. Conversion
4. Celebrating the saving event
5. We are simultaneously evangelized.

II. Jesus of Nazareth proclaimed this Good News among the poor, sinners, and the sick

1. His Kingdom is not a kingdom of the rich and powerful, but of the humble and sinners: the poor in spirit, those who weep, the persecuted (Mt 5); the little ones, children (Mt 18); sinners: the adulteress (Jn 8), Mary Magdalene (Lk 7), Zacchaeus (Lk 19).

2. The Jesus of the Good News is the Jesus of mercy and welcome: the prodigal son (Lk 15), the lost sheep (Lk 15), the Good Samaritan (Lk 10).

3. But it is alongside the sick that the figure of Jesus is surprising, marvellous, close at hand, expressive, and full of salvific manifestations:

* The Gospel tells us that Jesus went through Galilee, teaching and healing; his fame spread, they brought him the ill, and he cured them (Mt 4).

* People were amazed and exclaimed: He has done everything well; he makes the deaf hear and the mute speak (Mk 7:37).

* Jesus certainly did not cure everyone, but he communicated salvation to all he met; among these were many paralytics, deaf, blind, lepers (Mt 8, 9, 11; Mk 5; Jn 5).

* Jesus' words caused surprise: "I am willing Be cleansed" (Mt 8:13); "Do not be afraid; only have faith" (Mk 5:36). But, above all, his gestures and silences were surprising: the way he sees, attends, respects, pauses (Jn 8:1-11; 9; Mt 9:18-16) These words and these signs aroused astonishment and admiration.

* Another point I wish to stress is Jesus' capacity to reintegrate, employ, share, and develop the qualities of those he cured, in the face of society's exclusion; the cured sick person found his place once again (Mk 1:40-45; Lk 7:13; Jn 5:5-9).

* The presence, evangelization, and cures of Jesus thus manifest the arrival of the Kingdom

III. From Christ the Evangelizer to the Evangelizing Church

1. The evangelizing action of the Church springs from the evangelizing action of Christ (Mt 28:19; *Ad Gentes* 1 and 35; *LG*, 5; *EN*, 13 and 14)

2. The Church exists to evangelize, be a channel, celebrate. Her role is to announce, communicate the Good News She is the continuation of the evangelizing action of Jesus:

"He called the Twelve together and gave them power and authority over all devils and to cure diseases, and he sent them out to proclaim the kingdom of God and to heal" (Lk 9:1).

"So they set out and went from village to village proclaiming the good news and healing everywhere" (Lk 9:6), "... and they cast out many devils and anointed many sick people with oil and cured them" (Mk 6:13).

3. The Church has received Jesus' example of mercy and must embody it with words and gestures For this reason she is sent specifically to the world of health care to recall that health and illness are facts of life which must be integrated and given meaning; another aspect involves making known the values of the sick person, along with collaborating to create a more humane, worthy place for the care of the sick.

4. What we are speaking of has been lived out — with its brighter and darker spots — by many religious and lay groups as witness to the fact that the charism of service to the ill is alive. The history of the Church offers abundant testimony of this

IV. Our Response

1. This sending by Jesus of his Church is a real commission, a duty, an obligation

2. If the Church has always borne this reality in mind, she is particularly aware today of her concrete duty to evangelize and do so in the manner of Jesus:

a) The Second Vatican Council insists on this commission as follows:

* "In fulfillment of their duty as pastors..., let them treat the poor and the ill with paternal solicitude" (*CD*, 30).

* "...Priests ought to be especially devoted to the sick and the dying, visiting them and comforting them in the Lord" (*PO*, 8).

* They should seek Christ mainly in the poor, the sick..." (*OT* 8; *AA*, 8; *PC*, 10; *LG*, 28 and 46).

And Vatican II also addressed Christian lay people in these terms:

* The Christian vocation, by its very nature, is a vocation to the apostolate ... The lay person lives in the midst of the world and carries out his apostolate therein like yeast (*AA*, 2).

* Christians have a right to the apostolate through their union with Christ the Head, inserted by Baptism and strengthened by Confirmation (*AA*, 3)

* It is not just a question of announcing the message of Christ, but of impregnating and perfecting the whole temporal order with the Gospel spirit. This announcement must be revealed with words and deeds (*AA*, 4 and 5).

b) The current Pope, John Paul II, lives out this evangelical concern for the sick like no one else, manifesting it constantly and stressing it in two aspects of great transcendence for the entire Church: the publication of the Apostolic Letter *Salvifici Doloris* (February 11, 1984) and the creation of the Pontifical Council for Pastoral Assistance to Health Care Workers (February 11, 1985)

c) Here, in Latin America, the Puebla Meeting (1979) signified, above all, this Gospel orientation of a "preferential option for the poor, the sick" (*DP*, 26, 29, 32, 58)

3. All of this becomes urgent today. The Church must face the challenge presented by society, and here, in Latin America, that challenge is quite marked. If the Church does not want to content herself with a presence like that of the past, but seeks to be adequately, genuinely, and significantly "involved" in the current world, she must not lose sight of the phenomenon of profound change which has occurred and must still occur on a technical, structural, relief-oriented, and social level; the health sector is burdened today like no other by conflicts, progressive dehumanization, and an intense climate of secularism.

Particularly in Latin America, the problem is aggravated by the economic crisis and health facilities which are insufficient to guarantee the right to health for all citizens.

4. The Church's presence in the health field cannot be reduced to religious-sacramental assistance, but requires actions aimed at changing health policies to favor the neediest.

The evangelization of the world of health demands a prior knowledge of the real situation and its various repercussions.

The division into developed, underdeveloped, and developing countries is by now classical. In the health field, Latin America has standards far below what is humanly acceptable.

The following statements are more than sufficient:

* Nearly half the homes on the continent fail to meet minimum calory needs, prejudicing physical and intellectual performance.

* Nearly half the total population of Latin America does not have drinkable water available. This notably affects the extent of gastrointestinal diseases and general conditions of hygiene.

Children are affected most by inhuman living conditions, which cause the number of deaths in the 0-to-5 age group to increase. The infant mortality rate rises as a result of bronchial illnesses, diarrheas, parasites, and so on.

Hospital, medical, dental, and nursing services are insufficient, especially in rural areas and on the outskirts of cities. There tends to be elitist, high-priced health care (cf. CELAM-SIDEAT, *Towards a Pastoral Map of Latin America*, Bogota, 1987).

The Most Rev. Dario Castrillon, President of CELAM, in a meeting held in Dallas, Texas, February 9-13, 1987, explained the Latin American health situation to over 150 bishops in the following terms:

* The Latin American population is predominantly young. Between 27% and 44% of the population is under fifteen, and only 2% to 10% is over sixty-five. Average life expectancy is, however, quite modest, ranging from 51 to 72, according to the country.

The health of the Latin American population is very fragile, and, according to UNICEF, more than half the deaths could be avoided. General mortality is very high, though it is noticeably diminishing. In 1950 it reached 14.7 per 1,000 per year, but decreased to 7.7 per 1,000 in 1980.

Infant mortality varies from one country to another, ranging from 22 to 200 deaths in the first year of life for every thousand births.

The illnesses responsible for most deaths are not modern, but of the kind eliminated many years ago in the developed countries: diphtheria, whooping cough, measles, poliomyelitis, typhoid fever, yellow fever, malaria, tuberculosis, ulcerastion, and leprosy.

In spite of being made up of some of the best-endowed countries for food production, Latin America offers a now chronic picture of food shortages. In 1970 28 million children under age five suffered from malnutrition, and among those who died this was the leading cause. Today 52% of the population displays deficiencies in nutrition, with a marked caloric-proteinic deficit.

All Latin American countries have a health system, but not all have a health policy tending over time to meet the needs of the entire population through integral medical services. One of the ways these countries have found to provide a certain protection in this field is the institutionalization of social security, which, though still deficient, furnishes complete services for urban workers and generally partial coverage for their dependants and for rural workers.

The allocation of resources for health is inversely proportional to needs. Only 2 to 10 percent of the gross national product is devoted to it — less than half the amount in developed countries.

The greatest problem affecting health services, however, and thus the Latin American population, is the complete predominance of curative over preventive medicine, on an 8-to-1 basis.

Hospitals are responsible for more than 80% of care in nearly all Latin American countries. The predominance of curative over preventive medicine has been recognized since 1910 as being obsolete. Since then no one has doubted that prevention is the most rapid, simple, and economical solution to health problems.

Another important problem — arguing against hospital care — is the failure to use the natural products which are so abundant and rich in every country. Industrial pharmaceutical products are widely used, and some countries manufacture more than 20,000 different varieties, though the catalogue distributed by WHO with less than 300 products is known.

Health is closely related to socioeconomic factors. This influence is mainly detected in the following:

* Living conditions include inadequate nourishment, principally because income has little or no purshasing power.

* A lack of hygiene and basic conditions of salubrity as a result of crowding, hovels, *favelas*, or shantytowns, since it is impossible to come by housing.

* In the year 2000, half of the Latin American population will live in hovels. Far from disappearing, the housing shortage is worsening, with the precarious living conditions of vast sectors

affected by accelerated demographic growth and migration from the countryside to the city.

* Infectious diseases are propagated by the lack of drinkable water and sewers.

* Degenerative diseases result from violence and environmental pollution in the large cities (cf. the journal *Selare*, 38, March 1989).

5. The health care ministry, as service and assistance to concrete individuals, should be faithful to the language of God, but also to that of men, to their real needs. And if ministry is a creative and dynamic task, the Church must always go on reflecting and acting. Pedagogue Pablo Freire says that ministry is a praxis, i.e., action through reflection seeking to transform life.

The novelty is that pastoral action should be felt as a problem by all. And this always lights up new paths

" ...The whole creation is waiting with eagerness for the children of God to be revealed..., groaning in labor pains" (Rm 8:19-22)

V. Pastoral Directions

1. *Promoting justice.* Justice is the basis for true love In a world divided into blocs — rich/poor, healthy/sick, etc. — oppression is easier The struggle to transform all injustice and oppression into liberating hope is a challenge largely presenting itself today to the Church in our Latin American countries Differences in the health field are so great that we cannot remain with our arms folded.

2. *Preferential option for the poor.* This was the way of Jesus The Church here encounters a vast zone where States — above all, in these countries — will take many years to become active.

3. *Stimulating the health care ministry in particular*

a) *John Paul II summoned the Christian community* in his message to the sick during his first visit to Spain:

"To make the pastoral care of the sick more effective, it is necessary that the whole Christian community should feel called to collaborate in this task.

"Here there is a place for the members of the Church or religious organisms, Catholic lay associations and movements; here the parishes have a place, called to spur specific apostolic and volunteer groups assisting the ill. In this way the Christian community will make Christian love present in our increasingly secularized society."

b) *The sick person as protagonist*

"In the Church, the sick, by their testimony, should remind others of the value of essential and supernatural things and show that men's mortal lives are to be redeemed through the mystery of the death and resurrection of Christ" (*RE*, 5-7).

The ill invite us to rectify our scale of values They do not lead us towards superficial or functional behavior They remind us of the whole truth of our lives, inviting us to recognize and accept the fact of death and taking us to the depth of our faith. The Pope in Spain said that we need the sick person: "And, in addition, for us you are a constant lesson inviting us to relativize so many values and ways of life. To live out the Gospel values better and develop solidarity, goodness, assistance, love "

c) *Sacramental renewal*

"In recent decades, the celebration of the Sacrament of the Sick has undergone profound transformations. We have witnessed, on the one hand, a progressive overcoming of sacramentalism and, on the other, a significant decrease in requests for the sacraments. Both phenomena, together with liturgical reform, have stimulated a better understanding of the sacraments and a more intense search for models for celebration which are suited to the secularized and pluralistic health care context

"By means of Reconciliation, the Anointing of the Sick, and the Eucharist the patient is helped to live out the Paschal meaning of illness. The importance of these instruments of the Lord's redeeming love prompts a special commitment on the part of the pastoral worker" (cf. Spanish Bishops' Pastoral Commission, *La asistencia religiosa en el hospital*, Madrid 1987, no. 68)

d) *Pastoral care through life*

I have had the chance to experience the generous, self-sacrificing, and joyful dedication of so many religious, especially in Africa, India, and Latin America. This "consistent and faith-directed" presence is an authentic sign of ministry and salvation; the Kingdom becomes real and grows through consecration, life itself This is the great strength of the Church, particularly in poor countries, since the signs are clearer, less ambiguous

e) *Health, a meeting place*

Under this heading we could narrate many experiences The discovery that health, illness, the hospital, and the patient are a universal meeting place where barriers, languages, and political and religious ideologies collapse. A universal place, common to all, a summons, a platform, a visiting card Isn't this something grand? Isn't it a means the Church is holding in her hands and must know, discover, and put into action? In the local Chueches we have greatly insisted on this idea, for it is a mediation of the first order. In addition, it is the richest example we have from Jesus of Nazareth: he was always in contact with the sick — "I have been sent to bring the Good News to the poor" (cf. Lk 4:18). Those who are poor in terms of money, intelligence, human resources, and health.

f) *Opening the universal*

The Church is not Rome, Spain, Austria, or Europe The Church is greater — it is universal. This means that it is in many places and is composed by many people, ideologies, and cultures. Such variety and contrast is a genuine wealth and helps us to discover that there is not just one model for pastoral action; it helps us to grasp that what may be suitable in one place does not fit in or function in another. This experience, lived out and contrasted through numerous encounters, makes us less rigid and more universal.

g) *In communion with the Magisterium of the Church*

"The function of interpreting the Word of God, whether written or passed on, is entrusted to the *Magisterium of the Church*... and in adhering to this deposit (Tradition and Scripture), the People of God perseveres in the teaching of the Apostles" (*Dei Verbum*, 10), *"in breaking bread and in prayer"* (Ac 2:42), joined to its Pastors.

Christian obedience, "whether to the solemn Magisterium of the Church or to her ordinary and universal Magisterium — that is, the teaching manifested through the common adherence of the faithful under the guidance of the Sacred Magisterium" (Canon 750) — favors *communio Ecclesiae* as a living expression of her *unity*

Pastoral communion is not a vague sentiment. It is "an organic reality whose soul is charity" ("Nota Praevia," *LG*, 2) Calling us to obedience — sometimes at the price of many sacrifices — the Church, *Mater et Magistra*, wants to teach us a profound truth, i.e., her love, which is a synonym of her unity. Here the very essence of the mystery of the Church is outlined as a *"sacrament or sign and instrument of intimate union with God and of*

the unity of the whole human race" (*LG*, 1). It is here that the theological ground for the obligation to conserve *communion with the Church* at all times is found (Canon 209)

One of the founding aims assigned to our Pontifical Council for the Health Care Ministry by Pope John Paul II is the essential mission of safeguarding and encouraging in the local Churches this communion with the Magisterium of the Church in this vast sector of life represented by health, illness, and death, which present such delicate questions today (cf. *Dolentium Hominum*, no 6)

VI. Getting Down to Details

You can advance only if you know where you are In the health care ministry it is true that in recent years we have come a great way everywhere, though in some places more than in others; some stress organization and ideas, and others, life experience, and, of course, still others have managed to combine the two facets. Neverthheless, there is a great deal to be discovered and carried out; there are localities where a beginning still has to be made and others which started only a short time ago Some, however, have a number of years of reflection and activity behind them.

In looking towards the future, and on the basis of my experience over the last three years, I would pay attention to the following needs:

* The creation by each Bishops' Conference of a coordinating group to encourage this pastoral area, since the appointment of a bishop in charge of it is not sufficient

* To train people through a "Master's Degree in the Health Care Ministry" by making use of the Camillianum Institute in Rome, which offers studies in the Pastoral Theology of Health Care.

* To update those now devoted to this pastoral work.

* To train and stimulate a Volunteer Service for the health care ministry.

* To take into consideration in the training and programs of seminarians this pastoral field (the 1990 Bishops' Synod will deal with priestly formation and may offer a good occasion) Our Office has prepared and sent a document on the subject, as it did for the past Synod on the Laity

* All of these aspects would spur us towards a real change: accentuating evangelization over the sacramental dimension and making use of the new techniques for organization, integration, leadership, listening, and dialogue; there is a notable need for them universally

* To carry out serious reflection as well on the Church's religious institutions devoted to health care; I believe it is an immense force which has barely been taken advantage of. In this regard, we must discover new values, new ways of being present, and new styles.

* The pastoral worker needs to be trained in bioethics. This field cannot dispense with such training I feel a new mentality is emerging and that the establishment of bioethics centers and ethics committees will be a help.

* Finally, we must not forget that medicine and related sciences change swiftly; for this reason Church members in health care environments should not miss any opportunities and keep constantly up-to-date.

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Meetings

UNITED STATES

Three Large Cities, Two Objectives

Archbishop Fiorenzo Angelini and Fr. José Luis Redrado, President and Secretary, respectively, of the Pontifical Council, made a pastoral trip to the United States, September 11-17, 1989 The heavy program, in addition to both Church and government meetings, was especially devoted to visiting certain Catholic hospitals caring for AIDS victims.

New York: Accompanied by Monsignor James Cassidy, they visited two hospitals, St Clare's and St Vincent's, and the Terence Cardinal Cook Health Care Center, where they met and conversed with AIDS patients There were also several meetings with groups of Catholic physicians and health workers in different areas of care

Another important meeting took place at the New York Medical College, whose Chancellor is Monsignor Cassidy.

An interview at NIAF, the prestigious association of Italians in the United States, should be mentioned as well, along with Secretary General Gajarsa.

Boston: Massachusetts General Hospital, St Elizabeth's, and St Margaret's were visited. Attention was also paid to AIDS victims through both visits and meetings with leading figures in the social and medical fields who were informed about the activity of this Pontifical Office.

The visit concluded with a meeting with the leading officers of ARES Serono.

The stay was brief, but intense and fruitful for the objectives of our Council.

Washington: The visit to the AIDS patients at Mother Theresa of Calcutta's House of Peace made a special impression and proved to be deeply moving. The community of nuns participated in the Eucharist presided over by the Most Reverend Pio Laghi, Apostolic Pro-Nuncio in the

United States, which was a moment of profound emotion for the sick and the generous souls that consume their lives to help bear uncommon suffering in a fraternal and Christian way

In Washington there were numerous contacts with government officials concerned with health and some scientists whose collaboration was enlisted for the development of the institutional activity of our Pontifical Council in the near future.

The principal meetings were with:

* Dr. Louis W. Sullivan, Secretary of the Department of Health;

* Dr. David Nexon, Health Advisor of Senator Edward Kennedy;

* Dr. Cohen, Consultant to the House Committee on Energy and Consumer Affairs;

* Dr. Timothy Westmoreland, Consultant to the Subcommittee on Health and the Enviroment;

* Dr. Bill Roper, President Bush's Health Advisor (whom we visited at the White House);

* Dr. Robert Gallo, Director of the Tumor Cell Biology Laboratory at the National Cancer Institute in Bethesda;

* Dr. Edmund Pellegrino, Director of the Center for the Advanced Study of Ethics at Georgetown University;

* Dr. Robert K. Grey, Chairman, Hill and Knowlton Public Affairs Worldwide Company;

* Dr. Erminio Costa, Director of Fidia, Georgetown Institute of Neurosciences

We must devote a special word of thanks to Professors A. Turano and G. Frajese, along with Dr. Florimonte, for their kind assistance, which contributed to making the trip a success.

This new pastoral visit to large American Archdioceses proved quiet positive and was rich in experience helping our International Conference on AIDS at the Vatican, November 13-15, 1989.

We participated in interviews which had been prepared with generous care by Cardinal Archbishops O'Connor, Law, and Hickey, as well as the Most Rev. Pio Laghi, Apostolic Pro-Nuncio. We convey to them our heartfelt gratitude. The interest they have taken in us is a sign of their valuable efforts to fulfill the desires of John Paul II to be at the service of those suffering in the world.

BOGOTA (Colombia)

Church and Health in Latin America

A conference devoted to "Church and Health in Latin America" gathering together representatives of eleven countries was held in Bogota, October 2-6, 1989

The Conference was prepared and coordinated by *CELAM* and *FIAMC* (International Federation of Catholic Physicians, Latin American Section)

The Pontifical Council for Pastoral Assistance to Health Care Workers was represented by its Secretary, Fr. José L. Redrado, who was accompanied by Professor Franco Splendori, Consultor of the Council.

The meeting began with a short prayer presided over by the Most Rev. Augusto Aristizabal, the bishop responsible for the health care ministry in Colombia. Fr. Redrado then read the Message signed by Cardinal Casaroli in which, on behalf of the Pope, he greeted all the participants and encouraged them to carry out pastoral action which would be increasingly involved with the health field, still burdened with concrete deficiences because of a lack of resources, but which should be enthusiastically and hopefully stimulated

There followed words of welcome by the Most Rev. Guillermo Melguizo, Assistant Secretary of *CELAM*, and Dr. Hugo Obiglio, Vice President of *FIAMC*.

Those present devoted attention to three major topics:

1. "Approach to Health Realities in Latin America." This reflection faced the leading questions, above all, starting from concrete reality as previously determined by different groups and illuminated by two lectures: "Health and Society in Latin America," by Dr. Juan Jacombo Muñoz, former Colombian Health Minister, and "Evangelization and the Health Care Ministry," by Fr. Redrado.

2. "The Great Challenges." This included the problematic for the Church in dealing with ethics and medicine, psychiatry and pharmacology, the handicapped, the elderly, terminal patients, and organ trasplants. This meditation was intense and enlightening in both the content of papers and exchanges based on experience.

3. "Responses." What to do here and now was the third and final topic. Humanization and pastoral care, the organization of Catholic physicians, and the doctrine of the Pontifical Magisterium were the subjects pointing to some kind of response, aside from the propositions and recommendations of a practical nature addressed to *CELAM*, the Latin American Bishops' Conferences, *FIAMC*, and other Catholic medical organizations.

The meeting as whole must be seen in terms of not only reflection in these days, but, above all, its meaning, attaining awareness with a view towards the future — it is important to stress this point, for it was part and parcel of the Conference. We feel the participants returned to their respective countries stimulated by the abundance of activities being carried out and encouraged for richer action.

The horizons are vast. We know there are problems, but there is also a great deal of enthusiasm.

ROME

Two Encounters of Interest

1. The Seventh Symposium of European Bishops

The Seventh Symposium of the European Bishops, devoted to "Contemporary Attitudes to Birth and Death: A Challenge for Evangelization," was held in Rome, October 12-17, 1989; it was organized and coordinated by the European Council of Bishops' Conferences, whose president is Cardinal Carlo Maria Martini, Archbishop of Milan.

Seventy-five bishops participated, along with some of the secretaries of the Conferences and those representing religious, priests, lay people, expert opinion, and the different Departments of the Roman Curia. Our Council was represented by its Secretary, Fr. José L. Redrado.

The Symposium centered its reflection on three major papers, which were then discussed in the auditorium and meditated upon

in groups: "The Beginning and End of Life," "Birth and Its Evangelization: Yesterday, Today, Tomorrow," and "Contemporary Attitudes to Death: A Challenge for Evangelization." These papers, along with the magnificent Introduction and, above all, the brilliant final Summary presented by the President, Cardinal Martini, constituted the doctrinal content which served to assist those attending.

We feel the Symposium has made an effort to clarify certain concepts and has especially helped the Pastors of the local churches in Europe to reflect on two important aspects of our society, two privileged moments for evangelization: birth and death.

The closing ceremony of the Symposium was marked by the Holy Father's visit.

Pope John Paul II addressed the bishops and other participants, inviting them to announce Christ, the Lord of life, in the awareness that we are at the same time fighting for man.

2. Visit to AIDS Patients

On Sunday, October 22 the Pontifical Council carried out visits to several medical and residential facilities for AIDS patients in Rome. Archbishop Fiorenzo Angelini and Father Redrado, accompanied by Professor Carlos Peruci and Franco Splendori, visited AIDS units at three hospitals (the Gemelli Polyclinic, the Umberto I Polyclinic, and Spalanzani Hospital) and three homes (Padre Monti House, coordinated by the Sons of the Immaculate Conception, Villa Glori, and Don Orione House — the latter two are coordinated by Diocesan CARITAS). Through hospital care, including day hospitals and clinics, patients are treated in their acute phase; at the homes, patients are usually in an intermediate phase and mantain contact with a hospital.

Our experience was enriched by this visit in close contact with the sick, whom we greeted on a one-to-one basis in nearly all instances; there was also open and cordial dialogue with health personnel caring for them: doctors, nurses, and volunteers. At Villa Glori, after visiting the patients and the house, we had lunch with everyone, an occasion which enabled us to expand our dialogue and become better acquainted with the dedication, generosity, and joy of those serving the AIDS victims.

Journals

We wish to offer our readers a list of journals, some of which are regularly received at the offices of *Dolentium Hominum*. We have selected those dealing most directly with the world of health care, grouping them under four general headings and also indicating the language in which they are published. We trust that this will be of service to our readership.

I. THEOLOGY, PASTORAL CARE, AND ETHICS

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English

"INTERNATIONAL REVIEW"
The Human Life Center
Unviersity of Steubenville
Steubenville
U S A.

German

ETHIK in der Medizin
Springer Verlag
Heidelberger Platz 3
D-100 Berlin 33

ARZT UND CHRIST
Vierteljahrszeitschrift für medizinisch-ethische Grundsatzfragen
Schwabenverlag
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D-7302 Ostfildern

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MEDIZINSOZIOLOGIE
Zeitschrift der deutschen Gesellshaft
für Medizinische Soziologie
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